STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675792	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mansfield Nursing & Rehabilitation Center	1402 E Broad St Mansfield, TX 76063

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 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** 44970 Based on observations, interviews, and record review the facility failed to provide a safe, clean, comfortable, and homelike environment for 6 (Resident's #7, #8, #9, #10, #11, and #12) of 8 residents reviewed for environment sanitation and safety. The facility failed to ensure Resident #7's portable toilet was emptied after use and soiled briefs and wipes were discarded after completing incontinent care. The facility failed to ensure trash was discarded from the adjoined restroom for Resident's #8, #9, #10, and #11 to a biohazard waste location upon incontinent care. The facility failed to ensure hardware from a dis-assembled nightstand draw (exposing loose boards, screws, and metal frame) was removed from Resident's #12's environment. This deficient practice could result infections due to unsanitary environment, injuries, and/or accidents while propelling and ambulating independently in the facility. Findings included: Record review of Resident #7's face sheet, dated 08/16/24, revealed the resident was a [AGE] year-old female with an initial admitted [DATE]. Diagnoses included COPD, hypo-osmolality (low concentration of sodium in the blood), hyponatremia (low concentration of sodium in the blood), functional dyspepsia (reoccurring stomach symptoms), major depression disorder, cough, neuralgia (pain in the nerve) , and neuritis (nerve pain) nausea, anemia (water retention), pain, insomnia, and acute and chronic respiratory failure with hypoxia (inadequate gas exchange by respiratory system.) Record review of resident #7's Quarterly MDS dated [DATE] reflected a BIMS score of 12 indicating she was moderately impaired. Resident required staff assistance for hygiene, toileting, and bathing. The MDS reflected the resident was on oxygen. Record review of resident 7's Care plan dated 05/15/24 reflected resident requires dressing/grooming amount of assist:1 Resident care as per facility protocol . Toileting amount of assist: 1. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #8's face sheet, dated 08/15/24, revealed the resident was a [AGE] year-old male with an initial admitted [DATE]. Diagnoses included Cerebral Palsy (group movement disorder), Cerebellar ataxia (lack of voluntary coordination of muscle), Psoriasis (long lasting non-contagious autoimmune disease), and Intellectual Disability Disorder (learning disabled) Record review of Resident # 8's quarterly MDS dated [DATE] reflected a BIMS score of 6, indicating he was impaired severely cognitively, required total assistance for ADL, incontinent care. MDS addressed diagnosis. Record review of Resident # 8's quarterly care plan 05/23/24 reflected he was PASSR positive and has a diagnosis of Severe intellectual disability with expected decline in cognitive impairment over a period of time. He has impaired communication, Record review of Resident #9's face sheet, dated 08/16/24, revealed the resident was a [AGE] year-old male with an initial admitted [DATE]. Diagnoses included Polyneuropathy (damaged nerves in two areas), DM 2(unstable blood sugar levels). Record review of Resident # 9's Entry MDS dated [DATE] reflected a BIMS score of 9, indicating he was impaired moderately cognitively, required supervision and touching assistance for toileting. The resident's MDS addressed diagnosis. Record review of Resident # 9's base line care plan 08/14/24 reflected resident observation for needed additional care needs, monitor blood sugars every meal, and offer stacks between meals. Record review of Resident #10's face sheet, dated 08/15/24, revealed the resident was a [AGE] year-old male with an initial admitted [DATE]. Diagnoses included Cerebral infarction (stroke) History of falling, Depression (mood) and Encephalopathy (disease of the brain). Record review of Resident # 10's Entry MDS dated [DATE] reflected a BIMS score of 10, indicating he was impaired moderately cognitively, required total assistance for ADL and hygiene care, incontinent care. MDS addressed diagnosis. Record review of Resident # 10's initial care plan 07/28/24 reflected he was at risk of falling, infections, anti-depressant medication monitoring. Record review of Resident #11's face sheet, dated 08/15/24, revealed the resident was an [AGE] year-old male with an initial admitted [DATE]. Diagnoses included Acute Kidney Failure, Cerebral Infarction (stroke), Major Depressive Disorder (mood). Record review of Resident # 11's Entry MDS dated [DATE] reflected a BIMS score of 9, indicating he was impaired moderately cognitively, required substantial to maximal assistance with toileting. Record review of Resident # 11's initial care plan 07/28/24 reflected he was at risk of falling with last fall on 05/10/24, interventions in place to educate resident to use call light and wait for help. infections, anti-depressant medication monitoring. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #12's face sheet, dated 08/16/24, revealed the resident was a [AGE] year-old male with an initial admitted [DATE]. Diagnoses included Hemiplegia and hemiparesis (paralysis) affecting his left side, Vascular Dementia(dementia caused by a series of strokes), Cognitive communication deficit (difficulty communicating.) Record review of resident #12's MDS dated [DATE] reflected a BIMS score of 9 indicating he was moderately impaired cognitively. Resident required substantial assistance from staff for hygiene, toileting, and bathing. The MDS reflected the resident was on oxygen. Record review of resident 12's Care plan dated 05/15/24 reflected resident has weight loss, in the last 30 days. He has a history of falling, at risk of elopement and wanders due to diagnosis of vascular dementia. He wears a roam alert bracelet. In an observation on 08/15/24 at 10:35 AM of Resident #7's room, there was a portable toilet filled with a liquid yellow substance with the lid raised up. Observed a small trashcan next to the portable toilet, which was filled with soiled incontinent supplies (tissue, wipes, brief, and incontinent pad). No ordor was present in the room. In an observation on 08/15/24 at 2:45 PM, the adjoined bathroom for Residents #8, #9, #10, and #11 the trashcan was observed with soiled incontinent supplies (brief, wipes, and incontinent pad). No odor was presen in the restroom. In an observation of Resident #8 on 08/15/24 at 10:50 AM revealed he was not interviewable due to a communication deficit. In an interview and observation of Resident #10 on 08/15/24 at 10:55 AM revealed resident lying in bed, and the staff were assisting him with incontinent care. In an interview and observation of Resident #9 on 08/15/24 at 10:58 AM revealed resident walking with a walker, stated the staff does assist him with incontinent care and clean the restroom afterwards. Observed and interviewed Resident #11 on 08/16/24 at 11:30 AM in the dining room engaged with other residents. He confirms that the staff assist with incontinent care. In an observation of Resident's #12's room on 08/16/24 at 10:00 AM and 4:30 PM, there was a nightstand drawer, which was unassembled with sharp metal hardware components (exposing loose boards, screws, and metal frame) left on Resident's #12's bedside table. In an observation and interview with Resident #12, on 08/15/24 at 11:55 AM, revealed him sitting outside his room door in this wheelchair. An interview was attempted; however, he did not respond to detailed questions. He stated he was treated well. In an interview with LVN O on 08/15/24 at 2:55 PM revealed that he did not know that the restroom trashcan was filled with soiled incontinent supplies. LVN O said he monitored the environment and care tasks for CNA's during his shift. He completed rounds every 2 hours and expected the aide to as well. He said that during his rounds he did not check the restroom. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with CNA Z on 08/16/24 at 10:40 AM stated that residents were expected to be assisted by staff during incontinent care. CNA Z said that the portable toilet should be cleaned and emptied immediately after completing the incontinent task to prevent infections. CNA Z said that all of the soiled supplies should be discarded in a plastic bag and removed from the room. She stated that the nurse should be informed that maintenance equipment was left out and accessible to residents. CNA Z stated that residents could injure themselves by interacting with the equipment left behind. CNA Z said she did not observe the items when entering the room during the rounds. CNA Z said all nursing staff were responsible for resident safety and reporting environment hazards to prevent falls, injuries, cuts, abrasion, and resident tapering with sharp materials. She did not observed the drawer in the room. In an interview with CNA R on 08/16/24 at 11:00 AM, she said she was assigned to the room. She did not check the bathroom for sanitation. She conducts frequent patient rounds and assist residents with incontinent care. She stated all supplies should be discarded in a plastic bag and discard in the BW (feces, bowel, urine, manure .) location to prevent cross contamination. She had not assisted a resident during her shift with incontinent care. In an interview with the DON on 08/16/24 at 4:25 PM revealed that she expected all nursing staff to conduct regular environment and patient rounds, and to assess the environment for sanitation and hazards to residents. The staff would be expected to report environmental and maintenance concerns immediately to maintenance and submit work orders. The DON stated she expected the nursing staff to immediately disinfect, sanitize equipment before and after toilet use, assist the resident with hygiene to wash hands, doff gloves, place all biohazard waste, soiled incontinent supplies in a plastic bag, close bag tightly, discard gloves and bag in the biohazard location. The DON stated that the charge nurse, the ADON, and the DON were responsible for monitoring the ADL and toileting environment and sanitation task efficiently to prevent infections and injury hazards to residents and staff. The staff are responsible for conducting resident care and environment rounds. All safety hazards should be reported to the Maintenance Director immediately to prevent injuries to wandering residents. She expects the leadership to be checking, and will be conducting in-services to address the concerns. In an interview with LVN L on 08/16/24 at 4:30 PM, she stated that all nursing staff were responsible for reporting environmental concerns, such as sanitation, hazards, and potential hazards to residents and staff. Incontinent care should be completed immediately after the resident was clean and safe, and discarding in the BW (feces, bowel, urine, manure .) room to prevent infection. The staff are responsible for conducting resident care and environment rounds. All safety hazards should be reported to the Maintenance Director immediately to prevent injuries to wandering residents. LVN did not observed the metal parts on the night stand during rounds. In an interview with Maintenance Director (MD) on 08/16/24 at 5:07 PM, revealed the hardware of the drawer located on Resident #12's bed side table must have been left by the manufacturer or whoever moved the resident out. He agreed that the materials left out were a hazard and he would remove them immediately. He said during staff nursing rounds when hardware and other safety hazards were observed he should be notified immediately and submit a work order. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility policy dated February 2018 titled bedside commode, offering/removing. The purpose of this procedure is to assist the resident with using a bedside commode. Assemble the equipment and supplies needed. Equipment and Supplies The following equipment and supplies will be necessary when performing this procedure: Portable bedside commode; Bedpan; Disposable bedpan cover or paper towel; Toilet tissue; Wash basin; Soap; Towel; Wash cloth; and Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed). Steps in the Procedure .When the resident calls that he or she has finished, return to the room. Wash your hands. Put on gloves. Fill the wash basin one-half (1/2) full of warm water. Place the wash basin on the bedside stand within easy reach. This water will be used to wash the resident's hands. Help the resident clean him or herself with toilet tissue or warm water and a washcloth Remove gloves and wash your hands. Close the cover on the commode. Apply gloves. Allow the resident to wash his or her hands. (Use wash basin or clean wash cloth. Be sure water in basin is clean.) Take the bedpan into the bathroom. Check the feces or urine for unusual appearance. Measure and record output. Collect specimens as instructed. Empty and clean the bedpan. Wipe down the portable commode. Store it in its designated storage area. Remove gloves. Wash and dry your hands. Clean wash basin and return to designated storage area. Wash and dry your hands.

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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** 44970 Based on observations, interviews, and record review, the facility failed to ensure that respiratory care was provided consistent with professional standards of practice for one (Resident #1 and #7) of 3 resident reviewed for respiratory therapy. 1. The facility failed to ensure Resident #1's NC was stored in a clean bag and dated (bag was spotted with liquid white and brown substance). 2. The facility failed to ensure Resident #7's oxygen concentrator filter was clean and free of dust, crumbs, and white particles, and the humidifier water bottle was not dated. These failures could lead to respiratory infections, poor air quality, and not having their respiratory requirements met. Findings included: Resident #1 Record review of Resident #1's face sheet, dated 08/16/24, revealed the resident was a [AGE] year-old male with an initial admitted [DATE] and a re-admitted [DATE]. The resident's diagnoses included metabolic Encephalopathy (disease of the brain) COPD, emphysema (chronic lung disease that causes SOB), wheezing, (course whistling sound produced in respiratory airways during breathing), shortness of breath (not being able to breath), acute and chronic respiratory failure with hypoxia (inadequate gas exchange by respiratory system.). Record review of Resident #1's quarterly MDS dated [DATE] reflected a BIMS score of 10 indicating he was moderately impaired. The MDS reflected the resident was on oxygen. Record review of Resident #1's Care plan dated 05/15/24 reflected a medical diagnosis of COPD exacerbation (worsening of disease) Edited: 08/15/2024 interventions: assist the client to assume a position of comfort (elevate the head of the bed) as needed auscultate (listen to lung sounds) and breath sounds. Note adventitious breath sounds (wheezes, crackles) .Resident requires oxygen therapy R/T COPD. Edited: 08/15/2024 interventions, administer oxygen at 2-4 L via nasal cannula. Monitor and report signs of hypoxia (cyanosis, tachypnea (breathing rate), SOB, confusion, restlessness, nasal flaring, elevated blood pressure, increased respirations, increased pulse). Monitor/document respiratory status every shift. Observe oxygen precautions. Record review of Resident #1's physician orders dated 08/16/24 reflected nasal canula (continuous): O2 at 3-4 L/min every shift. Record review of Resident #1's progress note dated 08/15/24 at 3:17 PM, by LVN B, reflected Resident is post readmit day 1 today with primary DX: Acute Chronic Respiratory Failure with Hypoxia (area deprived of oxygen and Hypercapnia (abnormal elevated levels of carbon dioxide in the blood.) Resident is alert and oriented x 2 with confusion. Respiration noted even, resident is left BKA. Resident remains on oxygen@4 L via nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's August 2024 MAR/TAR dated 08/16/24 reflected Monitor oxygen humidification bottle every shift, Replace or refill as required every shift .change oxygen tubing, canula/Mask once a week. Once a day on Sunday, dated 08/16/24-Open ended) .oxygen concentrator filter: clean concentrator filter weekly. Wash with mild soap and water, dry with towel and replace once a day on Sunday. The TAR from August 2024 did not reflect documentation that the nursing staff had performed these medical tasks ordered by the MD. Observation on 08/16/24 at 10:36 AM revealed Resident #1's NC mask was stored in a plastic bag hanging on the wall with a camouflage hat stored inside. The outside of the bag was spotted with brown dried drippings. The bag was not dated. Observation and interview on 08/16/24 at 10:36 AM with Resident #1 revealed he had his oxygen nasal cannula on at 3 liters. Resident #1 stated he had returned from the hospital on 08/15/24. Resident #1 said staff were entering and checking on him often. Resident #1 said he used the NC mask overnight, and the overnight nurse removed the mask this morning. Observation and interview with the ADON on 08/16/24 at 10:47 AM revealed Resident #1's oxygen mask was located in the soiled plastic that was not dated. The ADON opened the bag and found a camouflage hat inside. The ADON said she would have the nurse change the NC mask, place in plastic bag, and date the bag . The ADON stated the risk of not dating and changing out the tubing, could cause an infection . The ADON said it was the responsibility of the charge nurses to clean oxygen concentrator filters as needed to prevent inadequate oxygen consumption to the resident. Observation and interview with LVN I on 08/16/24 at 10:55 AM revealed Resident #1 received oxygen by NC tubing and mask continuously. LVN I stated he had checked on Resident #1 upon arrival for his shift at 6:00 AM, and every 2 hours thereafter, and the tubing was bagged and dated. He said he did not see the nasal cannula mask, soiled bag, and no date until this observation. He stated he knew he was supposed to check on the resident's oxygen flow rate, tubing flow and date, and storage of tubing. He stated the tubing was not to be in a used plastic bag to prevent environment exposure that could lead to infection. LVN I said he would change the tubing, and store in a dated plastic bag. Observation and interview with LVN I at 11:30 AM revealed the plastic bag undated in the same location with the contents emptied. LVN I observed the soiled bag, and said he forgot to discard the bag. LVN I removed the bag and discarded properly. Resident #7's Record review of Resident #7's face sheet, dated 08/16/24, revealed the resident was a [AGE] year-old female with an initial admitted [DATE]. The resident's diagnoses included Metabolic Encephalopathy (disease of the brain) COPD, and acute and chronic respiratory failure with hypoxia (inadequate gas exchange by respiratory system.) Record review of resident #7's quarterly MDS dated [DATE] reflected a BIMS score of 12 indicating she was moderately impaired. The MDS reflected the resident was on oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of resident #7's Care plan dated 05/15/24 reflected resident requires oxygen therapy r/t COPD edited 07/3024. Interventions included Resident will not exhibit signs of hypoxia (cyanosis, tachypnea, dyspnea, confusion, restlessness, nasal flaring, elevated blood pressure, increased respirations, increased pulse). Approach Start Date: 12/29/2023 Administer oxygen at 4 L via NC. Observe oxygen precautions. Edited: 12/29/2023 Approach Start Date: 12/29/2023 Monitor and report signs of hypoxia (cyanosis, tachypnea, dyspnea, confusion, restlessness, nasal flaring, elevated blood pressure, increased respirations, increased pulse). Approach Monitor lung sounds every shift. Monitor oxygen saturation via pulse oximetry every shift. Record review of Resident #1's physician orders dated 01/10/24 Monitor resident's oxygen saturation every shift. Notify MD with O2 sat less than 90% and transfer to ER . Every Shift Open Ended Treatments; Nasal Cannula (Continuous): O2 @ 4 L/Min Every Shift; Change Nebulizer Mask and tubing weekly .Once A Day on Sunday 10:00 PM - 06:00 AM .Oxygen Concentrator Filter: Clean concentrator filter weekly. Wash with mild soap and water, dry with towel and replace. Once A Day on Sunday 10:00 PM - 06:00 AM. Record review of Resident #7's Progress note dated 08/09/2024 03:02 AM reflected, Resident in bed with no s/s respiratory distress noted. Receiving continuous O2 @ 4 lpm via N/C with 96% O2 sat remains on Lactulose 30 cc PO Q 6 hrs. day 2/3 with no adverse reaction. Record review of Resident #7's August 2024 MAR/TAR dated 01/10/24 reflected Monitor oxygen humidification bottle every shift, Replace or refill as required every shift .change oxygen tubing, canula/Mask once a week. Once a day on Sunday, dated 01/10/24 Open ended .oxygen concentrator filter: clean concentrator filter weekly. Wash with mild soap and water, dry with towel and replace once a day on Sunday 01/10/24 The August 2020 TAR, dated 8/16/24 did not reflect documentation that the nursing staff had performed these medical tasks ordered by the MD. In an observation on 08/16/24 at 11:00 AM, Resident 7's oxygen concentrator filter was filled with gray particles and dust throughout the machine. The machine as powered on and the humidifier water bottle was empty and not dated. In an interview with the DON on 08/16/24 at 4:25 PM revealed her expectation was once the doctor submitted an order for oxygen, the nurse should ensure physician orders were followed. She expected the nursing staff to conduct rounds checking oxygen levels, oxygen flow, tubing dated, and stored in a plastic dated bag when not in use. The DON stated she and the ADON were responsible for monitoring to ensure the orders were followed. The DON stated the tubing and humidifiers on the oxygen concentrators were scheduled to be changed every Sunday night by the night nurse. She stated the nursing staff should be checking for this. The DON stated the empty humidifier could cause the resident some irritation in the nose and the tubing causing dryness, when not being changed. In an interview with LVN L on 08/16/24 at 4:30 PM she stated she was not the nurse for Resident #1, but she was the wound and infection prevention nurse at the facility. She stated the tubing, and humidifiers on the oxygen concentrator were scheduled to be changed every Sunday night by the night nurse. She stated the nursing staff should be checking for this every time they round on the patient. She stated staff were to date the tubing every time it was changed, and the humidifier should be checked frequently to ensure fluids were in it in order to avoid any irritation to the resident's nose. She stated the risk of not changing out the tubing, could cause an infection . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/16/24 at 5:15 PM, the Administrator stated that it was her expectation for staff to monitor and clean resident oxygen machines as needed, date all equipment to prevent potential infections. She expects the ADON and DON to monitor and ensure all clinical tasks were completed as requested and scheduled by the MD. Record review of facility policy titled Oxygen Administration dated October 2010 reflected Steps in the Procedure 12 Check the mask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened. Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through .13. Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated (see Assessment) .14. Periodically re-check water level in humidifying jar .15. Discard used supplies into designated containers .16. Discard personal protective equipment in designated receptacles. Wash and dry your hands .thoroughly .17. Reposition the bed covers. Make the resident comfortable. Documentation: Documentation: After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: 1. The date and time that the procedure was performed. 2. The name and title of the individual who performed the procedure. 6. All assessment data obtained before, during, and after the procedure .7. How the resident tolerated the procedure Reporting: .2. Report other information in accordance with facility policy and professional standards of practice.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44970 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for kitchen sanitation. The facility failed to ensure the food preparation tables were clean, food was covered and all utensils were removed during meal prep, the lid was on the kitchen trashcan near food prep table and fish, fish was properly thawed, and dry storage containers were cleaned and free of dried food particles. This failure could place residents at risk for food-borne illness. Findings Included: In an observation of the facility's only kitchen on 08/16/24 beginning at 11:30 AM revealed: 1) 1- Large stainless-steel pan of apple cobbler on the prep table uncovered. 2) 1-Large stainless-steel pan of apple cobbler on the prep table uncovered and serving spoon inside the container. 3) 1-8 oz. carton of thickener under the prep table with the cap removed and lying on the bottom shelf. 4) 3-5-gallon clear dry unclean containers under a prep table (dried red, white, brown smudges) next to two hot plate covers. 5) 1-Prep table containing dropped food substance, brown spots, and rust. 6) 1 tall gray kitchen trash can with no lid, placed next to fish which was being thawed in a clear container with water, uncovered on the prep table. (continued on next page)

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	675792	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mansfield Nursing & Rehabilitation Center	1402 E Broad St Mansfield, TX 76063

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	In an interview on 08/16/24 at 11:35 AM with the facilities DM revealed that he forgot to place the cap back on the puree food thickener. The DM said he was prepping the cobbler and forgot to cover the pans and remove the spoon when he walked away. The DM said someone returned the trashcan lid after discarding the food. He said the dry storage containers and prep tables should be cleaned when he observed the prep table with food and crumbs. The Dietary Manager stated all prepared foods should be covered when not being prepped by a person and caps returned and stored in a clean area. The Dietary Manager stated all dietary staff were responsible for ensuring foods were cleaned, stored, and prepared correctly and all trashcan lids returned to prevent cross contamination to food being prepped. The Dietary Manager stated not doing these things could cause foodborne illnesses. The Dietary Manager stated it was his responsibility to ensure that safe food and storage practices were completed. It is his expectation for kitchen staff to cover the food when not preparing, clean canisters daily as need, ensure trash can was covered and fish defrosted and covered consistent with food standards. he would begin to in-service dietary staff on food storage, cleaning, and sanitation in the kitchen. He said the failures could result in cross contamination and residents having food borne illnesses from bacteria and environment exposure. In an interview on 08/16/24 at 5:15 PM, the Administrator stated it was the facility's expectation that all foods stored in the kitchen be prepared, stored, and protected from the environment. The ADM said the food serving utensils should not be left in food pans. The ADM said all trash can lids should be covered with a lid to prevent cross contamination. All food prep materials and containers should be cleaned daily and as needed. The Administrator stated she expected the DM to monitor and educate kitchen staff on the safety of preparing, cleaning, and storing food. The Administrator stated not doing these things could cause food related illnesses. The Administrator stated dietary staff would be in-serviced and the Dietary Manager would conduct weekly audits for food storage and temperature logs. In a record review of the facility policy titled Food Preparation and Handling dated 2018 reflected the, Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be prepared and handled according to the state and US Food Codes and HACCP guidelines. Thawing Foods: Thaw meat, poultry, and fish in a refrigerator at 41 F or less. Treat all raw products as though they are contaminated and handle with methods to reduce existing contamination or prevent cross-contamination.