STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676041	A. Building B. Wing	07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Mission at Blue Skies of Texas East	4949 Ravenswood Dr San Antonio, TX 78227

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately inform the resident, consult with the resident's physician, and notify, consistent with his or her authority, the resident representatives when there was a significant change in resident's physical, mental, or psychosocial status for 1 of 2 residents (Resident #17) reviewed for physician notification of changes in condition. The facility failed to notify Resident #17's physician when his blood sugar levels were out of physician ordered parameters on 6/25/2025. This deficient practice could place residents at risk of not receiving adequate and timely intervention and a decline in condition. The findings included: Record review of Resident #17's face sheet dated 6/27/25 revealed a [AGE] year old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included heart failure, type 2 diabetes (chronic medical condition in which the body does not produce enough insulin or does not use insulin effectively), and chronic kidney disease stage 3 (moderate decrease in kidney function due to damaged kidneys not filtering blood as well as they should, often caused by diabetes). Record review of Resident #17's most recent quarterly MDS assessment, dated 4/9/25 revealed the resident was severely cognitively impaired for daily decision-making skills and received insulin injections. Record review of Resident #17's Order Summary Report dated 6/25/25 revealed the following: - Blood glucose monitoring for signs and symptoms of hyper/hypoglycemia as needed for monitoring. May perform fingerstick for accu checks (blood glucose monitoring) if Dexacom (medical device used to monitor glucose continuously) not available, with order date 1/21/25 and no end date. - Insulin Lispro 100 unit/mL Solution pen injector, inject 11 units subcutaneously at bedtime related to type 2 diabetes, with order date 5/25/25 and no end date. - Insulin Lispro 100 unit/mL Solution pen injector, inject 20 unit subcutaneously before meals for type 2 diabetes. Notify provider if BS less than 75 ml/dl and/or greater than 350ml/dl with order date 5/25/25 and no end 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Lantus insulin 100 unit/mL Solution pen-injector, inject 65 unit subcutaneously two times a day. Hold for BS more than 350. Notify MD/NP for BG less than 75 or Greater than 350, with order date 5/1/25 and no end date. Record review of Resident #17's Medication Administration Record for June 2025 revealed: - 6/25/25 morning blood sugar reading was 386 ml/dl documented by LVN A - 6/25/25 at 11:00 a.m. blood sugar reading was 400 ml/dl documented by LVN A Record review of Resident #17's medical record revealed no documentation of notification to the physician on 6/25/25 for blood glucose readings more than physician ordered parameters of 350 ml/dl or more. During an interview on 6/25/25 at 1:34 p.m., LVN A stated when she clocked in at 6:50 a.m. on 6/25/25, Resident #17's insulin Lispro was not available. LVN A stated the insulin Lispro was delivered at approximately 10:00 a.m. on 6/25/25, and when it (insulin Lispro) was delivered, it was late, but he got it, his sugar was high. His blood sugar was 400. LVN A stated Resident #17 did not receive the scheduled morning dose, that was supposed to be administered before breakfast, and the blood sugar obtained at that time was 386. LVN A stated she had not made contact with the physician regarding Resident #17's elevated blood sugar reading and stated, I have to call the doctor about other things, it's on my list to tell him (the physician), but I have not called him about it yet. During an interview on 6/25/25 at 1:58 p.m., LVN B, who identified herself as the Staff Development Coordinator and Staff Educator, stated LVN A should have notified the physician regarding Resident #17's blood sugar level reading past the physician ordered parameters as soon as possible because a spike in blood sugar levels essentially meant the resident was hyperglycemic and measures should be taken to bring the sugar levels down or refer him to the hospital for further evaluation and treatment. During an interview on 6/25/25 at 2:20 p.m., the ADON stated, Resident #17's physician should have been notified when the resident's blood sugar level reading was past the physician ordered parameters as soon as the results were obtained. The ADON stated, a blood sugar reading over the physician ordered parameters could result in the resident's kidneys being affected. During an interview on 6/25/25 at 2:42 p.m., the DON stated Resident #17's physician should have been notified when the resident's blood sugar level reading was past the physician orders parameters as soon as possible, you don't wait to call (the physician), you call right then. The DON stated notification to the physician was crucial because the resident could go into a diabetic coma and the physician would be able to instruct what to do, such as monitoring blood sugar levels more frequently, monitor for symptoms, or give an alternate insulin. Record review of the facility document titled, Diabetes Mellitus-Hypoglycemia and Hyperglycemia Best Practices, dated March 2025 revealed in part, ,,,Residents with a diagnosis of Diabetes Mellitus will be monitored for signs and symptoms of Hypo and Hyperglycemia, with immediate intervention per doctor's orders and Diabetic Protocol .Unless otherwise ordered by the physician, report blood glucose levels greater than 350 or less than 60 .

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that a resident who is fed by enteral means receives the appropriate treatment and services to prevent complications of enteral feeding for 1 of 1 resident (Resident #151) reviewed for enteral feeding: The facility failed to ensure Resident #151's medications were diluted before administering the medications into the resident's feeding tube, did not label the resident's feeding formula and water containers with the appropriate identifiers and did not discard the feeding containers after the feeding was completed. This deficient practice could place residents who received enteral nutrition and medications at increased risk of aspiration, infection, bloating discomfort, and not receiving the full benefit of the medications administered. The findings included: Record review of Resident #151's face sheet dated 6/26/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included pneumonia (infection that inflames the air sacs in one or both lungs), gastro-esophageal reflux (condition in which stomach contents flow backward into the esophagus, the tube that connects the mouth to the stomach), heart failure and gastrostomy (feeding tube; a surgical procedure in which an opening is created through the abdominal wall directly into the stomach) status. Record review of Resident #151's baseline care plan dated 6/18/25 revealed the resident utilized a feeding tube and would be evaluated by Occupational Therapy, Physical Therapy, and Speech Therapy to improve overall functional mobility, ADLs and to improve oral intake. Record review of Resident #151's Order Summary Report dated 6/26/25 revealed the following: - Flush (feeding) tube with 20-30 ml (cc) of water before and after administration of medication pass every shift related to gastrostomy with order date 6/18/25 and no end date. - Docusate 100mg, give 1 tablet via g-tube (feeding tube) one time a day for constipation, with order date 6/24/25 and no end date. - guaifenesin oral liquid 200mg/10ml, give 20ml via g-tube three times daily for cough related to pneumonia, with order date 6/18/24 and no end date. - Pregabalin 200mg capsule, give 1 capsule via g-tube three times a day for pain with order date 6/18/25 and no end date - Enteral Feed Order every shift via feeding tube, Glucerna 1.2 at 65 mL/hour from 10:00 p.m. to 4:00 a.m. Free water flush 200 mL TID. Discard excess Glucerna after completed, with order date 6/26/25 and no end date. (continued on next page)

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Gravity feeding - Change feeding administration set daily; label the formula container, syringe, and administration set with the resident's name, date, time, and nurse's initials, every night shift, related to gastrostomy, with order date 6/18/25 and no end date. During an observation and interview on 6/25/25 at 9:11 a.m. revealed LVN C prepared to administer Resident #151's medications. LVN C dispensed 10 mL of Resident #151's liquid guaifenesin into a medication cup, placed the resident's Docusate tablet into a small plastic pouch and crushed it, and then obtained Resident #151's Pregabalin capsule and emptied the contents into a small plastic pouch. LVN C then returned to Resident #151's bedside and flushed the feeding tube with 30 mL of water. LVN C then poured the undiluted guaifenesin liquid into the feeding tube and flushed with 10 mL of water. LVN C then poured the undiluted Docusate powder into the feeding tube and flushed with 10 mL of water. LVN C then poured the undiluted contents of the Pregabalin into the feeding tube and flushed with 10 mL of water. LVN C then administered 30 mL of water after the medication pass. During an observation and interview on 6/25/25 at 9:24 a.m., Resident #151 stated he was provided formula and water from a feeding pump during the overnight hours from 10:00 p.m. to 4:00 a.m. Resident #151 pointed to the formula and water containers hanging from a feeding pole with formula and water in the containers and stated those were used for his feedings. Observation of the formula and water containers revealed they were not labeled. During an observation and interview on 6/25/25 at 9:25 a.m., LVN C stated she should have diluted Resident #151's medications in water before administering them into the feeding tube because not doing so would result in the feeding tube clogging and having to be replaced and could result in discomfort or the feeding tube would need to be replaced which would interrupt giving the resident his medications and feedings. LVN C observed the feeding formula and water containers hanging from the feeding pole and stated the containers should have been labeled because it would indicate how long the containers had been there, and who the containers belonged to. LVN C stated, that information was important because what if the bag (containers) were hanging for too long and it was old and should not be given to the resident. LVN C stated she began her shift on 6/25/25 at 7:00 a.m. and the feeding formula and water containers were administered during the overnight shift. During a telephone interview on 6/25/25 at 2:42 p.m., LVN D stated she had set up the feeding kit for Resident #151 during the overnight shift on 6/24/25. LVN D stated Resident #151 received nocturnal feedings from 10:00 p.m. to 4:00 a.m. LVN D stated she could not remember if she had labeled Resident #151's formula and water containers, but stated it was important because labeling the containers would indicate the date and time they were administered because the feeding formula was only good for 24 hours. LVN D stated, I should have thrown it (the formula and water containers) away after using it because he (Resident #151) won't get it again until 10:00 p.m. and that would be more than 24 hours and whoever came in after that would have to spike a new bag (container). LVN D stated it was a possibility another nurse could use the same set up. LVN D stated when she started the 10:00 p.m. feeding for Resident #151 at 10:00 p.m. on 6/24/25, there was one (feeding and water container) already and I remember having to throw away the old set because it was still hanging there. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/25 at 5:14 p.m., the DON stated, medications should be crushed individually and diluted with room temperature water before administering medications through a feeding tube because particles could get stuck in the feeding tube causing it to clog. The DON stated, if particles of medication get stuck in the feeding tube it could prevent the resident from getting the full benefits of the medication. The DON stated, feeding formula containers were supposed to be discarded after use because she believed the formula was only good for 24 hours. The DON stated she expected the formula and water containers to be labeled with the resident's name, the time it was opened, the expiration date, the nurse's initials, the time of the feeding and when the feeding was completed the formula was supposed to be thrown away. The DON stated, you can't use the same feeding more than once because it could introduce contaminants and make the resident sick. Record review of the facility document titled Enteral Tube Medication Administration, dated January 2025 revealed in part, .Purpose .To ensure the safe, accurate and appropriate administration of medications via enteral feeding tubes, minimizing the risk of aspiration, tube blockage, and drug-nutrient interactions in residents unable to take mediations orally .Review flushing instructions and fluid restrictions .Prepare Medications One at a Time .Crush each immediate-release tablet into a fine powder and dissolve in 15-30 mL of room temperature water .Viscous Liquids .Dilute thick or hyperosmolar liquids in 15-30 mL of water (or approved fluid) .Flush the tube with 15 mL (or prescribed amount) of water between each medication .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (Resident #17) of 3 residents reviewed for medications. The facility failed to stock an emergency supply of Lispro (fast-acting insulin) to maintain Resident #17's medical condition during a medication absence resulting in a blood sugar level of 386. This failure could place the residents at risk of not receiving therapeutic doses of their medication. Findings included: Record review of Resident #17's face sheet dated 6/27/25 revealed a [AGE] year old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included heart failure, type 2 diabetes (chronic medical condition in which the body does not produce enough insulin or does not use insulin effectively), and chronic kidney disease stage 3 (moderate decrease in kidney function due to damaged kidneys not filtering blood as well as they should, often caused by diabetes). Record review of Resident #17's most recent quarterly MDS assessment, dated 4/9/25 revealed the resident was severely cognitively impaired for daily decision-making skills and received insulin injections.Record review of Resident #17's Order Summary Report dated 6/25/25 revealed the following:- Insulin Lispro 100 unit/mL Solution pen injector, inject 20 units subcutaneously before meals for type 2 diabetes. Notify provider if BS less than 75 ml/dl and/or greater than 350ml/dl with order date 5/25/25 and no end date.Record review of Resident #17's Medication Administration Record for June 2025 revealed the scheduled bedtime dose of Lispro insulin was not administered on 6/24/25 and the scheduled 7:30 a.m. dose was not administered on 6/25/25. Record review of the MAR revealed LVN E documented an X in the section meant for the blood sugar reading and documented 9 with her initials. The MAR indicated the code 9 meant Other/See Progress Notes. Record review of Resident #17's MAR revealed LVN A documented an X in the section meant for the blood sugar reading and documented 15 with her initials. The MAR indicated the code 15 meant Awaiting Pharmacy fill. During an interview on 7/11/25 at 9:30 a.m., LVN A stated when she clocked in at 6:50 a.m. on 6/25/25, Resident #17's insulin Lispro was not available. LVN A stated the insulin Lispro was delivered at approximately 10:00 a.m. Resident #17 did not receive the scheduled morning dose, which was supposed to be administered before breakfast, and the blood sugar obtained at that time was 386. LVN A stated she did not administer the scheduled insulin as it was unavailable in the stat safe, and the pharmacy had not delivered it. In an interview with the medical director on 7/11/25 at 11:15 AM, he stated by Resident #17 missing dose of insulin with meals the resident was not negatively impacted, because Resident #17 is non-compliant with his diet. Additionally, he is on oral hypoglycemic medication, along with long-acting insulin which in theory provided necessary coverage. Interview with LVN D on 7/11/25 at 11:30 a.m., confirmed insulin is available in the stat safe. Additionally, the pharmacy sends out a one-month supply of insulin for all diabetic residents In an interview with the DON on 7/11/25 at 10:55 AM, the DON stated that the pharmacy now automatically delivers Insulin for all residents, and insulin is now available in the stat safe in case any resident needs it and runs out of insulin. Interview with the Administrator on 7/11/25 at 11:15 AM, the administrator said currently the facility maintains a one-month stock of insulin for all diabetic residents, and insulin is available in the stat safe. Observation on 7/11/25 at 11:20 AM noted insulin in the stat safe. Record review of the facility document titled Administering Medications dated December 2024 revealed in part, .The purpose of this procedure is to provide guidelines for the safe administration of.medications.Medication Administration Record (MAR): Also referred to as a drug chart, is the report that serves as a legal record of the drugs administered to a patient at a facility by a health care professional.The Director of Nursing (DON) will supervise and direct all nursing personnel who administer medications and/or have related functions. Medications must be administered in accordance with the orders, including any required time frame.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interview and record review, the facility failed to ensure that 1 of 2 residents (Resident #17) reviewed for medication errors was free of any significant medication errors. The facility failed to administer Resident #17's insulin Lispro medication (a quick acting medication used to lower blood sugar) as prescribed. This deficient practice could place residents at risk of inadequate therapeutic outcomes, increased adverse side effects, and a decline in health. The findings included:Record review of Resident #17's face sheet dated 6/27/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included heart failure, type 2 diabetes (chronic medical condition in which the body does not produce enough insulin or does not use insulin effectively), and chronic kidney disease stage 3 (moderate decrease in kidney function due to damaged kidneys not filtering blood as well as they should, often caused by diabetes). Record review of Resident #17's most recent quarterly MDS assessment, dated 4/9/25 revealed the resident was severely cognitively impaired for daily decision-making skills and received insulin injections.Record review of Resident #17's Order Summary Report dated 6/25/25 revealed the following:- Blood glucose monitoring for signs and symptoms of hyper/hypoglycemia as needed for monitoring. May perform fingerstick for accu checks (blood glucose monitoring) if Dexacom (medical device used to monitor glucose continuously) not available, with order date 1/21/25 and no end date.- Insulin Lispro 100 unit/mL Solution pen injector, inject 11 units subcutaneously at bedtime related to type 2 diabetes, with order date 5/25/25 and no end date.- Insulin Lispro 100 unit/mL Solution pen injector, inject 20 units subcutaneously before meals for type 2 diabetes. Notify provider if BS less than 75 ml/dl and/or greater than 350ml/dl with order date 5/25/25 and no end date.- Lantus insulin 100 unit/mL Solution pen-injector, inject 65 unit subcutaneously two times a day. Hold for BS more than 350. Notify MD/NP for BG less than 75 or Greater than 350, with order date 5/1/25 and no end date.Record review of Resident #17's Medication Administration Record for June 2025 revealed the scheduled bedtime dose of Lispro insulin was not administered on 6/24/25 and the scheduled 7:30 a.m. dose was not administered on 6/25/25. Record review of the MAR revealed LVN E documented an X in the section meant for the blood sugar reading and documented 9 with her initials. The MAR indicated the code 9 meant Other/See Progress Notes. Record review of Resident #17's MAR revealed LVN A documented an X in the section meant for the blood sugar reading and documented 15 with her initials. The MAR indicated the code 15 meant Awaiting Pharmacy fill. Record review of Resident #17's clinical record progress note authored by LVN E dated 6/24/25 and time stamped 4:04 p.m., revealed, called pharmacy to ask why Lispro insulin in not here as it was ordered through (computer) on 06/20/25. Pharmacy states they have no record of it being ordered. They will send tonight. Reported to ADON.Record review of Resident #17's clinical record progress note authored by LVN E dated 6/24/25 and time stamped 10:56 p.m., revealed the insulin Lispro was awaiting delivery from the pharmacy. Record review of Resident #17's clinical record progress note authored by LVN E dated 6/24/25 and time stamped 11:59 p.m., revealed the insulin Lispro was awaiting delivery from the pharmacy and was reported to the ADON.Record review of Resident #17's clinical record progress note authored by LVN A dated 6/25/25 and time stamped 9:49 a.m. revealed a request for a STAT delivery of the insulin Lispro and pharmacy stated it would be in the facility in a couple of hours.Record review of Resident #17's clinical record progress note authored by LVN A dated 6/25/25 and time stamped 10:00 a.m. revealed, insulin Lispro is in facility now.During a telephone interview on 6/25/25 at 12:02 p.m., LVN E stated she recalled ordering insulin Lispro for Resident #17 a few days ago. LVN E stated on 6/24/25 the insulin Lispro was not available in the medication cart, so LVN E placed a phone call to LVN B and asked if the insulin Lispro was in their emergency medication stock. LVN E stated LVN B told her it was not available in their emergency medication stock. LVN E stated she placed a call to the ADON and was instructed to document the insulin Lispro not being available in the resident's clinical record. LVN E stated she notified the NP twice but never got a call back. LVN E stated if Resident #17 did not receive his insulin it could result in the blood sugar spiking and might result in hospitalization. During an interview on 6/25/25 at 1:34 p.m., LVN A stated when she clocked in at 6:50 a.m. on 6/25/25, Resident #17's insulin Lispro was not available. LVN A stated the insulin Lispro was delivered at approximately 10:00 a.m. on 6/25/25, and when it (insulin Lispro) was delivered, it was late, but he got it, his sugar was high. His blood sugar was 400. LVN A stated Resident #17 did not receive the scheduled morning dose, that was supposed to be administered before breakfast, and the

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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 - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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 for 1 of 5 (memory unit) satellite kitchens. The facility failed to ensure dietary staff used facial hair restraints properly during plate preparation. This failure could place residents who received meals and/or snacks from the kitchen at risk for food borne illness. The findings included: Observation on 6/24/25 at 12:35 p.m. revealed CNA F was plating meals for the lunch service for residents in the memory unit. CNA F was observed wearing a facial hair restraint over his chin, but not over his moustache. CNA F continued to plate the lunch meal for residents in the memory unit while not wearing the facial hair restraint properly. Observation on 6/25/25 at 8:13 a.m. revealed CNA F plating a breakfast plate for residents in the memory unit and was observed wearing a facial hair restraint over his chin, but not over his moustache. CNA F, after observing the State Surveyor walk into the unit, pulled up the facial hair restraint over his moustache. During an interview on 6/25/25 at 8:41 CNA F stated he had the required food handler's certification for handling food. CNA F stated part of his duties required he plate meals for the residents. CNA F stated anytime there was food in the satellite kitchen he was supposed to be wearing the hair restraint. CNA F stated he was wearing the facial hair restraint improperly and it was not covering his moustache because it kept falling off and kept getting caught on his name tag. CNA F stated his hair, including hair on his face had to be covered because you did not want any hair falling on the resident's food causing a contamination. During an interview on 6/25/25 at 9:04 a.m., the Dietary Manager stated every unit in the facility had a satellite kitchen and the floor staff, including the CNA staff had training and required a food handler's certificate. The DM stated hair restraints were supposed to be worn while food is being served. The DM stated, proper use of the facial hair restraint included covering the moustache. The DM stated, if the hair restraint was not worn correctly, hair could fall into the food and contaminate it which could result in the resident choking or getting sick. Review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 2-402 Hair Restraints, 2-402.11, Effectiveness., (A) Except as provided in paragraph (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES.