STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676015	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabee Health Care Center	2208 N Loop 250 W Midland, TX 79707

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Based on interview and record review the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 of 12 residents (Residents #6, #14, and #22) reviewed for care plans in that: Resident #6 did not have a care plan in place for fall risk. Resident #14 did not have a care plan in place for dehydration or hand rolls. Resident #22 did not have a comprehensive care plan. This failure could affect residents by placing them at risk of not receiving individualized care and services to meet their needs. The findings included the following: Review of Resident #6's Resident Face Sheet, dated 12/5/24, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including unspecified dementia, and Diabetes Mellitus with Diabetic Neuropathy (nerve damage causing people to not feel their extremities). Review of Resident #6's Quarterly MDS Assessment, dated 10/23/24 revealed: She had a mental status of 3 of 15 (indicating severe cognitive impairment) with signs of delirium to include disorganized thinking that fluctuated. She needed substantial assistance for transferring to chair to bed. She took the following high-risk medications: anti-anxiety, anti-depressant, opioid. Review of Resident #6's Significant Change MDS, dated [DATE], revealed the Care Area Assessment triggered area: Falls. In the column indicating if it was care planned the facility documented they care planned for falls. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #6's electronic record, including the care plan revealed no care plan for falls. Review of Resident #14's Resident Face Sheet, dated 12/5/24, revealed he was a [AGE] year-old male admitted to the facility 10/21/20 with diagnoses including stroke and paralysis of both sides. Review of Resident #14's Significant Change MDS Assessment, dated 11/5/24 revealed: Cognitive statuswas unable to be assessed. Range of Motion impairment was noted of the upper and lower extremities on both sides. He was completely dependent for all ADL's. Review of Resident #14's Care Plan and electronic record revealed no care plan for dehydration and the hand rolls. Observation on 12/3/24 at 3:27 PM revealed Resident #14 was in bed, the head of his bed was raised, he had an air mattress and was hooked to a feeding tube. His hands were severely contracted (curled in and unable to be straightened) and he had hand rolls (rolled up dry wash cloths in them to absorb sweat and keep the contracture from getting worse). Observation on 12/5/24 at 9:48 AM revealed Resident #14 was in bed with the hand rolls in place. Interview on 12/5/24 at 9:52 AM LVN A stated the first thing she did in the morning was make sure Resident #14's hands were clean, and the hand rolls were in place. Review of Resident #22's Face Sheet revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia, high blood pressure, high cholesterol, gastroesophageal reflux disease, pain, edema (swelling to the lower extremities), and history of blood clots. Review of Resident #22's Quarterly MDS, dated [DATE] revealed: She scored 2 of 15 on a mental status exam indicating severe cognitive impairment. She displayed wandering behaviors 1 to 3 days during the look back period. She required moderate assistance to total dependence for all ADL's. She had active diagnoses of Alzheimer's disease, dementia, coronary artery disease, high blood pressure, high cholesterol, stroke, and anxiety disorder. She had 2 or more falls without injury reported since the last assessment. She was at risk of developing pressure ulcers. She received an antipsychotic medication and a diuretic medication. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She was on hospice services. Review of Resident #22's medication orders, dated 12/05/24, revealed the following orders: Alprazolam 0.25mg give 1 tablet by mouth every 4 hours as needed for anxiety/agitation (Order Date 8/23/24) Amantadine HCl 100mg give 1 capsule by mouth daily (Order Date 8/5/24) Amlodipine 10mg give 1 tablet by mouth daily (Order Date 8/5/24) Furosemide 20mg give 1 tablet by mouth daily as needed for edema (Order Date 8/5/24) Polyethylene glycol 17 grams/dose give 17 grams mixed in 8 ounces of beverage of choice by mouth daily (Order Date 8/5/24) Quetiapine 25mg give 1 tablet by mouth twice daily (Order Date 8/27/24) Levothyroxine 100mcg give 1 tablet by mouth daily (Order Date 8/5/24) Acetaminophen 325mg give 2 tablets by mouth every 6 hours as needed for pain (Order Date 8/8/24) Vitamin D3 25mcg give 1 tablet by mouth daily (Order Date 8/8/24) Review of Resident #22's electronic health record revealed no comprehensive care plan in place. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/05/24 06:03 PM with the Administrator and the DON, the DON stated that Resident #22 was admitted in August 2024 and had a full care plan in the old system that should have transferred into the new system. The Administrator stated that some things did not transfer from the old EMR system, and it was being addressed as it was discovered. The DON stated that Resident #6 should have had a care plan for falls due to her history of falls. The DON stated that an audit had been done in November 2024 for all residents with recent falls to ensure that care plans were in place and Resident #6 was overlooked because she had not had any recent falls. The DON stated that Resident #14 should have had a care plan or intervention under his skin care plan regarding his hand contractures and hand rolls/pads. The DON stated that the ADON for LTC was responsible for starting and maintaining care plans for all residents. (The ADON was not present for an interview at the time of survey.) The DON stated that she expected care plans to be done within the required time frame and that care plans reflected the needs and wants of each resident. She stated that she expected any special needs, such as AFO's, low bed and mats next bed to be addressed in care plans. The DON stated that the purpose of the care plan was to outline needs so that anyone who looked at any resident's care plan would know how to take care of the resident. The DON stated that CAAs did not automatically trigger a care plan in the EMR system and that the care plan had to be built based on assessment and knowledge of each resident. She stated that the nurses had a whole library of care area templates to choose from when creating a care plan. The DON stated the nurses did some training on how to do care plans in the new system. The Administrator stated that she expected care plans to be completed in the correct time frame and so that anyone who looked at the care plan should be able to understand the care of the resident. The Administrator stated that the care plan should have a clear view of what tasks/care nurses were responsible for, what tasks/care CNAs were responsible for, dietary or nutritional needs, and any special situations present for the resident. The Administrator stated that DON audited care plans especially since changing to the new EMR on 10/01/24. The Administrator stated that Resident #22 had been stable with no falls, no infections, and no new diagnoses, so there had been no reason to audit her care plan. DON stated that if a resident falls or had an infection, she looked at the resident's care plan to make sure it was current and updated it if needed. The Administrator stated that the DON looked at the entire care plan during her audits. The DON stated the facility held weekly IDT meeting to discuss every resident - weight, skin, falls, about all changes. The Administrator and the DON both stated that all resident information was supposed to transition into the new EMR system, and some things did not, which they believe was the reason for the failure. The DON stated that the facility did not have a policy regarding care plans. 45411

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 Based on observation, interview, and record review the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, included locked secured medications, the appropriate accessory and cautionary instructions, and the expiration date when applicable for 2 of 3 medication carts (Rehab hall and secured unit medication carts), 1 of 2 medication rooms (Secured unit medication room) and to maintain locked medication cabinets for 4 of 60 rooms (Residents #9, #10, #28, #94) reviewed for medication storage. The medication cart used for the secured unit had an insulin pen that had been opened and placed into use but had no open date on it. The medication cart used for the rehab hall had 2 insulin vials that had been opened and placed into use but had no open dates on them. The secured unit medication room had opened Tuberculin (TB) vial that had expired. (Tuberculin is used to test for Tuberculosis in the body, Tuberculosis is a contagious infection caused by bacteria that mainly affects the lungs). The medication cabinets for 4 of 60 rooms (Residents #9, #10, #28, #94) were unlocked and unsupervised. The failures could place residents at risk of not receiving the therapeutic benefit of medications or adverse reactions to medications and could place residents at risk for drug diversion or accidental ingestion. Findings include: INSULIN AND EXPIRED TB During an observation and interview on 12/04/24 at 02:38 PM revealed the medication room in the secure unit was inspected with LVN A present. There was a small refrigerator that contained a vial of Tuberculin that had an open date of 10/30/24 and the box indicated to discard 30 days after opening. LVN A said she was not aware the TB solution had already expired. LVN A said as far as she knew it was each nurse's responsibility to remove any expired medications from the refrigerator. LVN A said if someone received a test with that expired TB solution it could lead to false readings. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 12/04/24 at 05:39 PM revealed the medication cart in the rehab hall was inspected with LVN B present. Inside the cart were 2 insulin vials that had been opened and placed into use and had no open date written on them. The insulin boxes and vials indicated Discard unused portion 28 days after first opening, Use within 28 days after initial use. LVN B said she had not opened the insulin vials and had no idea who had done that. LVN B said whenever she opened an insulin vial she dated them and as far as she knew every nurse was responsible for dating the insulin when they opened it. LVN B said if an expired insulin was administered to a resident it might not be as effective and lower the resident's blood sugar. During an observation and interview on 12/05/24 at 11:04 AM revealed the medication cart in the secure unit was inspected with LVN A present. Inside the cart was an insulin pen that had been opened and placed into use but had no open date written on it. The insulin pen indicated that it was good for 28 days after being opened. LVN A said she was not aware of the insulin pen not being dated. LVN A said she would always date the insulin pens when she opened them so that they would know when to dispose of them. LVN A said if the insulin pens were not dated and if used after 28 days it could lead to resident's sugar not being lowered and the insulin could have lost its potency. During an interview on 12/05/24 at 05:32 PM the DON was made aware of the opened and undated insulin medications and also the expired TB vial in the medication room. The DON said it was expected for the nursing staff to date the insulin and TB medications when they were opened. The DON said the nursing staff was supposed to date it because those medications were usually good for only 30 days. The DON said they did random audits of the medication rooms and medications carts but not at all times. The DON said if staff administered expired insulin or TB test that could lead to not being as effective. The DON said the failure occurred because the nursing staff did not date the insulins or removed the expired TB from the medication room. During an interview on 12/05/24 at 05:48 PM the Administrator was made aware of the opened and undated insulin medications and also the expired TB vial in the medication room. The Administrator said she expected for the nursing staff to have applied standard nursing practices such as following nursing guidelines they were taught in nursing school. The Administrator said if the staff administered an expired medication it may or may have a negative outcome. The Administrator said the failure because the nurses that open the insulins failed to date the vials and pen and they also failed to remove the expired TB vial from the medication room. During an interview on 12/05/24 at 06:02 PM the DON said they did not have a specific policy or any current training in regard to dating medication when opened. UNLOCKED MEDICATION CABINETS Review of Resident #9's Resident Face Sheet, dated 12/5/24, revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia, hypertension (high blood pressure), hypothyroidism (low thyroid levels), Arthritis, Anxiety, Allergies, incontinence, constipation, and dermatitis. Review of Resident #9's Quarterly MDS Assessment, dated 10/11/24, revealed: She had long and short-term memory impairment with moderately impaired decision-making skills. She showed signs of delirium that included disorganized thinking that fluctuated. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Triggered medications included an anti-anxiety and a diuretic. Review of Resident #9's Care Plan, last revised 9/25/24, revealed: Problem: History of elevated Blood pressure and needs medication to keep it controlled. Goal: Blood pressures within normal range for resident Approaches included: Administer antihypertensive medication as ordered. Problem: Pain. Will not show decline in mobility due to pain not controlled. Goal: Remain comfortable as disease progresses. Approaches included: Administer pain medications as ordered. Takes acetaminophen twice a day routinely. Problem: Psychosocial Wellbeing, Depression: Chronic. Goal: Depression will not increase as evidenced by participation in activities, leaving room, and absence of crying and making statements that she is depressed. Approaches included: Assess effectiveness of anti-depressant medication therapy. Review of Resident #9's Continuity of Care Document, dated 12/5/24, revealed ordered medications: Benazepril 40 mg tablet, once a day for Hypertension. Citalopram 10 mg, once a day for anxiety Donepezil 10mg , once a day for dementia Hydrochlorothiazide 12.5mg capsule once a day for hypertension. Observation on 12/3/24 at 3:51 p.m. revealed Resident #9's resident room open, the medication cabinet in her room was closed but did not lock. Resident #9 was out of her room. Inside the cabinet were cards of: Memantine 28 mg Benazepril 40 mg Hydrochlorothiazide 12.5mg capsules Citalopram 10mg Donepezil 10mg tablets (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	And a box of Albuterol Sulfate. Interview on 12/4/24 at 12:50 p.m. LVN A stated she never checked the door to the medication cabinets, she put the key in, and the doors unlocked. LVN A was shown Resident #9's cabinet and stated Oh goodness. LVN A said she switched to the cabinet the medications were currently in because the other cabinet in the room required to be slammed and she (LVN A) did not want to scare Resident #9 like that. LVN A stated she guessed as the charge nurse she was responsible for monitoring the doors. LVN A said there were 4 nurses who passed medications: herself, another day shift nurse, and two night shift nurses. LVN A stated she never checked the cabinets to see if they locked before now; she just assumed they would lock. LVN A stated, It's like the gun cabinet; you can bet I will be double checking now. LVN A stated she never received an in-service about checking to make sure the cabinets were [NAME]. LVN A added Why would we? It's a lock; it's supposed to lock. Review of Resident #10's Face Sheet revealed she was an [AGE] year-old female admitted to the facility 6/18/20 with diagnoses including Alzheimer's disease, generalized anxiety disorder, protein-calorie malnutrition, constipation, pain, nausea, and diarrhea. Review of Resident #10's Annual MDS assessment dated [DATE] revealed: She had long and short-term memory impairment with severely impaired decision-making skills. She showed signs of delirium that included continuous inattention. Review of Resident #10's Continuity of Care Document, dated 12/5/24, revealed the following orders: Lactulose 10grams/15ml give 30ml by mouth three times a day as needed for constipation (Order Date 10/26/23) Lactulose 10grams/15ml give 30ml three times a day for constipation (Order Date 12/5/24) Observation on 12/03/24 at 4:00 pm revealed Resident #10's door open and the built-in medication cabinet in Resident #10's room was unlocked. One 32-ounce bottle of Lactulose (liquid laxative) was observed in the unlocked medication cabinet. Resident #10 was not in the room at the time of the observation. Review of Resident #28's Resident Face Sheet, dated 12/5/24, revealed he was an [AGE] year-old male admitted to the facility on [DATE] with diagnosis including Pseudomonas (having the pneumonia virus), anemia (low iron), pressure ulcer of the left hip (bed sore), tachycardia (unstable heart rhythm), altered mental status, dementia, pain, allergies, arthritis, hypertension (high blood pressure), hyperlipidemia (high cholesterol), Diabetes. Review of Resident #28's 11/17/24 Admission MDS, dated [DATE], revealed: He had long and short-term memory problems with severely impaired cognitive ability. He showed signs of delirium including inattention and disorganized thinking that were continuously present. Triggered medications included anti-anxiety, and opioid medication. Review of Resident #28's Care Plan, initiated 11/26/24, revealed: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Category: Pain: Chronic pain due to arthritis and general aches and pains. Goal: Will voice or show relieve or reduction in pain within one hour after receiving intervention for pain. Approaches included: Administer scheduled ibuprofen and monitor effects. Category: Hyper/Hypoglycemia (high and low blood sugar) Goal: Will remain free of complications from hyper or hypoglycemia Approaches included: Administer Metformin as ordered, hold if Capillary Blood Glucose is below 140. Review of Resident #28's Continuity of Care Document, dated 12/5/24, revealed orders for: Diclofenac Sodium 1% gel Four times a day Ibuprofen 600 mg tablets every 6 hours Hyoscyamine sulfate 0.125 mg tablet every 4 hours as needed Metformin 500 mg once a day hold for blood glucose level less than 140. Vitamin B1 100mg tablet once a day Loratadine 10mg once a day Observation of Resident #28's room on 12/4/24 at 11:20 AM revealed Resident #28 in bed asleep. Resident #28's door was open. The medication cabinet in Resident #28's room came open. In Resident #28's medicine cabinet were: 2 boxes of Diclofenac Sodium 1% gel Four times a day Ibuprofen 600 mg tablets every 6 hours Hyoscyamine sulfate 0.125 mg tablet every 4 hours as needed Metformin 500 mg once a day hold for blood glucose level less than 140. Vitamin B1 100mg tablet once a day Loratadine 10mg once a day (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #94's Resident Face Sheet, dated 12/5/24, revealed she was an 81-year-femaled admitted to the facility on [DATE] with diagnoses including hypokalemia (low potassium), hypertension (high blood pressure), hyperlipidemia (high cholesterol), hypothyroidism (low thyroid), hypo-somality (sleeps too much), edema (swelling, usually to lower extremities), allergies, and respiratory failure (difficulty breathing). Review of Resident #94's Care plan, updated 10/16/24, revealed: Problem: Nutritional Status: At risk in nutrition/hydration due to needs for assist with meal intake, risk for weight changes due to edema and diuretic use. Goal: Will encourage at least 75% of meal and offer fluids regularly Approaches included: Administer sodium and diuretic medication daily as ordered. Problem: Sleep: Difficulty with insomnia. Goal: Will be able to sleep 6 - 8 hours at night. Approaches included: Assess effectiveness of medication therapy Melatonin. Review of Resident #94's Continuity of Care Document, dated 12/5/24, revealed orders: Fexofenadine 180 mg -pseudoephedrine 240mg once a day Amlodipine 10mg once a day Digoxin 0.125mg once a day. Furosemide 20mg twice a day Gabapentin 100mg 2 capsules three times a day Levothyroxine 100 mcg tablet once daily Melatonin 3 mg tablet at bedtime Montelukast sodium 10mg once day Potassium Chloride 20 meq tablet, 5 tablets to equal 100 meq three times a day. Simvastatin 20 mg at bedtime Sodium Chloride 1,000 2 tablets twice a day Rivaroxaban 20mg at bedtime (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 12/04/24 on 12:01 PM revealed Resident #94 in the dining room. The door to the room was open the medication cabinet in her room was completely open with the work ledge down. All medications were easily accessible to people passing by. Medications included: Montelukast sodium -10 mg Vitamin D-1 Amlodipine desolate 10mg Levothyroxine 10mg in am Digoxin 0.125 mg Furosemide 20 mg bid Gabapentin 100mg Rivaroxaban 20 mg Simvastatin 20 mg Sodium chloride 1,000 mg Potassium 20 meq Iron tab ferrous sulfate 65 mg Melatonin 3 mg Fexofenadine 180 mg -pseudoephedrine 240mg Interview and observation on 12/4/24 at 12:35 PM, LVN C said she did not have trouble keeping cabinets locked. She said only the nurses had keys. LVN C was shown Resident #94's cabinet. LVN C said she just did not lock it behind her because she was in a rush. LVN C explained she gave Resident #94 their meds, closed the door and forgot to lock the cabinet because she was busy taking Resident #94 to the dining room. LVN C was shown Resident #28's medicine cabinet that was unlocked. LVN C stated the cabinets were supposed to be locked. LVN C stated they closed and should lock automatically. LVN C said she covered all medications on that cottage (20 rooms) and no one had orders to self-medicate. LVN C attempted to show that the cabinet closed automatically and admitted the cabinet did not lock automatically and she had to push the door closed and lock the door with the key. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/4/24 at 1:18 p.m. the DON and Administrator were informed of the cabinets that were unlocked and unattended. The DON stated she had never found a medication cabinet unlocked when she had the occasion to have the medication keys. The DON said she did not know why they would be unlocked, and it was brand new information to her. The Administrator added the Maintenance Department did not check the cabinet doors in the rooms to ensure they locked. The DON said she would rather nursing staff did that because of the medication. The DON said the nurses must not be pushing hard enough on the doors. The DON said there was no in-services on locking the cabinets because there did not need to be one until now. The Administrator and DON both said there was no policy about unlocked medication cabinets when a policy was asked for.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Based on observation and interview the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's four of four kitchens. The facility failed to ensure milk was not used or discarded by the use by date in 2 of 4 kitchens. The rehabilitation kitchen drawer had an accumulation of food debris in the drawers. The juice reservoirs under the juice dispensers of 2 of 4 kitchens were not clean and beginning to have white mold growing in the bottom. The rehabilitation kitchen refrigerator had fruits that were fuzzy with mold. Food was unlabeled in 2 of 4 kitchens. The handwashing sinks did not have trash cans that did not require staff to touch them in order to prevent re-contamination of hands in 2 of 4 hands. Dishes were stored face up in 1 of 4 kitchens. Hand hygiene was not performed when indicated by staff in 1 of 4 kitchens. Dirty rags were not kept separate from clean rags in 1 of 4 kitchens. These failures could affect residents who received meals prepared from the kitchens at risk for food borne illness and cross contamination. Findings included: Observation of the facility's main kitchen (Younger Unit) on [DATE] at 9:33 a.m. revealed a half-used gallon of milk that had a best by date of [DATE]. [NAME] D stated Oh that's expired milk, took the milk and dumped it down the sink. Observation of the rehabilitation kitchen on [DATE] at 10:05 a.m. revealed: - a drawer of individual serving saltine crackers that had a multitude of crumbs - the refrigerator had a container of unlabeled, unlabeled container of berries that was fuzzy with grey mold. - the reservoir beneath the juice containers had some grey circular mold flecks beginning to grow through it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676015	A. Building B. Wing	12/05/2024

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Mabee Health Care Center	2208 N Loop 250 W Midland, TX 79707

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of the [NAME] Cottage kitchen on [DATE] at 10:30 a.m. revealed: One of two handwashing sinks blocked by an empty milk crate. The other handwashing sink had a flip-lid trash can for paper towels. Interview on [DATE] at 10:45 a.m. Universal Aide E was asked about the flip-top trash can and said there was a foot-pedal type trash can by the blocked hand-washing sink. Universal Aide E asked why that was an issue. The surveyor washed their hands slowly throwing out the paper towel pushing the flip-lid down to dispose of the paper towel. Universal Aide E said Oh, that's cross contamination! Observation of the [NAME] Cottage Kitchen on [DATE] at 10:49 a.m. revealed: -The juice dispenser reservoir had an accumulation of juice and was beginning to have white spots of mold in it. -The resident refrigerator unlabeled (no resident name on it) with a best-by date of [DATE] -The facility refrigerator had a gallon of milk with a best by date of [DATE]. -The hand washing sink trash can had a flip top lid and no paper towels available. -Serving platters and coffee carafes were stored face up (open to air contamination) -In the second refrigerator was a bowl of unlabeled, undated peaches and a bag of shredded cheese. -Universal Aide F rinsed some dirty dishes, took off gloves and did not perform hand hygiene. The aide left to get a resident some iced-tea. - Under the sink was a stack of clean rags folded neatly. Immediately next to it was a stack of used rags (visible stains) touching the clean rags. In an interview on [DATE] at 1:37 p.m. Aide F stated she worked at the facility for 3 years and always worked at the cottages. Aide F stated she worked in the kitchen and was responsible for cooking breakfast and serving lunch. Aide F stated everyone was responsible for making sure the kitchen was clean and there was no set cleaning schedule and the aides got to it if they could. Aide F stated [NAME] Cottage did not have a dedicated cook like [NAME] Cottage did, but they would lose an aide if they did dedicate someone to the kitchen full time. Aide F stated the cook, or the coordinator was responsible for checking to see that foods were not expired and that things were labeled. Aide F said all dishes were supposed to be stored face down. Aide F said she did not know when the peaches were put in the bowl since she did not see them, but they made after [DATE]. Aide F stated they were trained to wash their hands or perform hand hygiene before and after all resident care or when they changed their gloves. She stated the surveyor probably caught her at a busy time and she did not perform hand hygiene. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on [DATE] at 2:35 p.m. the Administrator, with the DON present, stated housekeeping was responsible for cleaning out the drawers in the rehabilitation kitchen but the aides or the ADON were responsible for ensuring the reservoir was empty and clean. The DON stated there was no policy it was just to follow regulation and she did not remember the last in-service but there was an all-skills fair on [DATE] that all staff had to go to that covered hand hygiene and food handling. The DON added they facility also used a computer-based computer program that also covered hand-hygiene. The DON and Administrator stated they were mad because they made sure all the hand washing sinks in the cottages had a foot pedal trash can for handwashing.