STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675967	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northgate Plaza	2101 Northgate Dr Irving, TX 75062

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50445 Based on observation, interview, and record review, the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services for mobility for 1 of 5 residents reviewed for activities of daily living (Resident #1). The facility did not provide for assistance with activities of daily living by addressing the mobility/transfer needs of Resident #1. The failure could place residents requiring assistance to transfer at risk for developing wounds, infections, generalized deterioration, and loss of functional abilities. Findings included: Review of Resident #1's face sheet reflected he was an [AGE] year-old male admitted to the facility on [DATE]. Review of Resident #1's Quarterly MDS assessment dated [DATE] reflected Resident #1 was dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity) for transfers to and from the bed to chair/wheelchair. MDS did not indicate pressure-related ulcers. The MDS noted a BIMS score of one, indicating severe cognitive impairment. The MDS indicated that Resident #1 had not exhibited the behavior of rejection of care. Review of Resident #1's care plan dated 11/22/24 reflected that Resident #1 wanted his wheelchair at the bedside, that he had potential for pressure ulcers, and that he should have been out of bed unless contraindicated. The care plan also revealed that Resident #1 required one staff participation with transfer. are plan indicated client was admitted to hospice with a diagnosis of Chronic Obstructive Pulmonary Disease (lung damage affecting breathing). The care plan did not say when or how often Resident #1 should have been out of bed and did not include interventions for getting him out of bed, aside from requiring one staff. The care plan did not address any refusals by Resident #1 in regard to transfers. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 12/17/24 at 09:00 a.m., Resident #1's family member reported the facility had never gotten him out of bed since he returned from the hospital in May 2024. The family member reported that Resident #1 told her this. The family member reported that Resident #1 is confused at times but that he is, cognizant enough to tell you he wants up and is not being gotten up. The family member also reported that she was at the facility twice last week, typically visits once every three weeks, and has not seen the resident out of the bed since May 2024. She reported that Resident #1 cannot stand up or transfer himself and he requires staff to assist him. The family member did not mention whether Resident #1 had developed wounds or infections, lost skills, or deteriorated while at the facility. In an observation and interview on 12/17/24 at 09:45 a.m., Resident #1 was noted lying in bed on his back. He stated he would like to get out of the bed to the wheelchair but that, I have to have help to get up. Nobody is here to help me. He stated that he was not sure when he last got out of the bed but that it may have been three weeks ago. He also reported that he has low back pain but that when it comes to getting out of bed, It hurts but it has got to be done. A wheelchair was noted in Resident #1's room. Resident #1 did not mention refusing to get out of bed if/when offered, how often he told staff he wanted to get out of bed, which staff he told, when he told them, what they said when he asked, if he had developed any wounds or infections, deteriorated, or lost skills, or how he had been affected by not getting out of bed or how he felt about it. In an interview on 12/17/24 at 10:00 a.m., RN A stated she was a full time RN for the 300 Hall, had worked at the facility about three months, worked a rotating schedule including weekdays and every other weekend, and that she did not remember seeing Resident #1 up out of bed or in his wheelchair in the past three months. RN A stated she did offer to get him up once last week when the family was at the facility and complained that Resident #1 was not being assisted out of bed. She stated that Resident #1 refused to get up at that time when offered. She stated she did not chart the refusal as there was nowhere in the system that it is typically charted. In regard to not getting Resident #1 out of bed she stated, We should encourage him more. Being on one side is not good. He will get wounds. She stated that we turn him, but he turns back. She reported there is no other full-time nurse for the 300 Hall. In an interview on 12/17/24 at 12:00 pm, agency CNA B reported 12/17/24 was her first day at the facility, that she was providing care for Resident #1, and that he has not been assisted out of the bed today. In a telephone interview on 12/17/24 at 01:00 p.m., RN C, Hospice Nurse, reported that she had been the case manager for Resident #1 since last week and that she saw him once last week. She stated that she had not seen Resident #1 out of bed and, I don't see why they couldn't get him up. In a telephone interview on 12/17/24 at approximately 01:10, Physician A stated that he was not aware of any issues with Resident #1 being assisted to getting out of bed to a wheelchair but that he would defer any further questions to the NP D. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 12/17/24 at 01:14 p.m., RN E, Hospice Nurse, reported that she had taken care of Resident #1 for approximately 7 or 8 months, seeing him once per week. She reported she last saw him two weeks ago. She reported that during the past 7 or 8 months she never saw Resident #1 out of his bed. She stated she notified the prior facility Director of Nurses, a female she did not remember the name of, four or five times that she was concerned that Resident #1 was not being assisted out of bed. She stated the prior facility Director of Nurses reported she would take care of it, but RN E stated she didn't think she really took it seriously. RN E reported that in early December 2024, she twice notified the current DON, that Resident #1 was not being assisted out of the bed. She stated that he was new and dealing with many things, but that he said he would take care of it. RN E stated, This is wrong. I feel like they just left him there to die. It's been months and that man has not moved out of bed. She reported she was concerned about wounds developing due to Resident #1 not getting out of bed. In a telephone interview on 12/17/24 at 01:32 p.m., Hospice CNA F reported she had been providing care to Resident #1 for about one month, five times per week. She stated that in her time at this facility she had not seen Resident #1 out of the bed. She reported, The nurse tried, stating that RN E told facility management that Resident #1 needed to be assisted to get out of bed. She also stated that RN E had ordered and gotten a wheelchair for Resident #1. She reported that she had never heard Resident #1 ask to get up, had never heard facility staff ask him if he wanted to get up, and had never heard him refuse to get up. In a telephone interview on 12/17/24 at 02:27 p.m., NP D stated she had worked at this facility since July 2024. She reported regarding Resident #1 being assisted by staff out of bed, I've been trying to get therapy involved but it is an issue because he is on hospice. She also reported she thought Resident #1 refused to get up at times. She reported that she would like to see Resident #1 get up as tolerated, possibly multiple times a day. She reported there is no medical reason that he cannot get up to a wheelchair. She reported that when a Resident is not assisted out of bed to wheelchair when needed and they remain in the bed, they are at risk of developing wounds, they have an increased chance of pneumonia, and they can experience a decline in health and decompensation . She did not indicate that Resident #1 had experienced any of these things. In an interview on 12/17/24 at 03:00 pm, OT G stated that he works full time in the therapy department Monday through Friday. He reported that Resident #1 was no longer on Hospice and the therapy department could not assist in transferring him. He stated it was up to nursing services to transfer the resident from the bed to the chair. He stated that prior to being placed on hospice, Resident #1 required one person assist and that the therapy department would get him up every day, but that since he was placed on hospice in May, he has not seen him out of the bed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/17/24 at 03:15 p.m., the DON reported he had not been informed by a hospice nurse that Resident #1 was not being assisted out of bed. DON stated that while everyone was responsible for the care of the resident, the facility retained the responsibility for ensuring that the resident was receiving appropriate care, such as transfers, regardless of whether a resident was on hospice care or not. DON reported he had heard that Resident #1 had refused to get up out of bed. He reported these refusals of everyday care were not necessarily charted. DON reported he had worked at this facility for about 5 weeks. He stated he had never seen Resident #1 out of bed. He stated he did not know if staff had offered this to the resident every day. DON reported it was his expectation that staff would offer to get Resident #1 out of bed anytime and whenever Resident #1 requested. He reported that if a resident had continued to refuse, the refusals should be charted, and the issue addressed in the care plan. He reported that a resident who was not assisted out of bed could be placed at risk for skin breakdown and infections such as upper respiratory infections and urinary tract infections . DON indicated that he was not aware that Resident #1 had experienced any of these things. In an observation on 12/20/24 at 03:45 p.m., Resident #1 was observed sitting in a wheelchair in the dining room. No distress was noted. He was noted as alert and calm. He was noted with oxygen in place by nasal cannula. In an interview on 12/18/24 at 02:08 CNA H reported she was PRN at this facility and typically worked 6am-6pm on all halls. She reported that she had worked at this facility for about [AGE] years. She reported that she saw Resident #1 up in a wheelchair today (12/18/24) and yesterday (12/17/24), but that she had not seen him up or in a wheelchair when she was here last week. She stated that prior to last week she had not worked at this facility for about a month. Prior to that time, she stated she did not remember when she last saw Resident #1 up to a wheelchair, but that she did remember seeing him in a wheelchair in the dining room with his coffee in prior months. She reported that Resident #1 required two-person assist to transfer. She stated the facility had enough staff to assist this resident up to a wheelchair. She reported if this was not done it might be because Resident #1 did not like having the oxygen tank attached to his wheelchair and would ask to return to his room. She reported it was expected that staff would ask residents three times a day if they would like assistance to get up. In an interview on 12/18/24 at 02:27 p.m., CNA I reported she had been at this facility for two months and that she rotated halls. She reported that when a resident was two-person assist that the aides would work together to help them. She reported that Resident #1 was assisted to get up by another staff member approximately two weeks ago to go to a doctor's appointment. She reported that was the only time she had ever seen or known that Resident #1 had gotten up to a chair since she started working here about two months ago. She stated she thought he hadn't gotten up because there were a lot of things he didn't like. She said she suspected that, but that he had never told her he would not get up. She stated she did ask residents if they want to get up. She stated that if a resident refused to get up, they charted it. In an interview on 12/19/24 at 02:35 p.m., CNA J stated she had worked at this facility for about 2 years on day shift. She reported, its been a few months since the last time she saw Resident #1 out of bed or in his wheelchair. She stated he had refused to get up at times. She stated she does not know why Resident #1 might not have been assisted out of bed. She stated she had been able to get him dressed and up to a chair at the beginning of December. She stated that a resident who was not assisted with getting out of bed could experience bedsores. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/19/24 at 03:25 p.m., RN K, reported he had been at this facility since approximately August 2023. He reported he did not remember seeing Resident #1 up to a wheelchair. He reported his expectation was that staff would offer to get residents up every day if not contraindicated or refused. He reported that any ongoing refusal (days or weeks) should result in a care plan meeting and a meeting with hospice and family. In a review of records, the Plan of Care Response History was reviewed for 11/20/24 through 12/15/24 and revealed that Resident #1 was transferred a total of 5 times. All other days were marked as activity did not occur or family/or non-facility staff provided care 100% of the time for that activity. No additional notes were provided. Review of nursing and provider progress notes from October 2024 to current (12/18/24) did not reflect that Resident #1 had refused offers to transfer, or that there was any contraindication to transfers to the wheelchair. Review of records: Resident #1 MDS completed 11-19-24 did not indicate any unhealed pressure ulcers or treatment required for skin ulcers. Care plan dated 11-22-24 for Resident #1 did not indicate any active wounds. Review of skin assessment dated [DATE] did not indicate any pressure-related skin issues. Review of progress notes from 11/10/24 to 12/10/24 did not indicate active infection. Policies regarding care plans were not obtained from the facility.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 46486 Based on interview and record review, the facility failed to use the services of a registered nurse for 8 consecutive hours 7 days a week for all four quarters reviewed for RN coverage. The facility did not have RN coverage for eight consecutive hours on 42 days during the review period. This failure could place residents at risk of lack of nursing oversight and higher level of care needed. Findings included: Record review of the PBJ reports dated Quarter 1 2024 (October 1 - December 31), Quarter 2 2024 (January 1-March 31), Quarter 3 2024 (April 1 - June 30) and Quarter 4 2024 (July 1 - September 30) reflected there were no consecutive 8 hours of RN coverage on 12/16/2023; 12/17/2023; 12/23/2023; 12/24/2023; 12/30/2023; 12/31/2023; 01/06/2024; 01/07/2024; 01/20/2024; 01/21/2024; 01/27/2024; 01/28/2024; 02/03/2024; 02/04/2024; 02/10/2024; 02/11/2024; 02/17/2024; 02/18/2024 04/20/2024; 04/21/2024; 04/27/2024; 04/28/2024; 05/05/2024; 05/11/2024; 05/12/2024; 05/18/2024; 05/19/2024; 05/25/2024; 05/26/2024; 06/08/2024; 06/22/2024; 07/07/2024; 08/03/2024; 08/10/2024; 08/17/2024; 08/24/2024; 08/31/2024; 09/01/2024; 09/07/2024; 09/14/2024; 09/21/2024; 09/22/2024 Record review of the facility's employee roster undated revealed there were five RNs employed at the facility. In an interview on 12/18/2024 at 1:39 PM, the Staffing Coordinator revealed she had worked there since August and stated that the staff ratio is based off the daily census but required to have an RN coverage eight hours a day. The staffing coordinator stated that the facility had utilized agency staff that assisted with RN coverage and that September 2024 was the last month with no eight-hour RN coverage. She stated that when there was no RN coverage the resident would be put at great risk of poor care, so when there was no RN coverage, she called the DON. In an interview on 12/18/2024 at 3:00 PM, the DON, who was an RN, stated he worked full-time at the facility for 2 months and stated there has not been RN coverage at least one weekend per month. The DON stated if there was a need for an RN, he makes himself available to come into the facility to meet the need. The DON stated that the potential harm of not having RN coverage would be lack of supervision and missed pertinent treatment of the residents. Requested punch card hours for RN coverage and the operations manager who was filling in for the administrator stated they were unable to provide punch cards for the following dates: (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/16/2023; 12/17/2023; 12/23/2023; 12/24/2023; 12/30/2023; 12/31/2023; 01/06/2024; 01/07/2024; 01/20/2024; 01/21/2024; 01/27/2024; 01/28/2024; 02/03/2024; 02/04/2024; 02/10/2024; 02/11/2024; 02/17/2024; 02/18/2024; 04/20/2024; 04/21/2024; 04/27/2024; 04/28/2024; 05/05/2024; 05/11/2024; 05/12/2024; 05/18/2024; 05/19/2024; 05/25/2024; 05/26/2024; 06/08/2024; 06/22/2024; 07/07/2024; 08/03/2024; 08/10/2024; 08/17/2024; 08/24/2024; 08/31/2024; 09/01/2024; 09/07/2024; 09/14/2024; 09/21/2024; 09/22/2024 Record review of the facility's Staffing Policy called RN Requirements dated 2-2024, stated: Policy: RN Hours Procedures: Total hours per resident day (HPRD): A minimum of 3.48 hours of total nursing staff per resident day Registered nurse (RN) hours: At least 0.55 hours of RN care per resident day Nurse aide hours: At least 2.45 hours of nurse aide care per resident day RN on-site: An RN must be on-site 24 hours a day, 7 days a week to provide direct resident care The remaining 0.48 hours can be filled by any combination of RNs, nurse aides, and licensed practical or vocational nurses (LPN/LVNs).

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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. 46525 Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food safety. 1. The facility failed to ensure the ice machine's left and right-sided vents were free from dust. 2.The facility failed to ensure food items in the refrigerator and dry storage room were labeled and stored in accordance with the professional standards for food service. 3. The facility failed to discard items stored in refrigerator and dry storage that were not properly labeled or past the 'best by', discard by or expiration dates. 4. The facility failed to have Dietary staff change gloves when they touched other surfaces while handling food or upon re-entering the kitchen. 5. The facility failed to ensure chicken set to thaw in a sink was left to thaw under cold running water. 6. The facility failed to ensure the kitchen was free of pests. 7. The facility failed to ensure all cans stock in area for kitchen use were free from dents and indentations These failures could place residents at risk for food-borne illness and cross contamination. Findings Included: Observations of the Kitchen on 12/16/24 at 09:39 AM revealed the following: -Ice Machine plastic vents, located on the left and right side of the machine, the vent slats had dust on them. -Eyewash station next to the handwashing sink, the basin had dust and small pieces of debris inside it. -On the wall across from the DM's office was a prep table that spanned the entire length of the wall. In the prep table was a sink on the end nearest the DM's office (right side). In the sink was an extra-large clear plastic bag with thawing chicken. The bag was open to air and sitting in water, not under cold running water. There was no label of item description, no pull date and no discard by date. -On the opposite end (left side) of the extra long prep table was a 62 oz. can of sliced mushrooms dated 11/5/24. The can lid had been cut opened and left sitting up, leaving the can open to air. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Under the prep table in the middle, 1 extra-large white bin with lid had a label with faded/faint writing, stated sugar, dated 07/21/24. There was no discard by date. - Under the prep table in the middle, 1 extra-large white bin with lid had a label with faded/faint writing, stated rice, dated 07/21/24. There was no discard by date. - Under the prep table in the middle, 1 extra-large white bin with lid had a label with faded/faint writing, stated thickener, dated 07/21/24. There was no discard by date. - Under the prep table in the middle, 1 extra-large white bin with lid had a label with faded/faint writing, stated flour, dated 07/21/24. There was no discard by date. Observations of Reach-in Refrigerator on 12/16/24 at 09:41 AM revealed the following: -On the 2nd shelf from the top was a small clear plastic pitcher with a thick red liquid, no label of item description, no prep/opened date, no discard by date. -3rd shelf from the top, 1-46 oz clear plastic container of thickened orange juice, previously opened, dated 05/03/24, manufacturer expiration date 11/12/24. There was no open date, no discard by date. -Bottom shelf, a tray dated 12/16/24, with 6-4 oz. clear plastic cups covered with plastic wrap: 1 cup with light brown liquid, 2 cups with orange juice and 3 cups with dark red thin liquid. There was no label of item description, no discard by date. Observations of Kitchen (receiving side of steam table) on 12/16/24 at 10:00 AM revealed the following: -On a medium sized prep table, across from the receiving side of the steam table, there was a 5-container dry cereal dispenser (from right to left): Dry cereal #1 was a puffed rice cereal, under the dispenser spout was a trap (catches extra pieces) with a small amount of cereal in the trap, no opened date, no discard by date. -Dry cereal #2: Corn cereal flakes, no opened date, no discard by date. -Dry cereal #3: Bran cereal flakes, no opened date, no discard by date. -Dry cereal #4: All bran (wheat) circle cereal, cereal in dispenser was not what was on the label (picture), no label of item description, in the trap was approximately 7 pieces of cereal and a permanent black marker sticking up out of the trap, no opened date, no discard by date. Observations of Dry Storage Room on 12/16/24 at 10:28 AM revealed the following: -1 extra-large zip top bag of tortilla chips, no label of item description, no opened date, no discard by date. -1-5.75 lb. plastic container of fish fry breading mix, previously opened, dated 10/20/24, manufacturer expiration date 12/17/25, no opened date, no discard by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-1-1-liter bottle of Honey syrup, previously opened, dated 11/22/24, no discard by date. There was 1 small dark colored ant that crawled on the bottle. - On the 2nd row of the 2nd shelf on the right side of the room, there were 3 small dark colored ants that crawled on the shelving. Observations of Walk-in Refrigerator on 12/16/24 at 10:12 AM revealed the following: -Left side: on shelf, 2nd row from the top: 1-16 oz. container with lid, of beef base, previously opened, dated 08/27/24. There was no opened date, no discard by date. -1-7lbs. can refried beans dated 11/26/24 had a large dent on top of the can. Observations of the Kitchen on 12/18/24 at 12:00 PM revealed the following: -The cook with gloves on left the serving side after taking 5 plates and lying them out to serve on, went around to the receiving side with gloves still on, pushed a rack with prepped trays back, gathered several small bowls, put them on a tray then reached over to the serving side and set the tray down. The cook then touched the receiving side railing just before entering back in the main kitchen to the serving side. He did not change gloves or wash his hands and began service. In an interview on 12/16/24 at 09:48 AM with DM, she stated she was unaware of how long to keep opened liquid containers in the refrigerator, leftovers and opened items in the dry storage area. She stated she would get that information. The DM stated the staff cleans the area they work in, for example the cooks clean the area around the stove and the serving side of the steam table, and the Dietary Aides do the receiving side of the kitchen. Cooks also clean the refrigerator and freezer, and aides stock the food. She stated they have pest control come out; she believes every 15 days. She stated pest control was last there just last week and treats for cockroaches and other things. She stated she had not seen any ants before in the kitchen. She was unsure of how to report a pest issue but stated she does not call pest control however she would report it the Administrator and he can call them to come back out. The DM said she kept dented cans in her office to keep separate from the non-dented cans. She stated that items in the dry storage, the refrigerators and freezers should be labeled. In an interview on 12/18/24 at 11:43 AM with the DM, she stated she had the information regarding how long items are kept in the refrigerator and dry storage. She stated the previously opened liquids are kept until the expiration date (manufacturer's), leftovers in the refrigerator are kept for 72 hours and they go by the manufacturer's expiration date for opened items in the dry storage on how long they are kept after being opened. She could not articulate what the harm to the residents was if dust was on the vents or if food was from a dented can. When asked what the potential harm to the resident was for product packaging being left opened to air or not properly sealed, she said, for me, we have to be more cautious and ensure bags/packaging is sealed. Review of the facility's Food Storage/Rethermalization-Microwaving/Hot Liquids Policy & Procedures Revision 11/2017; 6/2019; 10/2021; 2/2023; 2/2024, reflected Procedures: 4. All perishable foods including leftovers must be dated, labeled and will be disposed of after 72 hours or by package expiration date. (continued on next page)

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	675967	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the U.S. FDA Food Code 2022 reflected: Chapter 2 . section 2-301 Hands and Arms. 2-301.11 Clean Condition. Food Employees shall keep their hand and exposed portions of their arms clean. 2-301.12 Cleaning Procedure. (C). To avoid recontaminating their hands or surrogate prosthetic devices, food employees may use disposable paper towels or similar clean barriers when touching surfaces such as manually operated faucet handles on a Handwashing Sink or the handle of a restroom door. 2-201.14 When to Wash. Food Employees shall clean their hands and exposed portions of their arms as specified under section 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single service and single-use articles. and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; (C) After caring for or handling service animals or aquatic animals as specified in 2-403.11(B); (D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco products, eating, or drinking; (E) After handling soiled equipment or utensils; (F) During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw food and working with ready-to-eat food; (H) Before donning gloves to initiate a task that involves working with food; and (I) After engaging in other activities that contaminate the hands. Chapter 3 . section 3-201.11 Compliance and Food Law: . C. Packaged Food shall be labeled as specified in LAW, including 21 CFR 101 Food Labeling [* .(b) A food which is subject to the requirements of section 403(k) of the act shall bear labeling, even though such food is not in package form. (c) A statement of artificial flavoring, artificial coloring, or chemical preservative shall be placed on the food or on its container or wrapper, or on any two or all three of these, as may be necessary to render such statement likely to be read by the ordinary person under customary conditions of purchase and use of such food. The specific artificial color used in a food shall be identified on the labeling when so required by regulation in part 74 of this chapter to assure safe conditions of use for the color additive.], 9 CFR 317 Labeling, [*(a) When, in an official establishment, any inspected and passed product is placed in any receptacle or covering constituting an immediate container, there shall be affixed to such container a label .Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. Section 3-302.12 Food Storage Containers, Identified with Common Name of Food: Except for containers holding FOOD that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food. Section 3-501.13 Thawing. Except as specified in (D) of this section, Time/Temperature Control for Safety Food (TCS) shall be thawed: (A) Under refrigeration that maintains the FOOD temperature at 5oC (41oF) or less; or (B) Completely submerged under running water: (1) At a water temperature of 21oC (70oF) or below, (2) With sufficient water velocity to agitate and float off loose particles in an overflow, and (3) For a period of time that does not allow thawed portions of READY-TO-EAT FOOD to rise above 5oC (41oF) , or (4) For a period of time that does not allow thawed portions of a raw animal FOOD requiring cooking as specified under 3-401.11(A) or (B) to be above 5oC (41oF), for more than 4 hours including: (a) The time the FOOD is exposed to the running water and the time needed for preparation for cooking, or (b) The time it takes under refrigeration to lower the FOOD temperature to 5oC (41oF). Section 3-501.17 . Commercial processed food: Open and hold cold . B. 1. The day the original container is opened in the food establishment shall be counted as Day 1. 2. The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. C. 2. Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (A) of this section. 3. Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section. Definitions 3. Food Receiving and Storage - When food, food products or beverages are delivered to the nursing home, facility staff must inspect these items for safe transport and quality upon receipt and ensure their proper storage, keeping track of when to discard perishable foods and covering, labeling, and dating all PHF/TCS foods stored in the refrigerator or freezer as indicated. Chapter 5 . Section

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	eCFR- Code of Federal Regulations are indicating within the text by an *- www.ecfr.gov

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50445 Based on observation, interview, and record review, the facility in accordance with professional standards and practices, failed to maintain medical records on each resident that are complete and accurately documented, for 1 of 5 residents reviewed for documentation (Resident #1). The facility did not accurately document refusal of transfers by Resident #1. The failure could place residents at risk for not receiving resident-centered plans of care. Findings included: Review of Resident #1's face sheet reflected he was an [AGE] year-old male admitted to the facility on [DATE]. Review of Resident #1's Quarterly MDS assessment dated [DATE] reflected Resident #1 was dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity) for transfers to and from the bed to chair/wheelchair. MDS did not indicate pressure-related ulcers. The MDS noted a BIMS score of one, indicating severe cognitive impairment. The MDS indicated that Resident #1 had not exhibited the behavior of rejection of care. Review of Resident #1's care plan dated 11/22/24 reflected that Resident #1 wanted his wheelchair at the bedside, that he had potential for pressure ulcers, and that he should have been out of bed unless contraindicated. The care plan also revealed that Resident #1 required one staff participation with transfer. The care plan indicated client was admitted to hospice with a diagnosis of Chronic Obstructive Pulmonary Disease (lung damage affecting breathing). The care plan did not say when or how often Resident #1 should have been out of bed and did not include interventions for getting him out of bed, aside from requiring one staff. The care plan did not address any refusals by Resident #1 regarding transfers. In a review of records, the Plan of Care Response History was reviewed for 11/20/24 through 12/15/24 and revealed that Resident #1 was transferred a total of 5 times. All other days were marked as activity did not occur or family/or non-facility staff provided care 100% of the time for that activity. No additional notes were provided. Review of nursing and provider progress notes from October 2024 to current (12/18/24) did not reflect that Resident #1 had refused offers to transfer, or that there was any contraindication to transfers to the wheelchair. In a telephone interview on 12/17/24 at 09:00 a.m., Resident #1's family member reported the facility had never gotten him out of bed since he returned from the hospital in May 2024. The family member reported that Resident #1 told her this. The family member reported that Resident #1 is confused at times but that he is, cognizant enough to tell you he wants up and is not being gotten up. The family member also reported that she was at the facility twice last week, typically visits once every three weeks, and has not seen the resident out of the bed since May 2024. She reported that Resident #1 cannot stand up or transfer himself and he requires staff to assist him. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 12/17/24 at 09:45 a.m., Resident #1 was noted lying in bed on his back. He stated he would like to get out of the bed to the wheelchair but that, I have to have help to get up. Nobody is here to help me. He stated that he was not sure when he last got out of the bed but that it may have been three weeks ago. He also reported that he has low back pain but that when it comes to getting out of bed, It hurts but it has got to be done. A wheelchair was noted in Resident #1's room. Resident #1 did not mention refusing to get out of bed if/when offered, how often he told staff he wanted to get out of bed, which staff he told, when he told them. In an interview on 12/17/24 at 10:00 a.m., RN A stated she was a full time RN for the 300 Hall, had worked at the facility about three months, worked a rotating schedule including weekdays and every other weekend, and that she did not remember seeing Resident #1 up out of bed or in his wheelchair in the past three months. RN A stated she did offer to get him up once last week when the family was at the facility and complained that Resident #1 was not being assisted out of bed. She stated that Resident #1 refused to get up at that time when offered. She stated she did not chart the refusal as there was nowhere in the system that it is typically charted. Regarding not getting Resident #1 out of bed she stated, We should encourage him more. Being on one side is not good. He will get wounds. She stated that we turn him, but he turns back. She reported there is no other full-time nurse for the 300 Hall. In a telephone interview on 12/17/24 at approximately 01:10, Physician A stated that he was not aware of any issues with Resident #1 being assisted to getting out of bed to a wheelchair but that he would defer any further questions to the NP D. In a telephone interview on 12/17/24 at 01:32 p.m., Hospice CNA F reported she had been providing care to Resident #1 for about one month, five times per week. She stated that in her time at this facility she had not seen Resident #1 out of the bed. She reported, The nurse tried, stating that RN E told facility management that Resident #1 needed to be assisted to get out of bed. She also stated that RN E had ordered and gotten a wheelchair for Resident #1. She reported that she had never heard Resident #1 ask to get up, had never heard facility staff ask him if he wanted to get up, and had never heard him refuse to get up. In a telephone interview on 12/17/24 at 02:27 p.m., NP D stated she had worked at this facility since July 2024. She reported regarding Resident #1 being assisted by staff out of bed, I've been trying to get therapy involved but it is an issue because he is on hospice. She also reported she thought Resident #1 refused to get up at times. She reported that she would like to see Resident #1 get up as tolerated, possibly multiple times a day. She reported there is no medical reason that he cannot get up to a wheelchair. She reported that when a Resident is not assisted out of bed to wheelchair when needed and they remain in the bed, they are at risk of developing wounds, they have an increased chance of pneumonia, and they can experience a decline in health and decompensation . She did not indicate that Resident #1 had experienced any of these things. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/17/24 at 03:15 p.m., the DON reported he had not been informed by a hospice nurse that Resident #1 was not being assisted out of bed. DON stated that while everyone was responsible for the care of the resident, the facility retained the responsibility for ensuring that the resident was receiving appropriate care, such as transfers, regardless of whether a resident was on hospice care or not. DON reported he had heard that Resident #1 had refused to get up out of bed. He reported these refusals of everyday care were not necessarily charted. DON reported he had worked at this facility for about 5 weeks. He stated he had never seen Resident #1 out of bed. He stated he did not know if staff had offered this to the resident every day. DON reported it was his expectation that staff would offer to get Resident #1 out of bed anytime and whenever Resident #1 requested. He reported that if a resident had continued to refuse, the refusals should be charted, and the issue addressed in the care plan. He did not state how a failure to document refusals could affect a resident. In an interview on 12/18/24 at 02:08 CNA H reported she was PRN at this facility and typically worked 6am-6pm on all halls. She reported that she had worked at this facility for about [AGE] years. She reported that she saw Resident #1 up in a wheelchair today (12/18/24) and yesterday (12/17/24), but that she had not seen him up or in a wheelchair when she was here last week. She stated that prior to last week she had not worked at this facility for about a month. Prior to that time, she stated she did not remember when she last saw Resident #1 up to a wheelchair, but that she did remember seeing him in a wheelchair in the dining room with his coffee in prior months. She reported that Resident #1 required two-person assist to transfer. She stated the facility had enough staff to assist this resident up to a wheelchair. She reported if this was not done it might be because Resident #1 did not like having the oxygen tank attached to his wheelchair and would ask to return to his room. She reported it was expected that staff would ask residents three times a day if they would like assistance to get up. In an interview on 12/18/24 at 02:27 p.m., CNA I reported she had been at this facility for two months and that she rotated halls. She reported that when a resident was two-person assist that the aides would work together to help them. She reported that Resident #1 was assisted to get up by another staff member approximately two weeks ago to go to a doctor's appointment. She reported that was the only time she had ever seen or known that Resident #1 had gotten up to a chair since she started working here about two months ago. She stated she thought he hadn't gotten up because there were a lot of things he didn't like. She said she suspected that, but that he had never told her he would not get up. She stated she did ask residents if they want to get up. She stated that if a resident refused to get up, they charted it. In an interview on 12/19/24 at 02:35 p.m., CNA J stated she had worked at this facility for about 2 years on day shift. She reported, its been a few months since the last time she saw Resident #1 out of bed or in his wheelchair. She stated he had refused to get up at times. She stated she does not know why Resident #1 might not have been assisted out of bed. She stated she had been able to get him dressed and up to a chair at the beginning of December. She stated that a resident who was not assisted with getting out of bed could experience bedsores. In an interview on 12/19/24 at 03:25 p.m., RN K, reported he had been at this facility since approximately August 2023. He reported he did not remember seeing Resident #1 up to a wheelchair. He reported his expectation was that staff would offer to get residents up every day if not contraindicated or refused. He reported that any ongoing refusal (days or weeks) should result in a care plan meeting and a meeting with hospice and family. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policies regarding documentation of resident refusals of care were not obtained from the facility.