

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675949	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2024
NAME OF PROVIDER OR SUPPLIER The Waterton at Cowhorn Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 5524 Cowhorn Creek Texarkana, TX 75503	
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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on interview and record review, the facility failed to ensure that the residents and/or representatives had the right to participate in the development and implementation of his or her person-centered plan of care, and to ensure that the planning process facilitated the inclusion of the residents and/or representatives for (AR #1, AR #2, AR #44, AR #6, and AR #8). The facility failed to ensure , AR #1, AR #2, AR #44, AR #6, and AR #8, were involved in the review of the comprehensive assessment and were able to discuss their individualized care needs for services to include their need for medical and nursing care, medications, therapy, psychological and dietary needs. The failure could affect residents by placing them at risk for not receiving adequate or individualized care. Findings include: During a confidential group interview on 12/03/2024 at 2:00 p.m., Anonymous Resident's #1, #2, #44, #6, and #8 stated they had not been invited to or attended a care plan meeting about their care within the last 6 months. They each stated they desired to be included in their care plan and wanted to have an active say in their care. They each stated they were aware it was their right to be present at their care plan meetings. During an interview with AR #1 revealed she had not been to her own care plan meeting since she admitted over a year ago. AR #1 stated it was important to her to be a part of her plan of care and she did not want strangers to decide her care. During record review of AR #1's care conference meeting notes in EHR revealed no notes were present for any care plan meetings. AR #1 was a resident for greater than 1 year. During record review of AR #2's care conference meeting notes in EHR revealed the last care plan meeting for AR #2 was in July of 2024. No care plan meeting was recorded for October 2024. During record review of AR #44's care conference meeting notes in EHR revealed the last care plan meeting for AR #44 was completed with the MDS Coordinator and Social Worker as the only participates in [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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During record review of AR #6's care conference meeting notes in EHR revealed the last care plan meeting for AR #6 was in June of 2024. During record review of AR #8's care conference meeting notes in EHR revealed the last care plan meeting for AR #8 was in July 2024. During an interview on 12/04/2024 at 2:50 p.m., the MDS Coordinator stated it was the responsibility of the social worker to invite each resident and their family and ensure they attended. She stated she let the social worker know what resident was due for an MDS and needed their care plan updated and she would send out letters at the end of the month for the next month to inform the family. During an interview on 12/04/2024 at 3:30 p.m., the social worker stated she sent letters to the family inviting them at the end of each month for the resident's due for a care plan meeting the next month. She stated she assigned times and days to each resident for a care plan meeting. She stated she typed the notes for each care plan meeting they had in the care conference meeting tab in the EHR. The social worker stated most of the time she and the MDS Coordinator or ADON were the staff present in the care plan meetings. She stated the families often denied coming to the meeting. She stated she invited the resident, but they would not always participate. She stated she had not documented their refusal to participate in their care plan meetings. During an interview on 12/04/2024 at 11:00 a.m., the DON stated there were people that regularly went to their care plan meetings, but she will make sure from this point forward that they remind the residents to come to the care plan meetings. She stated the resident could feel like their needs aren't being met or they are unable to voice their care concerns. During an interview on 12/04/2024 at 12:45 p.m., the ADM stated she felt like the IDT was good at doing the care plan meetings. She was unaware that the resident's had concerns about not attending their meetings. She stated the care plan meetings were to be attended by all members of the IDT team and were to be done quarterly and as needed. The Administrator stated the SW was responsible for coordinating the care plan meetings. The Administrator stated it was important for the residents and family to have an active voice in care decisions. Review of an undated policy titled Care Planning/Interdisciplinary Team on 11/02/2023 at 4:15 p.m., revealed, The care planning team shall be composed of but not necessarily limited to the following personnel: a. RN assessment coordinator, b. Director of nursing, c. Medical director, d. attending physician, e. Therapist, f. Activity director, g. Social service director, h. Dietician/food service manager, i. Pharmacist, j. other individuals as the resident's need dictates.the social worker shall be responsible for notifying team members when a meeting is scheduled, providing reports, ect., to be reviewed, and maintaining written reports of all meetings.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019 Based on observation, interview and record review, the facility failed to ensure each resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 20 residents (Resident #31) reviewed for reasonable accommodations. The facility failed to ensure Resident #31's, call button was within reach while in bed. This failures could place residents at risk for a delay in assistance and decreased quality of life, self-worth, and dignity. Findings include: Record review of Resident #31's face sheet dated 12/2/2024 revealed a [AGE] year-old male admitted on [DATE] with diagnoses that included Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (stroke that occurs on the right side of the brain affecting the left side of the body), Acute ischemic heart disease (refers to a range of conditions related to reduced blood flow to the heart) and age-related physical debility (a condition of decreased physiological reserves due to aging). Record review of Resident #31's quarterly MDS assessment, dated 11/27/2024, revealed Resident #31 had a BIMS of 10, which indicated he was moderately impaired cognitively. The MDS showed that Resident #31 required extensive assistance with ADLs. Record review of Resident #31's Comprehensive Care Plan revised 10/9/2024 revealed Resident #31 had impaired physical mobility related to CVA (cardiovascular accident) with intervention indicating Resident #31 required extensive to total assistance. During an interview and observation on 12/2/2024 at 9:55 a.m., it was observed that Resident #31's call button was positioned on the left side out of reach of resident's left hand. Resident demonstrated that he was not able to reach his call light that was out of reach. Resident #31 said he had difficulty pushing the button on his call light. He said if he needed help, he would yell for assistance. During an observation and interview on 12/4/2024 at 11:45 a.m. Resident #31 observed sitting up in wheelchair in his room. Resident #31 said he could not get to his call light, and it was observed in his trash can. Resident #31 said the staff placed his call light on his left side. During an interview on 12/4/2024 at 11:48 a.m., with CNA D said Resident #31 was able to push his call light button and would come to the nurse station if he needed anything. CNA D said she would place his call light on his left side where he could reach it. CNA D said he could only use his left side because he was unable to move his right arm. CNA D said the resident should have his call light on his left side near his abdomen where he can reach it. CNA D said she makes rounds every 2 hours. (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/4/2024 at 12:00 p.m., CNA E said she had been in-serviced on call light placement. She said she would place the call light on the side the resident was the strongest and within reach. CNA E said if a call light was not properly placed or within reach, a resident could have a fall and not able to reach for call light. CNA E said all nurses and CNAs are responsible for making sure call lights are within reach. During an interview on 12/4/2024 at 12:15 p.m., LVN B said she would place the call light for a resident with right-sided weakness on his left side. LVN B said a resident may need something from the nurse and not be able to reach them if a call light was not properly placed. During an interview on 12/4/2024 at 1:10 p.m., the DON said she would expect the CNAs to place the call light within a resident reach. The DON said Resident #31 would benefit from a touch call light verses the button call light. The DON said she expected the call light to be within reach and a resident would not be able to call for help if not placed within reach. During an interview on 12/4/2024 at 1:29 p.m., the ADON said it depended on if a resident had contractures if they received a push touch call light. She said the staff should make sure a resident was able to properly use the call light system. The ADON said Resident #31 had the button call light and said he was able to push the button. The ADON said she expected the CNAs to make sure the call lights were within reach. She said a resident would not be able to call nurse or staff for assistance if they needed help. The ADON said she expected the nurse staff to keep call light within reach if Resident #31 was up in his wheelchair. The ADON said the staff has changed out Resident #31's call light and provided a longer cord with a pat/touch button for easier use. During an interview on 12/4/2024 at 1:41 p.m., the ADM said she expected the staff to ensure a resident were able to use and reach call lights. She said she expected the residents to have the proper call light and to be kept within reach. The ADM said the call light was their mechanism to ask for assistance. Record review of the facility's policy Answering the Call light dated September 21, 2022 revealed . The purpose of this procedure is to respond to the resident's request and needs .Procedure: General guidelines . 1. Explain the call light to the new resident .2. Demonstrate the use of the call light .3. Ask the resident to return the demonstration so that you will be sure that the resident can operate the system . 4. Be sure the call light is plugged in at all times .5. When the resident is in the bed or confined to a chair, be sure the call light is within easy reach of the resident .6. Some residents may not be able to use their call light. Be sure you check with the resident frequently .7. Report all defective call lights .		

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on interview and record review the facility failed to send a copy of the notice of facility-initiated discharge to a representative of the Office of the State Long-Term Care Ombudsman for 1 of 3 residents (Resident #59) reviewed for discharge. The facility failed to send a transfer or discharge notice in writing to the facility's Ombudsman as soon as practicable when Resident #59 was discharged to another facility on 11/15/2024. This failure could place residents at risk of being discharged and not having access to available advocacy services, discharge/transfer options, and the appeal processes. The findings include: Record review of Resident #59's, undated face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. Resident #59 had diagnoses which included insomnia (inability to sleep), repeated falls, and schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech, and behavior. The face sheet indicated Resident #59 was discharged on [DATE] to another nursing facility. Record review of Resident #59's quarterly MDS dated [DATE] revealed he had a BIMS of 09, which indicated a moderate cognitive impairment. Resident #59 required supervision with all ADLs. Record review of Resident #59's care plan dated 11/15/2024, revealed Resident #59 would be safe until transfer to a secured unit. During an interview on 12/02/2024 at 9:15 a.m., the Ombudsman stated she was not notified of any discharges by the facility without having to send several emails to request a list of discharges. She stated she was unaware Resident #59 was transferred to another facility. She stated the last time the facility reported discharges to her was in August of 2024 even though she requested them monthly. During an interview on 12/04/2024 at 10:00 a.m., the SW stated she was unaware of who was responsible for reporting discharges to the Ombudsman. She stated she was not aware that reporting the facility-initiated discharges was a regulation, she thought it was a courtesy. During an interview on 12/04/2024 at 11:00 a.m., the DON stated she was not aware notification of the Ombudsman of discharged residents was a requirement. She stated she though only if they were giving the resident a 30-day discharge was that a requirement. The DON stated there was no procedure in place and no one assigned to undertake that task, but she would assign it to the SW to oversee. The DON stated not notifying the Ombudsman could result in resident's being discharged unfairly. (continued on next page)		

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/04/2024 at 1:40 p.m., the ADM stated the SW was now solely responsible for notifying the Ombudsman of the facility's discharges. The ADM stated no one person was responsible for sending the information prior to survey. She stated September, October, and November discharges were not sent to the Ombudsman yet. The ADM stated discharges should be reported to the Ombudsman as soon as practical, unless a 30-day notice was issued, and a copy of the notice was sent to the Ombudsman the same day the notice was provided to the resident. The ADM stated she was unsure of what the Ombudsman did with the discharge notifications, so she was uncertain of how not receiving a discharge notification could affect the residents being discharged . The ADM stated she would in-service the SW and monitor discharge notifications to ensure the Ombudsman was notified appropriately in the future. A related policy was requested from the DON and ADMIN on 12/03/2024 at 11:56 a.m. and 4:30 p.m. but was not provided upon exit.		

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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** 44596 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 #59) reviewed for discharge MDS assessments. The facility did not ensure Resident #59's discharge MDS assessment was completed and transmitted within 14 days of completion. This failure could place residents at risk of not having records completed and submitted in a timely manner as required. Findings included: Record review of Resident #59's, undated face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. Resident #59 had diagnoses which included insomnia (inability to sleep), repeated falls, and schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech, and behavior. The face sheet indicated Resident #59 was discharged on [DATE] to another nursing facility. Record review of Resident #59's quarterly MDS dated [DATE] revealed he had a BIMS of 09, which indicated a moderate cognitive impairment. Resident #59 required supervision with all ADLs. Record review of Resident #59's care plan dated 11/15/2024, revealed Resident #59 would be safe until transfer to a secured unit. Record review of Resident #59's EHR indicated no discharge MDS was completed or transmitted prior to survey intervention. During an interview on 12/03/2024 at 2:38 p.m., the MDS Coordinator said she was responsible for completing and submitting MDS. She said Resident #59's discharge assessment should have been completed and submitted within 14 days of his discharge. She said the corporate MDS coordinator monitors the MDS assessments she completed. She said it was important to complete and submit discharge assessments because it ensured that proper documentation was collected prior to discharge. She said the facility ran reports on MDS assessments completion and submission. She said she did not know how Resident #59's discharge assessment got missed. During an interview on 12/04/2024 at 1:30 p.m., the ADM said she expected the MDS coordinator to follow the MDS Completion and Submission policy. She said the MDS Coordinator was responsible for submitting discharge assessment timely. She said the corporate MDS Coordinator should be ensuring the facility's MDS Coordinator completed and submitted assessment timely. She said timely assessment submission was important ensure the facility was following CMS guidelines. (continued on next page)		

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Record review of a facility's MDS Completion and Submission Timeframes policy revised 07/2017 indicated . our facility will conduct and submit resident assessments in accordance with currency federal and state submission timeframes .the assessment coordinator or designee is responsible for ensuring that resident assessment are submitted to CMS QIES assessment submission and processing system in accordance with current federal and state guidelines .timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual . Record Review of the CMS RAI Version 3.0 Manual, dated October 2023, indicated, in Chapter 2, page 2-39 09. Discharge Assessment-Return Not Anticipated (A0310F), Must be completed (item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days). The RAI Manual further revealed the discharge assessment-return not anticipated must be submitted within 14 days after the MDS completion date (Z0500B +14 calendar days) .		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on interview and record review, the facility failed to ensure the baseline care plan that included the instructions for resident care needed to provide effective and person-centered care was completed and provided to the resident and/or their representative for 2 of 6 residents reviewed for new admissions (Residents #28 and #177). The facility did not ensure the baseline care plan that included the instructions for resident care needed to provide effective and person-centered care was provided to the resident and/or their representative for Resident #28. The facility did not ensure the baseline care plan that included the instructions for resident care needed to provide effective and person-centered care was completed and provided to the resident and/or their representative for Resident #177. These failures could place residents at risk of not receiving care and services to meet their needs. Findings included: 1.Record review of a face sheet dated 12/02/2024 revealed Resident #28 was a 73- year-old- female, admitted on [DATE] with the diagnoses of hemiplegia (one sided paralysis), cerebral infarction (stroke), and anxiety. Record review of Resident #28's admission MDS assessment dated [DATE] revealed Resident #28 had a BIMS of 06, which indicated moderate cognitive impairment. Resident #28 was coded to require maximal assistance of 1 staff member for ADL's. Record review of Resident #28's baseline care plan dated 09/20/2024 indicated the base line care plan was completed on 09/20/2024. The baseline care plan was unsigned by the resident or representative. During an interview on 12/02/2024 at 10:15 a.m., Resident #28 stated she did not remember the baseline care plan meeting and had no copy of the baseline care plan. She stated she would like a copy to see when she will be able to discharge. 2.Record review of a face sheet dated 12/02/2024 revealed Resident #177 was a [AGE] year-old male, admitted to the facility on [DATE] with the diagnoses of diabetes mellitus (condition affecting blood glucose levels), cirrhosis (liver disease), and anxiety. Record review on 12/02/2024 of Resident #177's EHR showed no completed MDS assessments and no completed baseline care plan. (continued on next page)		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128 Based on interview and record review, the facility failed to ensure that 1 of 17 residents reviewed for vision services, received proper treatment and assistive devices to maintain vision abilities. (Resident #47) The facility failed to transport Resident #47 to an appointment with an ophthalmologist on 10/02/24 and 12/04/24. This failure could affect residents by causing them to have decreased vision awareness when ambulating, difficulty seeing and participating in activities, and decreased self-esteem. Findings included: Record review of a face sheet dated 12/02/24 revealed Resident #47 was a [AGE] year-old female, was admitted on [DATE] with diagnoses including dementia, glaucoma with increased episcleral venous pressure (an eye disorder with increased pressure in the eye and veins), anxiety and depressive episode (periods of depression). Record review of the most recent MDS dated [DATE] indicated Resident #47 had moderately impaired vision and required corrective lenses. The MDS indicated Resident #47 had a BIMS score of 12 which indicated moderate cognitive impairment. The MDS indicated Resident #47 normally used a wheelchair. The MDS indicated Resident #47 was dependent on staff for chair/bed-to-chair transfers. Record review of a care plan last revised on 11/20/24 revealed Resident #47 required assistance with bathing, grooming, hygiene and dressing. The care plan revealed Resident #47 had a diagnosis of dementia and required some cues and redirection. Record review of History and Physical note dated 08/27/24 revealed Resident #47 had chronic vision changes. Record review of a Progress Note dated 09/20/24 revealed, .RP called and said that she found transportation for res. to go to eye appt. in [NAME]. Res. has appt. on 12/4/24 @ 1:30pm with Dr. (ophthalmologist). The note was electronically signed by LVN B. Record review of an Eye Appointment reminder provided by the RP revealed Resident #47 had an appointment with an ophthalmologist on 10/02/24 at 12:00 p.m. The appointment information was written on a sticky note attached to an email from the ophthalmologist office. During an interview on 12/02/24 at 9:51 a.m., Resident #47 said she had been having problems with her vision. She said she had not been taken to her eye doctors' appointment in October 2024. She said her RP handled those things for her and she did not know why she was not taken that appointment. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER The Waterton at Cowhorn Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 5524 Cowhorn Creek Texarkana, TX 75503	
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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/02/24 at 2:49 p.m., Resident #47's RP said she had talked to ADON A the morning of 12/02/24 about having Resident #47 transported to [NAME] to the ophthalmologist. The RP said Resident #47 had been complaining about her eyes for some time. The RP said Resident #47 had told her she saw black spots out of one eye and could not see anything out of the other. She said the resident had cataracts. She said the ophthalmologist in [NAME] was a specialist. She said no other doctor would agree to take her and this one had. She said she has been trying to get the resident transported up there for a while. She said Resident #47 had an appointment back in October 2024 but had to cancel the appointment because she could not find transportation to the appointment. She said the Social Worker helped her find a transportation company, but they told her the facility was responsible for transporting Resident #47. She said the resident had another appointment scheduled on 12/04/24. She said ADON A told her that she would have to check with the Administrator because they did not transport residents that far and would need the van for other residents. During an interview on 12/03/24 on 8:38 a.m., the Social Worker said she did assist residents with arranging transportation to and from appointments. She said she helped with the vision appointments, but the DONs made the appointments. She said there had been issues with transportation to [NAME] for Resident #47 appointment because of her benefits. She said the facility transporting the resident themselves would be a question for the Administrator. During an interview on 12/03/24 at 8:44 a.m., ADON A said Resident #47 went to see a local eye doctor during 09/2024. She said Resident #47 had said she was having problems with her vision and could not see her television at night. She said Resident #47 had seen two local eye doctors. She said neither doctor felt comfortable taking her because she could not lie flat. She said they then referred Resident #47 to the ophthalmologist in [NAME]. She said Resident #47 had an appointment on 12/04/24. She said she did not know when the previous appointment was. She said Resident #47 did not make the previous appointment because of transportation issues. She said the facility was responsible for transporting the resident, but they did not transport residents that far out. She said the social worker had been working on getting Resident #47 transported with a transport company using her Medicaid benefits. She said she did not know what the plans were for transporting the resident to her appointment on 12/04/24. During an interview on 12/03/24 at 9:08 a.m., Resident #47's RP said on 12/03/24 the social worker met her at the door of the facility and said she still did not know anyone to take Resident #47 to her appointment. She said the Administrator was supposed to call her but had not. She said there was a previous appointment scheduled but she did not know about it until 2 days before and the resident was not transported to the appointment. During an interview on 12/03/24 at 9:40 a.m., Resident #47's RP said the Administrator had called her and said they could not transport the resident to her appointment in [NAME] on 12/04/24. She said she was told that she would have to transport Resident #47. (continued on next page)		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/03/24 at 9:44 a.m., the Administrator said Resident #47 had an appointment with the ophthalmologist on 12/04/24. She said the resident's RP was transporting her to the appointment. She said the resident had seen a couple of local doctors. She said they did not feel she was appropriate for their services. She said to her knowledge the appointment on 12/4/24 was the first appointment for the resident in [NAME] with the ophthalmologist. She said she did not know anything about an appointment on 10/02/24. She said she had known about the appointment for 12/04/24 for the last few weeks. She said the resident's insurance would not cover transportation to the appointment in [NAME]. She said families took residents to appointments all of the time. She said there was no hesitation from Resident 47's RP to transport the resident to her appointment. During an interview on 12/03/24 at 11:03 a.m., a scheduler with the ophthalmologist office in [NAME] said there had been an appointment initially scheduled for 10/03/24 and then it was moved to 10/02/24. She said the appointment was rescheduled on 09/30/24 to 12/04/24 by a family member but there was no note indicating why the appointment had been moved. During an interview on 12/03/24 at 11:34 a.m., LVN B said Resident #47 had been having vision problems. She said Resident #47 had seen several local doctors. She said the resident needed cataract surgery. She said Resident #47 was not a candidate with the local doctors because she had to lie flat for 30 minutes and was unable to do so. She said Resident #47 did have an appointment scheduled some time during the first of October 2024 in [NAME] with an ophthalmologist. She said the appointment had been cancelled. She said she was not sure why. She said the resident may have been sick or it could have been because of transportation. She said the resident did miss the appointment in October. She said ADON A would know why. She said the family moved the appointment to 12/04/24. During an interview on 12/03/24 at 2:35 p.m., Resident #47's RP said had expected the facility to transport Resident #47 to her eye doctor's appointment in [NAME] on 10/02/24. She said she did not find out about the appointment until 2 days before. She said she was unable to find transportation for Resident #47, so she had to have the appointment rescheduled for 12/04/24. She said she was having to transport Resident #47 to the appointment on 12/04/24 because she had been told the facility could not use their van to transport her all the way to [NAME]. During an interview on 12/04/24 at 8:27 a.m., Resident #47 said her RP was going to take her to the eye doctor later. She said she sure hoped they could help her. She said she could not see out of one eye and the other eye was fuzzy. She said the television just looked like a black spot. She said she had been having problems seeing for awhile. (continued on next page)		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/04/24 at 9:14 a.m., Resident #47's RP said on 9/30/24 she was at the facility visiting Resident #47. She said Resident #47 had the Eye Appointment Reminder with the sticky note on it with the appointment date of 10/02/24 at 12:00 p.m. written on it. She said staff at the local eye doctor had made the appointment and mailed the information to the resident. She said on 9/30/24 she talked to ADON A and LVN B and they were aware of the appointment on 10/02/24. She said on 9/30/24 ADON A told her the facility could not transport the resident because they needed the van for other residents. She said her having to take the resident to the appointment in [NAME] on 12/04/24 had created problems for her. She said she felt she had no other choice but to take the resident herself because the facility had not transported her. She said if she did not take the resident she would be devastated because she was so upset when the appointment had to be cancelled in October 2024 due to lack of transportation. She said she felt the facility was responsible for transporting the resident to her appointment in [NAME]. She said she was concerned about the resident having to be transferred in and out of her wheelchair so many times. She said she was not physically able to transfer the resident to her wheelchair and was having to take another family member with her to help with transferring the resident once they get to the eye doctors office. During an interview on 12/04/24 at 12:30 p.m., the Administrator said she felt staff were not aware of the appointment on 10/02/24. She said she had spoken to ADON A and ADON A told her that she was misunderstood, and she was not aware of the appointment on 10/02/24. Record review of a Coordination of Ancillary Services facility policy dated 12/2023 indicated, .To establish a system to assure the coordination of care with the professional services participating in the patient's/resident's care. The Social Services department will coordinate the care for ancillary medical services such as psychological, dentistry, podiatry, optometry, audiologist, hospice, etc .If a patient/resident needs to be seen by a service that does not come to the facility, then the Social Worker or designee can assist staff in arranging such an appointment .		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on interview and record review, the facility failed to ensure residents received appropriate treatment and services to prevent further decrease of ROM for 1 of 4 residents reviewed for limited range of motion. (Resident #68) The facility did not ensure Resident #68 had a contracture prevention services in place for the treatment of his left sided hemiplegia with decreased range of motion. This failure could place residents at risk for decrease in mobility, range of motion, and contribute to worsening of contractures. Findings included: 1. Record review of an undated face sheet revealed Resident #68 was a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of hemiplegia (one-sided paralysis), diabetes mellitus type II (condition affecting blood glucose levels), and cerebral infarction (stroke). Record review of Resident #68's quarterly MDS dated [DATE] revealed he had a BIMS score of 10 which indicated moderate cognitive impairment. Resident #68 had upper and lower ROM impairment on one side of his body. Resident #68 was dependent with ADLs and received no OT, PT, or restorative nursing for ROM. Record review of Resident #68's care plan dated 11/18/2024 revealed he required assistance with ADL's related to left sided hemiplegia. During an interview on 12/02/2024 at 10:40 a.m., Resident #68 stated he wished the facility would allow him to do therapy or get an aide to work on keeping his stroke side limber. He stated he had no ability to move it and at times he felt a stiffness in his wrist and fingers. He stated he was unable to move anything on his left side from his shoulder down to his toes. He stated it had been well over 60 days since he had been on any type of therapy, and he felt he was losing everything he had gained when he was on therapy services. During an interview on 12/03/2024 at 9:00 a.m., the DOR stated there was no restorative nursing program at the facility. She stated the only type of program they had was a program that worked with VA residents as a requirement of their insurance. She stated it would be nice to have a restorative plan to discharge the residents that stay long term to so they would no lose all the skills they build during therapy. The DOR stated Resident #68 was not on the VA program and had not received PT or OT since September 2024. She stated it was important for the Resident's to have ROM exercises to prevent contractures and keep contractures from worsening. (continued on next page)		

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/04/2024 at 11:00 a.m., the DON stated there was no restorative program that therapy discharged residents to on completion of their therapy goals. She stated the CNAs were trained to do ROM, but it was not documented as something they provided the residents each day. She stated ROM was an important exercise for all residents but especially ones with potential for contractures like Resident #68. During an interview on 12/04/2024 at 01:11 p.m. the ADM said it was the responsibility of the nursing to ensure contracture management and prevention was in place. The Administrator said training should be done with CNAs to inform them which resident required ROM to be performed on them and how to do it properly. The Administrator said contracture management and prevention helped maintain whatever flexibility may be left, helped maintain limb strength, and prevented further contraction. The contracture management policy was requested on 12/03/2024 at 3:30 p.m. and 12/04/2024 at 9:00 a.m. from DON. No policy was provided prior to exit.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019 Based on observations, interviews, and record review the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrated that this was not possible or resident preferences indicated otherwise for 1 of 20 residents (Resident #72) reviewed for nutrition. The facility failed to follow the facility's weight policy of weighing Resident #72 after a 11.3-pound weight loss from admission on 10/28/2024 to 11/1/2024 indicating a 5.51% weight loss. There was no weight obtained within 24 hours after signification weight loss >5 % on 11/1/2024. This failure could place residents at risk for malnourishment, weight loss, skin breakdown, and decreased quality of life. Findings included: Record review of Resident #72's face sheet dated 12/03/2024 revealed he was [AGE] year-old male who was admitted to the facility on [DATE]. Resident #72 had diagnoses which included neuromuscular dysfunction of bladder (neuromuscular dysfunction of the bladder occurs when the nerves that control the bladder are damaged or not functioning properly), pulmonary candidiasis (pulmonary candidiasis is almost exclusively a fungal infection that occurs in patients who have underlying disease or who are immunocompromised) vitamin D deficiency (a common vitamin deficiency that causes issues with your bones and muscles. It most commonly affects people over the age of 65 and people who have darker skin. It's preventable and treatable), narcolepsy without cataplexy (a condition that makes people very sleepy during the day and can cause them to fall asleep suddenly), hemiplegia affecting left nondominant side (a symptom that involves one-sided paralysis), Essential (primary), Hypertension (a common condition that affects the body's arteries.), cerebrovascular disease (a condition in which the blood supply to the brain is interrupted or severely reduced, resulting in the death of brain tissue due to lack of oxygen and nutrients.), aphasia following cerebral infarction (the ability to use or comprehend language is frequently lost or impaired as a result of brain trauma (as from a stroke, head injury, or infection) , and dysphagia following cerebral infarction (have difficulty swallowing and may even experience pain while swallowing). Record review of Resident #72's Admission MDS dated [DATE] revealed he was admitted on [DATE]. Resident #72 was understood and understood others. The MDS indicated Resident #72 had a BIMS score of 13, which indicated he was cognitively intact. The MDS indicated Resident #72 had a diagnosis of malnutrition. The MDS indicated Resident #72 was 72 inches in height and weighed 205 pounds and had not had a weight loss of 5% in the past month or loss of 10% or more in the last 6 months. The MDS did not indicated Resident #72 had a feeding tube (gastrostomy/peg tube) upon admission and prior to admission to the facility. The MDS revealed Resident #72 was on a mechanically altered diet. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #72's care plan dated 11/20/2024 indicated he had a potential for nutritional problems with interventions in place to obtain and monitor lab/diagnostic work as ordered, provide, serve diet as ordered, monitor intake, and record every meal, weigh per facility protocol. The care plan revealed resident had a PEG tube related to CVA with interventions in place to check tube for patency, placement and residual prior to administering medication, formulas or flushes. Care plan indicated to flush tube with water every shift as ordered, keep head of bed elevated 30 degrees at all times, monitor residents' weight monthly or as ordered and monitor skin integrity. The care plan revealed Resident #72 had weight loss related to recent pneumonia, Urinary tract infection (UTI) and a history of CVA with dysphagia updated on 12/3/2024. Record review of Resident #72's weight summary in electronic medical record indicated he weighed: 204.9 pounds on 10/28/2024 (admission) 193.6 pounds on 11/1/2024 Record review of Resident #72's weekly weight notebook revealed he weighed: 204.9 pounds on 10/28/2024. (admission) 202 pounds on 11/4/2024. 198 pounds on 11/11/2024. 194 pounds on 11/18/2024. Record review of Resident #72's daily activities tracking form dated 11/27/2024 revealed Resident #72 had a weight change. Record review of Resident #72's weight variance report dated 6/3/2024-12/3/2024 revealed 5.5% weight loss identifying the following weights: 204.9 pounds with BMI 27.79 on 10/28/2024 at 6:29 p.m. 193.6 pounds with BMI 26.25 on 11/1/2024 at 11:20 a.m. During an observation and interview on 12/2/2024 at 12:18 p.m., CNA F obtained weight of Resident #72 using a Hoyer lift with another staff member. CNA F obtained a weight of 178 pounds. The RP was present during observation of weight assessment and said Resident #72's weight prior to his stroke was in the 230's. Resident #72's RP said was recovering from recent pneumonia and an UTI which she felt caused his weight loss. The RP said Resident #72's diet was upgraded prior to coming to thickened liquids and pureed. During an interview on 12/3/2024 at 2:43 p.m. RN H said Resident #72 was eating by mouth prior to coming to the facility and his feeding tube was only being maintained (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 12/4/2024 at 10:45 a.m., the Clinical of Operations nurse said the facility had a performance improvement project initiated on 10/31/2024 after discovering weight discrepancies entered on previous months. The Clinical of Operations said it was identified an employee was entering the weights in system incorrectly. The performance improvement project included weighing all residents for base weight, weighing weekly any weight loss or gain and notify the RD and MD and designate one staff member to weigh residents. During an interview on 12/4/2024 at LVN B said CNA F was the one who checks resident weights. LVN B said the DON provides CNA F a list of residents with weight measurements due daily. LVN B said the DON was responsible for monitoring for weight loss. LVN B said it could be bad if a significant weight loss was not identified. LVN B said the nurses/staff would need to identify the reason for the weight loss. She said it could be GI issues, swallowing difficulties, or teeth. LVN B said the nurses would need to add interventions, notify the NP so interventions could be in place. LVN B said a resident could decline if weight loss was not identified. During an interview on 12/4/2024 at 1:41 p.m., The interim DON said the previous DON was responsible for monitoring weights. The interim DON said she ADON does not look at the weights. She said it was identified the previous DON controlled the weights, and she would email dietician about weight loss. The dietician would do an assessment to determine if an intervention was needed or she would come the facility. The interim DON said a resident could have a lack of nutrition and could cause deficiency. During an interview on 12/4/2024 at 1:42 p.m., the ADM said she expected the nurses to weight residents upon admission and as ordered by the physician. The ADM said she expected the staff to document the weights in the electronic record. She said a weight loss should be reported immediately so that the facility can get an intervention in place and identifying the cause of the weight loss. A resident could affect their overall health . Record review of the facility's policy titled Weight evaluation and Intervention undated revealed .The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss .Weight Evaluation .1. The nursing staff will measure resident weights on admission, and weekly for 3 weeks thereafter .2. Weights will be recorded in the EMR, weight record chart or notebook and in the individual's medical record .3 Any weight changes of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will notify the dietitian, responsible party and primary physician .4. The dietician will review the weight record monthly to follow individual weight trend over time .5. The threshold for significant unplanned and undesired weight loss will be based on the following criteria .a. 1 month - 5 % weight loss is significant .b. 3 months- 7.5 % weight loss is significant c. 6 months 10 % weight loss is significant.		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128 Based on interviews and record reviews, the facility failed to ensure a gradual dose reduction was attempted for 1 of 3 residents (Resident #39) reviewed for unnecessary medications/ gradual dose reduction. The facility failed to ensure a gradual dose reduction (GDR) was attempted or document contraindication for a gradual dose reduction for Resident #39's ordered Abilify (antipsychotic medication used to treat certain mental/mood disorders) 5 milligrams orally daily ordered 06/29/23. This failure could place residents at risk for possible psychotropic medication side effects, adverse consequences, decreased quality of life and dependence on unnecessary medications. Findings included: Review of a face sheet dated 12/04/24 revealed Resident #39 was an [AGE] year-old female that admitted to the facility on [DATE] with the diagnoses of stroke, Schizophrenia (a chronic mental disorder that affects a person's ability to think, perceive reality, and interact socially) and muscle weakness. Review of the quarterly MDS assessment dated [DATE] revealed Resident #39 had a BIMS score of 3, which indicated a severe cognitive impairment. The MDS revealed Resident #39 was dependent on staff with ADLs. The MDS revealed Resident #39 received antipsychotic medication 7 days out of 7 days. Record review of a care plan last revised on 10/01/24 revealed Resident #39 received the antipsychotic medication Abilify related to schizophrenia. There was an intervention to attempt a gradual dose reduction as recommended. Record review of physician consolidated orders dated December 2024 for Resident #39 revealed an order for Abilify 5 milligrams orally once daily with a start date of 06/29/23. Record review of a Medication Administration History dated 11/01/2024 - 11/30/2024 revealed Resident #39 had received Abilify 5 milligrams each day as ordered by the physician. Record review of the pharmacy Recommendations created between 01/01/24 - 01/13/24 revealed Resident #39 was receiving Abilify 5 milligrams every day. The recommendation was Abilify 2.5 milligrams every day. There was a follow through that indicated, Note written to physician. There was no indication the physician had reviewed the note or responded to the recommendation. Record review of a Consultant Pharmacist /Physician Communications (GDR) dated 01/12/24 indicated the Nurse Practitioner disagreed with the recommendation due to the resident continued to have symptoms and had failed the previous failed reduction. The communication was signed by the Nurse Practitioner. The signature was undated. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/04/24 at 11:08 a.m., the [NAME] President of Operations said the GDR was signed by the Nurse Practitioner on the evening of 12/03/24. She said that the Nurse Practitioner never dated anything. She said she would have expected for the GDR to have been reviewed and signed in January 2024. She said GDRs not being reviewed in a timely manner could cause residents to not have their gradual dose reduction and could cause them to be over medicated. During an interview on 12/04/24 at 12:30 p.m., the Administrator said she would have expected for the GDR for Resident #39 to have been reviewed and signed by the Nurse Practitioner when it was due in January 2024. She said she did not feel like Resident #39 was negatively affected by the GDR not being signed in January. During an interview on 12/04/24 at 12:57 p.m., the Nurse Practitioner said at the first of each month she reviewed GDRs that were due for the month. She said she did sign the GDR for Resident #39 on 12/03/24. She said the original may have gotten lost, so she was asked to re-sign the GDR. She said she was not going to lie, she did not remember specifically if she reviewed or signed the GDR in January 2024 but if it was given to her in January it was done. Record review of an undated Psychoactive Drug Monitoring facility policy indicated, .Residents who receive antidepressant, hypnotic, antianxiety, or antipsychotic medications are monitored to evaluate the effectiveness of the medication. Every effort is made to ensure that residents receiving these medications obtain the maximum benefit with the minimum of untoward effects .The medical necessity is documented in the resident's medical record and in the care planning process .The continued need for the psychoactive medication is reassessed regularly by the prescriber and the care planning team. If continuation is deemed necessary, this is indicated in the medical record .Unless medically contraindicated, periodic dosage reductions are attempted and the results documented .All of the following conditions are satisfied prior to initiation and /or continuation of therapy .documentation that previous dosage reductions have been unsuccessful .		

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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** 44128 Based on observation, interview, and record review the facility failed to ensure each resident received and the facility provided food and drink that was palatable, attractive, and at a safe and appetizing temperature for 8 of 17 residents (Resident #4, Resident #19, Resident #27, Resident #29, Resident #36, Resident #38, Resident #54, and Resident #64) and 4 anonymous residents reviewed for palatable food. 1. The facility failed to ensure residents received food that tasted good. 2. The facility failed to ensure residents did not receive cold food. 3. The facility failed to provide condiments such as salad dressing, sugar, and coffee creamer to residents. These failures could place residents at risk of weight loss, altered nutritional status and diminished quality of life. Findings included: 1. Record review of a face sheet dated 12/02/24 revealed Resident #4 was an [AGE] year-old female and was admitted to the facility on [DATE] with diagnoses of diabetes, chronic kidney disease, and anxiety disorder. Record review of a MDS assessment dated [DATE] revealed Resident #4 was understood and understood others. The MDS revealed Resident #4 had a BIMS score of 12, which indicated moderate cognitive impairment. During an interview on 12/02/24 at 9:37 a.m., Resident # 4 said the food just does not taste good. She said she did not like the food and the food was often cold. 2. Record review of a face sheet dated 12/02/24 revealed Resident #19 was a [AGE] year-old female and was admitted to the facility on [DATE] with diagnoses of diabetes, nausea, and major depressive disorder (a serious but common mood disorder that can affect how a person feels, thinks, and act). Record review of a MDS assessment dated [DATE] revealed Resident #19 was understood and understood others. The MDS revealed Resident #19 had a BIMS score of 13 which indicated the resident had intact cognition. During an interview on 12/02/24 at 9:46 a.m., Resident #19 said the food was terrible. She said the food was always cold. (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 12/02/24 at 12:46 p.m., Resident #19 said her lunch isn't worth a damn. She said she ordered popcorn shrimp. There was food on her plate that appeared to be a tomato sauce, with tomatoes and beef. She said it did not taste good at all. She said she did not know what the food was. She said she had a salad but no dressing. There was no salad dressing on her plate. She said she did not taste the cornbread. She said it looked dry. 3. Record review of a face sheet dated 12/02/24 revealed Resident #27 was a [AGE] year-old female and was admitted to the facility on [DATE] with diagnoses of depressive episodes, nausea, and anorexia (an eating disorder causing people to obsess about weight and what they eat). Record review of a MDS assessment dated [DATE] revealed Resident #27 was understood and understood others. The MDS revealed Resident #27 had a BIMS score of 15 which indicated the resident had intact cognition. During an interview on 12/02/24 at 9:46 a.m., Resident #27 said the food was never served on time. She said the food did not taste good. She said kitchen staff try to do something fancy, but it turns out terrible. She said the food was always cold when it got to her. She said she ate in her room. 4. Record review of a face sheet dated 12/02/24 revealed Resident #29 was a [AGE] year-old female and was admitted to the facility on [DATE] with diagnoses of other depressive episodes, nausea, and anxiety disorder. Record review of a MDS assessment dated [DATE] revealed Resident #29 was understood and understood others. The MDS revealed Resident #29 had a BIMS score of 15 which indicated the resident had intact cognition. During an interview on 12/02/24 at 10:00 a.m., Resident #29 said the food was often served cold. She said her coffee was always cold. She said she did not like black coffee. She said she rarely gets any sugar or cream. 5. Record review of a face sheet dated 12/02/24 revealed Resident #36 was a [AGE] year-old female and was admitted to the facility on [DATE] with diagnoses of muscle weakness, abnormal weight loss, and other recurrent depressive disorders. Record review of a MDS assessment dated [DATE] revealed Resident #36 was usually understood and usually understood others. The MDS revealed Resident #36 had a BIMS score of 7 which indicated severe cognitive impairment. During an interview on 12/02/24 at 09:51 a.m., Resident #36 said the food was sometimes burnt. She said she ate in her room and her food was cold sometimes. 6. Record review of a face sheet dated 12/02/24 revealed Resident #38 was an [AGE] year-old female and was admitted to the facility on [DATE] with diagnoses of muscle weakness, muscle wasting and major depressive disorder (a serious but common mood disorder that can affect how a person feels, thinks, and acts). Record review of a MDS assessment dated [DATE] revealed Resident #38 was understood and understood others. The MDS revealed Resident #38 had a BIMS score (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of 14 which indicated the resident's cognition was intact. During an interview on 12/02/24 at 09:53 a.m., Resident #38 said the food was lousy. She said the food was always cold and tasted like leftovers. 7. Record review of a face sheet dated 12/02/24 revealed Resident #54 was a [AGE] year-old female and was admitted to the facility on [DATE] with diagnoses of muscle weakness, diabetes, and anemia (when you have low levels of healthy red blood cells to carry oxygen throughout your body). Record review of a MDS assessment dated [DATE] revealed Resident #54 was understood and understood others. The MDS revealed Resident #54 had a BIMS score of 15 which indicated the resident's cognition was intact. During an interview on 12/02/24 at 10:12 a.m., Resident #54 said the food sucks. She said, they feed us the same crap over and over and over. She said the food did not taste good. She said 90% of the time the food was cold. During an observation and interview on 12/02/24 at 12:43 p.m., Resident #54 said she had a salad with lunch but no dressing or salt and pepper. There was no dressing, salt, or pepper on her lunch tray. She said lunch was supposed to be chili, but it tasted like spaghetti sauce without the noodles. She said her food was lukewarm. She said the cornbread was very dry and looked like yesterday's (12/01/24) cornbread that we had. The lunch was served on a plate, instead of a bowl. The cornbread had a dry appearance. 8. Record review of a face sheet dated 12/02/24 revealed Resident #64 was an [AGE] year-old female and was admitted to the facility on [DATE] with diagnoses of anxiety disorder, Vitamin D deficiency, and anemia (when you have low levels of healthy red blood cells to carry oxygen throughout your body). Record review of a MDS assessment dated [DATE] revealed Resident #64 was understood and understood others. The MDS revealed Resident #64 had a BIMS score of 14 which indicated the resident's cognition was intact. During an interview on 12/02/24 at 9:59 a.m., Resident #64 said the food was often served to them cold. Resident #64 said the food was always hard and over cooked. During an observation and interview on 12/03/24 at 12:45 p.m. a lunch tray was sampled with Dietary Manager and 2 surveyors. The sample tray consisted of beef stroganoff, green beans , roll. The food was seasoned and warm. There was no cake on the tray. Cake was served to the residents. The Dietary Manager said the kitchen ran out of cake. The Dietary Manager said this was his fault. He said he forgot to tell the staff to cut the pieces smaller so there would be extra. The cake was substituted with sherbet. The sherbet was melted and tasted like melted sherbet. The Dietary Manager said the sherbet was melted. (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a confidential resident group interview on 12/03/24 at 2:00 p.m., Anonymous Resident #1, Anonymous Resident #3, Anonymous Resident #4, and Anonymous Resident #7 stated they had the same food (chili beans) for lunch and supper on 12/02/24. They stated they had green beans and broccoli 4 days out of the last 5 days. Anonymous Resident #3 stated they quit eating the vegetables, so they were left with only meat and a soggy rolls most meals. Anonymous Resident #3 said repetitive cold non seasoned vegetables made them want to puke just looking at them. The residents stated they went hungry most nights and ate 100% of their breakfast because they were starving. During an interview on 12/04/24 at 10:36 a.m., the Dietary Manager said he was filling in because the previous Dietary Manager had recently quit. He said his first day at the facility was 12/02/24. He said Dietary Managers should make rounds to visit with every resident concerning the food. He said he did not know if that had been done. He said the Dietary Manager should also in-service staff concerning following menus, recipes, and getting food out of the kitchen on time. He said residents not liking the food could cause weight loss and could cause residents to not feel comfortable and happy in their home. During an interview on 12/04/24 at 12:30 p.m., the Administrator said concerning food complaints they interview the residents and update their preferences. She said there had been issues with the food. She said herself and the previous dietary manager had made rounds asking the residents about the food. She said they do try different things to cater to each of the residents' individual taste. She said residents not liking the food might cause them not to eat the food. Record review of a Meal Service facility policy dated 10/01/18 indicated, .A respectful, positive dining experience is essential to the residents' quality of life and helps to identify residents' needs and improve their overall nutritional status. Residents will be properly groomed and their needs attended to during the meal service .Placement, color and texture of foods will meet the residents' needs .		

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 44596 Based on interview, and record review, the facility failed to ensure there were no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack was served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span for 6 of 8 residents (confidential residents in group) reviewed for frequency of meals. The facility failed to ensure residents were offered snacks at bedtimes as required due to mealtimes being more than 14 hours apart. This failure could affect all residents who received meals served from the facility's only kitchen by placing residents at risk for, unplanned weight loss, and side effects from medication given without food, and diminished quality of life. Findings included: Record review of the posted Meal Service Times in the dining room revealed the following: Breakfast - 8:00 AM Lunch - 12:00 PM Evening meal 5:00 PM- There was no posting to advise any resident a snack or availability of type of snack after specified times. During a confidential interview on 12/03/2024 at 2:00 p.m. of 8 residents, it was brought to the attention of the state surveyors that they had not been provided snacks during the day or at bedtime. During a confidential interview AR #1,3, 4,5, 7, and 8 stated they have asked for snacks before bedtime and told the kitchen wasis closed and no snacks wereare available. They stated no snacks wereare passed out to them at any time during the day unless they were having an activity that had snacks. During an interview on 12/03/2024 2:30 p.m., LVN B stated she worked day shift, and she stated the kitchen would make a sandwich for a resident if you asked but there was no one that was assigned to pass out snacks. She stated at night she thought they put them on the nurse's station and the aides passed the snacks out. During an interview on 12/04/2024 at 8:20 a.m., [NAME] C stated she did not make snacks for residents because she was busy making meals for residents. She stated there was no list of residents who received snacks, and no one had ever trained her on preparing snacks for the residents. [NAME] C stated there were several times during the week when breakfast was not out by 8:00 a.m. She stated it all depended on if the kitchen staff showed up on time to do their jobs. She stated the residents were probably hungry by breakfast because 5:00 p.m. to 8:00 a.m. was a long time with no food. (continued on next page)		

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 12/04/2024 at 10:20 a.m., the DM stated resident snacks should be made every evening before they kitchen staff left and placed at the nurse's station. He stated it was the nursing department's responsibility to pass them out and set them up for each resident. He stated he was just filling in for the DM and was unsure if they staff had been preparing snacks, but he would ensure they did in the future. During interview on 12/04/2024 at 1:30 p.m., the ADM stated snacks should be provided at bedtime and anytime a resident request a snack. The ADM stated the bedtime snacks should be offered after dinner. The ADM stated if resident were not offered snacks, resident will be hungry and diabetic residents could have low blood sugar. The ADM stated residents can request snacks. The ADM stated the Activities department had snacks when they had functions throughout the day. The ADM stated a long gap in time between meals required a snack to be available to all residents. Record Review of the Facility Policies and Procedures for Resident Food Services dated 07/2021 revealed, SNACKS- Procedures: Nursing offers bedtime snacks. Nursing is to set up snack on the resident bedside table and ensure it is in reach before leaving the room.		

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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. 44128 Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards in 1 of 1 kitchen reviewed for food service safety. 1. The facility failed to ensure the sugar was stored in a bin with a closed lid. 2. The facility failed to ensure all food items were labeled and dated in Freezer #1. 3. The facility ensure the deep fryer was clean free of grease splashes and food particles. 4. The facility failed to ensure the doors of Freezer #1, Refrigerator #1 and the lid of the milk cooler was clean and free of food smears. These failures could place residents at risk of foodborne illness and food contamination. Findings include: During an observation on 12/02/24 at 8:48 a.m., there were white smears on the door of the refrigerator. On the lid of the milk cooler there was a brown smear. During an observation on 12/02/24 at 8:50 a.m., the sugar bin stored inside the pantry was open to air. During an observation on 12/02/24 at 8:51 a.m., the deep fryer was covered in greasy residue. The greasy residue was down both sides and down the front of the fryer. The cover to the deep fryer was covered in greasy residue with many scattered food particles. There were 6 burners on the stove. Each had a greasy build up and was covered in food splashes. The crevices of the stove top had a built up of food particles. During an observation on 12/02/24 at 8:52 a.m., inside freezer #1 there were 2 packages of undated beef franks. There were 2 bags of a beige rectangle shaped food item with no date or label. There were 3 packages of tan colored stick shaped food items with no date or label. There were 2 packages round light brown food items with no date or label. There was 1 package of an unknown breaded food item with no date or label. The outside door of the freezer had multiple brown smears. During an observation on 12/03/24 at 11:11 a.m., the deep fryer was covered in greasy residue. The greasy residue was down both sides and down the front of the fryer. The cover to the deep fryer was covered in greasy residue with many scattered food particles. There were 6 burners on the stove. Each had a greasy build up and was covered in food splashes. The crevices of the stove top had a built up of food particles. There were no changes from 12/02/24. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 12/03/24 at 11:12 a.m., there was a greasy brown substance smeared on lid of the milk cooler. The substance wiped off when touched. The outside door of Freezer #1 had multiple brown smears. There were white smears on the door of the refrigerator. During an observation and interview on 12/04/24 at 10:27 a.m., [NAME] C said cleaning equipment in the kitchen was the responsibility of the cooks. She said she had noticed how dirty the deep fryer was. She said she had asked the previous Dietary Manager for the necessary supplies to clean the deep fryer, but none of the supplies were ever provided to her. She said the cooks were also responsible for cleaning the stove top. She said she agreed the stove top had food splashes and a greasy build that had been there awhile. She said, the other cook does not work like we do. She said there was not a cleaning checklist. She said it was the cook's responsibility to date and label all foods as the food was put away. She said the previous dietary manager left approximately 2 weeks ago. She said all food bins were supposed to be kept closed. During the interview, the cook pulled a plastic bag out of the freezer with a light-colored frozen food item. The bag was undated and unlabeled. She said it was rolls in the bag. She said the bag was supposed to be dated and labeled. During an interview on 12/04/24 10:36 a.m., the Dietary Manager said he was filling in because the previous Dietary Manager had recently quit. He said his first day at the facility was 12/02/24. He said sugar was supposed to be stored in a covered bin and staff were to make sure the bin was closed after each use. He said the sugar being left open could cause the sugar to become contaminated and could cause someone to get sick. He said the cook was supposed to keep the deep fryer clean. He said he agreed the deep fryer was dirty. He said the deep fryer had a greasy build up all over. He said the dietary aids were supposed to help keep equipment surfaces clean. He said all surfaces should be wiped down and kept clean. He said he did not know what the brown substance was on the top lid of the milk cooler. He said he agreed that the burners on the stove were dirty and had a greasy build up. He said he was about to clean those. He said cooks should be cleaning those at the end of their shifts. He said equipment not being clean could cause food contamination and could cause someone to get sick. He said all kitchen staff should be dating and labeling foods. He said when foods come in it should be dated and labeled. He said food not being dated could cause food borne illness because the food could be out of date. He said unlabeled food items could cause a resident to be served a food that they were allergic to. During an interview on 12/04/24 at 12:30 p.m., the Administrator said dietary staff were responsible for making sure that food bins were closed, that all equipment was clean and food items were dated and labeled appropriately. She said she would expect food bins to be kept closed, all equipment be kept clean and food items to be dated and labeled appropriately. She said if food bins were being left open, something could get into the food bin. She said just the food bin being open did not have a negative impact on the resident. She said she did feel the residents' kitchen should have been kept clean. She said all items should be dated and labeled so they could be identified and cooked appropriately. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of a General Kitchen Sanitation facility policy dated 10/01/18 indicated, .The facility recognizes that food-borne illness has the potential to harm elderly and frail residents. All Nutrition & Food service employees will maintain clean, sanitary kitchen facilities in accordance with the state and US Food Codes in order to minimize the risk of infection and food borne illness .Clean and sanitize all food preparation areas, food-contact surfaces, dining facilities and equipment. After each use, clean and sanitize all . food-contact surfaces of equipment .Clean food-contact surfaces of grills, griddles and similar cooking devices and the cavities and door seals of microwave ovens at least once a day .Keep food-contact surfaces of all cooking equipment free of encrusted grease deposits and other accumulated soil .Clean and sanitize all multi-use utensils and food-contact surfaces of equipment used in the preparation or storage of potentially hazardous food prior to each use .Clean non-food-contact surfaces of equipment at intervals necessary to keep them free of dust, dirt, and food particles and otherwise in a clean and sanitary condition . Review of a 2022 Food Code for the U.S. Food and Drug Administration indicated, .3-304.12 .During pauses in food preparation or dispensing, food preparation and dispensing .in food that is not time/temperature control for safety food with their handles above the top of the food with containers or equipment that can be closed, such as bins of sugar, flour, or cinnamon .Annex 4. Establish First-In-First Out (FIFO) Procedures. Product rotation is important for both quality and safety reasons. First-In-First-Out (FIFO) means that the first bath of product prepared and placed in storage should be the first one sold or used. Date marking food as required by the Food Code facilitates the use of a FIFO procedure in refrigerated, ready-to-eat, TCS (temperature control storage) foods. The FIFO concept limits the potential for pathogen growth, encourages product rotation, and documents compliance with time/temperature requirement .		