STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676052	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Immanuel's Healthcare	4515 Village Creek Rd Fort Worth, TX 76119

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to refer all Level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for a Level II resident review for one (Resident #5) of five residents reviewed for PASRR services. The facility failed to refer Resident #5 for a Level II PASRR Evaluation upon receipt of a bipolar diagnosis. This failure could place residents at risk of not receiving necessary care and services to attain or maintain their highest practicable physical, mental, and psychosocial well-being. Findings included: Review of Resident #5's Face Sheet, dated 06/11/25, reflected she was a [AGE] year-old female, who was admitted to the facility on [DATE], with diagnoses including Sick Sinus Syndrome (a heart rhythm disorder where the sinoatrial node, the heart's natural pacemaker, malfunctions) and Heart Failure (a condition where the heart cannot pump enough blood to meet the body's needs). Resident #5 also had a diagnosis of Bipolar Disorder (a mental illness characterized by extreme shifts in mood, energy, and activity levels, fluctuating between periods of mania, or hypomania, and depression), with a documented onset date of 11/01/22. Review of Resident #5's MDS Assessment, dated 03/14/25, reflected she had a documented diagnosis of Bipolar Disorder. Review of Resident #5's PASRR Level I Screening, dated 03/09/22, reflected she did not qualify for a PASRR Level II Evaluation at that time. There was no evidence that Resident #5 had a mental illness, intellectual disability, or developmental disability. Review of Resident #5's electronic medical record reflected no evidence that any additional PASRR Screenings/Evaluations had been completed since the initial PASRR Level I Screening was conducted on 03/09/22. (continued on next page)

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the MDS Coordinator on 06/11/25 at 10:52AM, she stated Resident #5's initial PASRR Level I Screening was completed on 03/09/22. Resident #5 did not qualify for services at that time, as there was no indication that Resident #5 had a mental illness, intellectual disability, and/or developmental disability. The MDS Coordinator said Resident #5 was later diagnosed with bipolar disorder (11/01/22). The MDS Coordinator stated at that time, Resident #5 should have had a PASRR Level II Evaluation completed to determine if she qualified for services. The MDS Coordinator stated she was not employed by the facility at that time, so she did not know why a new PASRR Level II Evaluation was not completed. She stated she planned on conducting a facility-wide audit to ensure no other residents had missed receiving a required PASRR Screening/Evaluation. The MDS Coordinator stated she did not believe there was a risk in Resident #5 not receiving a new PASRR Screening/Evaluation upon her new diagnosis of bipolar disorder, as services were not provided for mental illnesses. She stated the risk would be present if there was a need for services related to an intellectual disability, and/or developmental disability. A policy related to PASRR Evaluations was requested on 06/11/25 at 10:55AM. The Director of Nursing stated the facility did not have a policy related to this and that the expectation was to follow HHSC guidelines.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and determine that drug records were in order and that an account of all controlled drugs were for 1 of 5 residents (Residents #55) reviewed for pharmacy services. 1.The facility failed to implement a system to consistently and accurately reconcile controlled medications for Resident #55's Lorazepam Oral Tablet 0.5 MG This failures could place residents at risk of not having the medication available due to possible drug diversion. Findings included: 1. Review of Resident #55's Quarterly MDS Assessment, dated 03/13/25, reflected the Resident #55 is an [AGE] year-old female. The BIMs score was blank, section C Cognitive Patterns C0100 Cognitive patterns documented that resident was rarely/never understood. Their diagnoses included the following: HTN, non-Alzheimer's dementia, senile degeneration of the brain (progressive decline in cognitive function, including memory, language, and reasoning, often associated with aging). The resident was on hospice care. Review of Resident #55's Comprehensive Care Plan, dated 01/03/25, reflected the resident used anti-anxiety medication Lorazepam r/t Anxiety. Facility interventions included: Intervention included to give anti-anxiety medications ordered by physician. Monitor/document side effects and effectiveness. Record review of Resident #55's physician orders reflected: Lorazepam Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth every 4 hours as needed for anxiety/agitation until 06/19/2025 23:59 Verbal Active 03/17/2025 until 06/19/2025. Lorazepam Oral Tablet 0.5 MG (Lorazepam) Give 2 tablet by mouth every 4 hours as needed for anxiety/agitation until 06/19/2025 23:59 Record review of resident# 55's progress notes on 06/11/2025 reflected: (Late Entry). On Thursday June 5, 2025, at 12:24 pm this nurse administered one Lorazepam Oral Tablet 0.5 MG to resident. However, this nurse accidently charted that she gave two Lorazepam Oral Tablet 0.5 MG to resident because resident has two different orders for lorazepam. This nurse has striked out the incorrect documentation. DON has been notified of error. Will continue with plan of care in place. This entry was written by LVN A. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 06/10/2025 at 11:45 AM of the Nurses Cart station1 revealed the medication blister pack for Resident #55's Lorazepam 0.5mg (controlled medication used for anxiety/agitation) had 2 blister seals broken. One damaged blister had the pill still inside secured with tape, and the other damaged blister the pill was missing. At the time the surveyor inspected the medication cart; the count for Resident #55's Lorazepam 0.5mg was documented as 12 pills, the actual number of pills counted in the blister pack was 11 pills. In an interview on 06/10/25 at 11:50 AM, LVN A She stated that she did not notice that the Lorazepam pill was a missing until the surveyor brought it to her attention. LVN A stated she was unaware when the blister pack seal was broken and stated that the resident had never taken the medication (lorazepam 0.5mg). She stated that she did not notice the other broken seals on resident #55's Lorazepam 0.5mg medication blister pack. She stated that the risk of a damaged blister would be a potential for drug diversion. She stated the nurses were responsible to check the medication blister packs for broken seals during the count of narcotics during the change of the shift. She stated the count was done at shift change and the count was correct. She stated she did not see the broken blister during the count. In an interview on 06/10/25 at 1:04 PM, the DON stated if the blister pack seal was broken on any controlled medications the pill should be discarded by two nurses. The DON stated it was not acceptable to keep a pill in a blister pack that was opened. She stated that if a blister pack seal is broken it should not be taped over with tape. The DON stated the risk would be losing the medication because the seal was broken. She stated nurses were responsible for checking the medication blister packs for broken seals during the count on the change of shifts. The DON stated the pharmacy consultant checks the medication room and the medication cart monthly. In an interview on 06/10/25 at 2:06 PM, the DON stated that the LVN A told her that LVN A administered the Lorazepam 0.5mg to Resident #55 on 06/05/2025 but had documented on the wrong place. The DON stated that Resident #55 had an order to give one to two tablets and LVN A told her that she made an error and had documented that she gave two pills instead of one pill. She stated that the LVN A was going to do a late entry to reflect the administration on 06.05.2025. In an interview on 06.11.2025 at 9:07 AM LVN A stated that she administered lorazepam 0.5mg to Resident #55 on 06/05/2025 but forgot to sign the narcotic count sheet but had documented on the MAR in the wrong place so it appeared like she gave two pills instead of one. She stated that she had done a late entry to correct the error. She stated that the risk of not documenting medication administered could lead to an overdose because the medication can be readministered by another nurse. In an interview on 06/11/2025 at 11:53 AM with LVN C reflected that she works in station one and always counts the narcotics with the out going nurse at the beginning of her shift and the oncoming nurse at the end of her shift. She stated that she always made sure the count was correct. She stated that she has never given Resident #55 Lorazepam 0.5mg. She stated that she never gives her key to anyone without counting the narcotic medications. She has been in-serviced on narcotic storage and handling. Risk of not accurately counting and documenting controlled medications could increase the risk of diversion and residents missing medication. Attempt on 06/11/2025 at 1:24PM to interview LVN D unsuccessful unable to leave voicemail because the mailbox was full. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Attempts on 06/11/2025 at 1:25PM to interview LVN E who worked 10-6pm unsuccessful left voice mail with call back number. Review of the facility's policy Controlled Substances edited 4.3.2024, reflected the following: The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976). 1. Only authorized licensed nursing and/or pharmacy personnel have access to Schedule II controlled substances maintained on premises. 2. The director of nursing services identifies staff members who are authorized to handle controlled substances. 3. Controlled substances are counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals sign the designated controlled substance record. 4. If the count is correct, an individual resident controlled substance record is made for each resident who will be receiving a controlled substance. Do not enter more than one (1) prescription per page. This record contains: a. name of the resident. b. name and strength of the medication. c. quantity received. d. number on hand. e. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	name of the prescriber. f. prescription number. g. name of issuing pharmacy. h. date and time received. I. time of administration. j. method of administration. k. signature of person receiving medication; and l. signature of nurse administering medication. Storing Controlled Substances 1. Controlled substances are separately locked in permanently affixed compartments, except when using single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. 2. The charge nurse on duty maintains the keys to controlled substance containers. The director of nursing services maintains a set of back-up keys for all medication storage areas including keys to controlled substance containers. Dispensing and Reconciling Controlled Substances 1. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. 2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage. b. Medication administration records. c. Declining inventory records; and d. Destruction, waste and return to pharmacy records. 3. Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. 4. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services. 5. The director of nursing services documents irreconcilable discrepancies in a report to the administrator. a. If a major discrepancy or a pattern of discrepancies occurs, or if there is apparent criminal activity, the director of nursing notifies the administrator and consultant pharmacist immediately. b. The administrator, consultant pharmacist, and/or director of nursing services determine whether other action(s) are needed, e.g., notification of police or other enforcement personnel. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. The medication regimen of residents using medications that have such discrepancies are reviewed to assure the resident has received all medications ordered and the goal of therapy is met (example: a resident receiving a pain medication complains of unrelieved pain). d. The director of nursing services consults with the provider pharmacy and the administrator to determine whether any further legal action is indicated. 6. Unless otherwise instructed by the director of nursing services, when a resident refuses a non-unit dose medication (or it is not given), or a resident receives partial tablets or single dose ampules (or it is not given) the medication is destroyed and may not be returned to the container. 7. Waste and/or disposal of controlled medication are done in the presence of the nurse and a witness who also signs the disposition sheet. 8. Medications returned to the pharmacy are recorded and signed by the director of nursing services (or designee) and the receiving pharmacy. 9. Disposal methods are used to prevent diversion and/or accidental exposure to controlled or hazardous substances. Fentanyl patches are disposed of in one of the following ways (per state regulations): a. By folding in half, sticky sides together and flushing down the toilet; or b. Using approved drug disposal products specifically for fentanyl patches. 10. Controlled substances are not surrendered to anyone, including the resident's provider, except for the following: a. For a resident on pass or therapeutic leave. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. To a resident or responsible party upon discharge from the facility; or c. To the DEA or other law enforcement officials functioning in a professional capacity in exchange for a receipt documenting the transaction. 11. In the event there is concern about controlled substances being discharged with the resident and/or resident's representative, the attending physician may choose not to discharge the resident with those medications. 12. Some controlled substances may be stored in the emergency medication supply. Reconciliation of controlled substances in the emergency supply is conducted at intervals established by the director of nursing services. 13. Controlled substances remaining in the facility after the order has been discontinued or the resident has been discharged are securely locked in an area with restricted access until destroyed. 14. Accountability records for discontinued controlled substances are kept with the unused supply until it is destroyed or disposed of as required by applicable law or regulation. 15. The consultant pharmacist or designee routinely monitors controlled substance storage records. 16. The director of nursing services maintains and disseminates to appropriate individuals a list of staff who have access to medication storage areas and controlled substance containers. 17. For guidelines pertaining to disposing of controlled substances, see Discarding and Destroying Medications policy.

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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** Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, for one (Resident#34) of five residents reviewed for the storage of drugs and biologicals. The facility failed to ensure that Medications (Resident #34's Nystatin 100,000 units topical powder) was locked. This failure could result in access to medication by unauthorized persons and could result in misuse of medication. Findings included: Review of Resident #34's Quarterly MDS Assessment, dated 05/19/25, reflected the resident#34 is a [AGE] year-old female with a BIMs score of 15 indicating she is cognitive function is intact. The resident had diagnoses Hypertension (high blood pressure), morbid (severe) obesity due to excess calories, Hyperlipidemia, (abnormally high levels of fat in the blood), chronic obstructive pulmonary disease (a term for lung and airway diseases that restrict your breathing). Review of Resident #34's Comprehensive Care Plan, dated 02/2/2024 Reflected (Residents name) has an ADL Self Care Performance Deficit r/t Activity Intolerance, Fatigue, Limited Mobility. Facility interventions o BATHING: The resident requires 1 staff participation with bathing. o PERSONAL HYGIENE/ORAL CARE: the resident requires 1 staff participation. An observation on 06/09/2025 at 10:53AM CNA F gave resident #34 a bed bath and provided peri care. After the bed bath, Resident #34 removed a plastic bottle of nystatin 100,000 units topical powder with Resident #34's name and handed it to CNA F and asked CNA F to apply the powder under her breasts. The resident stated that she kept the powder in her drawer. In an Interview 06/09/2025 at 11:13AM CNA F revealed that the resident always asked her to apply the powder, but sometimes the resident did the application by herself. She said that she thought it was the residents home supply. In an interview on 06/10/25 at 11:20 AM, LVN A She stated that she did not know that Resident #34 had medication (nystatin 100,00 units powder) in her room. She stated that all medication should be stored in the medication cart or the treatment cart and not in the resident's room. LVN A stated that risk to the patient having medication in the room could be drug diversion or another resident having access to the medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the 06/09/2025 at 1:22pm the DON stated all medication are kept in the nurse carts and Resident#34 should not have had the nystatin 100,000 unit in her room. She also stated that only nurse should apply medicated powder on residents. The risk to the patient having medication in the room is access to other residents. Review of the facility's policy Medications Storage and Labeling -, Revised February 2023, reflected the following: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have access to keys. Medications and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.

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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. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen safety. 1. The facility failed to seal opened items in plastic bags in the freezer area on 06/09/25. 2. The facility failed to ensure an expired item in the dry storage pantry area was removed on 06/09/25. 3. The facility failed to ensure the dented cans in the dry storage area with the other canned food were removed from the shelf on 06/09/25. 4. The facility failed to ensure an expired item in the refrigerator area was removed on 06/09/25. These deficient practices could affect residents who received meals and/or snacks from the facility's only kitchen by placing them at risk for cross contamination and other food-borne illnesses. Findings included: Observation of the facility's kitchen dry storage, refrigerator, and freezer areas on 06/09/25 at 9:09 AM, included the following food items were in unsealed packages and containers, expired, and dented cans with the other canned food: Dry pantry area: * 1 white plastic container of 18 lb. cream cheese icing was unsealed and exposed to air. * 1 plastic container labeled, White Rice was unsealed and exposed to air. * 1 plastic container labeled, Powder Milk was unsealed and exposed to air. * 1 expired container of 1 gallon jalapeno peppers with an expiration date of 04/12/25. * 1 dented 11 oz. can of medium green lima beans. Refrigerator area: * 1 gallon of Caeser Salad Dressing was unsealed and exposed to air and did not have a shelf-life date and expiration date. * 1 plastic container of pickles with an expiration date of 04/23/25. Freezer area: *1 box of bacon was unsealed and exposed 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	*1 box of frozen vegetables was unsealed and exposed to air. *1 box of baby lima beans was unsealed and exposed to air. *1 box of beef luncheon patties was unsealed and exposed to air. *1 box of sugar frozen cookie dough was unsealed and exposed to air. *1 box of sopapilla dough was unsealed and exposed 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	In an interview with the DS on 06/09/25 at 9:55 AM, revealed he had been employed at the facility for 7 years. The Dietary Supervisor stated that he supervised 9 employees in the kitchen that work various shifts. He stated he was unaware there were expired and unsealed items in the kitchen's dry storage, refrigerator, and freezer areas. The DS stated he was unaware there was 1 dented can stored on the shelves with the other canned food in the dry pantry area. He stated all kitchen staff were responsible for ensuring all food items in the kitchen's dry pantry, refrigerator, and freezer areas were sealed, labeled, and checked for expiration dates. The DS stated that the dented cans in the dry pantry area should have been removed from the shelves with the other canned foods and should be placed in his office where there was an area designated for dented cans. The DS stated that there should not be any food items in the kitchen's dry pantry, refrigerator, and freezer areas that were not labeled, sealed, expired, including any dented cans in the dry pantry area. The DS stated that he provided monthly reeducation and retraining via In-Service Trainings for all kitchen staff and the trainings included proper food storage, labeling, and ensuring that there were not any dented cans in the facility's dry pantry, refrigerator and freezer areas. The DS stated that the monthly In-Service Trainings included proper food handling and sanitization to prevent food-borne illness and safety per the facility's policy. The DS stated that it was his expectation is for the kitchen staff to immediately inform him every time they throw away any food items that were expired, unsealed, and exposed to air that were found in the kitchen's dry storage, refrigerator, and freezer areas. The DS stated that staff are to inform him every time they found a dented on the shelves. The DS stated that he was responsible for ensuring that the the food items in the kitchen were labeled, dated, sealed, and not expired. DS stated that he performs a weekly audit of the kitchen's dry pantry, refrigerator, and freezer areas to ensure everything in all areas were labeled, dated, sealed, which included checking the expiration dates on the food items. The DS stated his expectation for her staff, was that they were to use the FIFO (the principle and practice of maintaining precise production and conveyance sequence by ensuring that the first part to enter a process or storage location is also the first part to exit) procedures to ensure there were not any unsealed, and expired food items throughout the kitchen's dry panty, refrigerator, and freezer areas. The DS gave the surveyor a presentation of implanting the FIFO method in the facility's dry pantry area. The DS stated all staff in the kitchen have received training on how to use the First In, First Out Method, which meant kitchen staff should label the food with the dates they store them, and when staff were restocking the shelves, they were to put the older foods in front or on top so they could be used first. The DS stated this system allowed the kitchen staff to use the older food items first to ensure that there were not any expired items in the kitchen. The DS stated the items found in the kitchen by the state surveyor were things that he missed in his weekly audits. The DS stated on 06/09/25, he would immediately retrain and reeducate all kitchen staff via an In-Service Training on food storage, labeling, checking for expired items, proper sealing of containers, bags, and packages, and utilizing the FIFO Method in the kitchen. The DS stated that all the items that the surveyor found in the kitchen would be immediately thrown away. The DS stated that he would continue to reeducate the kitchen staff to ensure everyone knew what his expectations were the kitchen and to follow the guidelines in the facility's Food Storage Policy so that everyone would be on the same page. The DS stated the risk of someone, which included a resident eating food from the facility kitchen's dry storage, refrigerator and freezer areas, expired foods, dented cans were that they could become ill and become sick due to eating something that could cause food-borne illnesses. The DS stated there were risks of food borne illness anytime someone ingested food items from the kitchen any items that had not been labeled and stored properly and from dented cans. The DS stated the harm of someone, which included a resident ingesting food from the facility kitchen's dry storage, refrigerator and freezer areas, expired foods, eating something from a dented can could cause someone to vomit and become ill. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676052	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Immanuel's Healthcare	4515 Village Creek Rd Fort Worth, TX 76119

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with the Dietary Aide G on 06/09/25 at 10:17 AM, she stated she had been employed at the facility for 4 years. She stated that she was unaware there were expired and unsealed items in the kitchen's dry storage, refrigerator, and freezer areas. She stated she was unaware there was 1 dented can on the shelves with the other canned food items. The Dietary Aide G stated that all the staff were responsible for storing the food items on the shelves and checking the expiration dates, dented cans to make sure there were not any unsealed items in the kitchen. She stated that monthly and sometimes twice a month, the DS will have an In-Service Training(s) with all kitchen staff on food storage, labeling and dating, removing expired items from the shelves in the dry pantry, freezer, and refrigerator areas and for dented cans and the use of the FIFO method. The Dietary Aide G stated that if items are unsealed and exposed to air are found by kitchen staff, they are to immediately throw the items in the trash can and inform the DS about the item(s) that were thrown away. Dietary Aide G stated that when there is a new shipment of food items delivered to the kitchen, the kitchen staff are to use the FIFO method that they were educated on via In-Service Trainings. Dietary Aide G stated that the FIFO method means when new food items are delivered, they are to be placed in the back of the older food items and the older food items are placed in the front to ensure that the older food items are used first. Dietary Aide G stated that if there were any dented cans in the dry pantry area, they are to immediately to be removed from the shelves with the other canned foods and stored in the area in the dry storage area labeled, dented cans, which is in the DS office. She stated that after placing the dented cans in the proper area, she would immediately notify the DS. Dietary Aide G stated if any food items from the facility's dry panty, refrigerator and freezer areas and dented cans were to be eaten by anyone, they have a potential risk of becoming very sick and ill. Dietary Aide G stated that if food is unsealed in the freezer, the food will be freezer burned and stated the risk of anyone ingesting any of the aforementioned items, they could have stomach aches, vomiting, and have parasites in their bodies. In an interview with the Dietary [NAME] H on 06/10/25 at 11:44 AM, she stated that she had been employed at the facility for 7 years. She stated she was unaware there were expired and unsealed items in the kitchen's dry storage, refrigerator and freezer areas. She stated she was unaware there was 1 dented can on the shelves with the other canned food items. She stated all the staff were responsible for storing the items on the shelf and checking the expiration dates, dented cans to make sure there were not any unsealed items in the kitchen's dry storage, refrigerator and freezer areas. Dietary [NAME] H stated that if she found any item(s) in the kitchen's dry storage, refrigerator and freezer areas, she would immediately throw them away and then tell the DS of her findings and notify him the location of her finding(s). Dietary [NAME] H stated that during her employment at the facility she had taken numerous In-Service trainings on food storage, labeling, dented cans, and ensuring that expired items are immediately thrown away. She stated that the In-Service Training included using the FIFO method. Dietary Aide stated that the FIFO method means that older food items are placed in the front on the shelves in the dry pantry area and the newer food items are placed behind the older food items on the shelves. She stated that dented cans are to be removed from the shelves and placed in the area labeled, dented cans in the DS office. She stated if any food items are unsealed in the freezer, the food will be freezer burned. She stated that if anyone ingests food from the kitchen that was expired or came from unsealed packages or containers, their body could breakdown and become sick, vomit, have stomach issues and have an adverse reaction after ingesting the food. [NAME] H stated that if anyone ingests food from the kitchen that was expired or came from unsealed packages or container, they could be harmed by parasites entering their bodies, which can make them ill. Record review of the facility's undated policy titled, Dietary Food Storage, reflected: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Policy: All foods and supplies will be stored appropriately upon receipt to protect them from contamination. Procedure: 1. The Dietary Manager or designee is responsible for checking in and properly storing staples, perishables, canned goods and supplies as they arrived. 2. The storage areas should be .ready for new deliveries, with old products positioned in a manner that will cause them to be used first. 12. Cooked foods are placed in suitable containers, dated, labeled . Record review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under § 3-202.18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #57) of 6 residents, reviewed for infection control. 1.LVN B failed to don PPE prior to performing the high contact resident care activity on a resident who was on enhanced barrier precaution. This failure placed residents at risk for healthcare associated cross contamination and infections. Findings included: Record review of Resident #57's Quarterly MDS Assessment, dated 05/14/25, reflected the resident was a [AGE] year-old male, had a BIMs score of 12 indicating he was moderately cognitively impaired. The resident had diagnoses which included bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic), hemiplegia (condition characterized by paralysis on one side of the body), dysphagia (difficulty swallowing foods and liquids), gastronomy status (the presence of a gastronomy tube or artificial opening in the stomach, which is used for feeding or accessing the stomach). Record review of Resident #57's Comprehensive Care Plan, edited 05/13/25, reflected (Residents name) requires tube feeding r/t Dysphagia*Enhanced barrier precautions. Facility interventions included: Ensure enhanced barrier precaution. An observation on 06/10/25 at 11:30 AM revealed Resident #57's room had an Enhance Barrier Precaution signage outside his room, and cart set up with PPE. LVN B prepared Resident #57's medication and set up feeding. LVN B performed hand hygiene with sanitizer and entered residents room, administered medication and feeding osmolite 1.5 via feeding tube. LVN B did not don PPE. An interview on 06/10/25 at 11:36 PM revealed LVN B knew that Resident #57 was on enhanced barrier precaution, and she should have donned PPE before accessing the resident's (Resident#57) feeding tube. She stated that failure to use PPE could put the resident at risk for infection. She stated that she had been in-serviced on enhanced barrier precautions. An interview on 06/10/25 at 1:41 PM with DON revealed that her expectation was that the staff should use appropriate PPE while providing care to residents on enhanced barrier precautions. She stated that risk to the patient was infection. She stated that the staff has been in-serviced on infection control and enhance barrier precautions. The facility policy titled Enhanced Barrier Precautions dated August 2022, reflected: Enhanced Barrier Precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). Personal protective equipment (PPE) is changed before caring for another resident. Face protection may be used if there is also a risk of splash or spray. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: 1. dressing. bathing/showering. transferring. providing hygiene. changing linens. changing briefs or assisting with toileting. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and wound care (any skin opening requiring a dressing).