STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676178	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Duncanville Healthcare and Rehabilitation Center	419 S Cockrell Hill Rd Duncanville, TX 75116

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44021 Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 1 (Resident #19) of 5 residents reviewed for ADLs. On 07/08/24 at 9:47 AM the facility failed to ensure Resident #1 had his fingernails cleaned and trimmed. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life. Findings included: A review of Resident # 19's face sheet dated 06/04/24 reflected a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted to the facility on [DATE], with the following diagnosis: Dementia (impaired ability to remember, think, or make decisions), and Anxiety. A review Resident #19's Quarterly Minimum Data Sheet (MDS), dated [DATE] reflected Resident #19 was assessed to with a Brief Interview for Mental Status (BIMS) score of 04 indicated that he had severe cognitive impairment. Rejection of Care - Presence and Frequency indicated a score of 0, indicating that the behavior was not exhibited. The MDS also indicate under Functional Status that Resident #19 requires extensive assistance with ADL's. A Review of Resident #19's Comprehensive Care Plan, dated 06/04/24 reflected a focus area of The resident has an ADL self-care performance deficit with and intervention area that reflected Personal hygiene: The resident requires total assistance by 1 staff with personal hygiene and oral care. Further review of Resident #19's Comprehensive Care Plan reflected a focus area of The resident is resistive to care refusing showers, change of clothing, change of linen and to allow staff to clean his room the care plan did not reflect that Resident was resistive to nail care. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 07/08/24 at 9:47 AM Resident #19 was observed supine, covered in a sheet. The residents' nails were noted to be 1/2 inch to 3/4 inch long and were yellowish in color with areas beneath the nails that appeared brown, black, and dark red. The resident was noted to have two superficial scratches to his forehead The scratches were approximately 2.5 inches long running in a vertical pattern with what appeared to be dried blood at the boarders of the scratches. The other scratch was approximately 1 in long and was orientated vertically with the other scratch at approximately a 30-degree angle intersecting with the longer scratch making a y symbol. The area where the scratches intersected appeared to have dried blood at that spot. The resident stated that he tries to get out of bed every day, but the staff must have been running late that day. When Resident #19 was asked where he got the scratches on his forehead from, he indicated with his right hand going towards his forehead and stated that he probably did it scratching his head. In an interview on 07/08/24 at 11:53 AM CNA M revealed that Resident #19 gets his showers regularly and that he is non-combative, and that Resident #19 sometimes does not like to get his nails trimmed, she agreed that the nails were long. In an observation and interview on 07/08/24 at 1:47 PM LVN H was observed pushing Resident #19 in a wheelchair towards his room. Resident #19 was dressed in clean clothes and wearing a ball cap, Resident #19's nails were observed to still be 1/2 to 3/4 inches long on both hands, the nails were clearer and devoid of any black, brown, or dark red discolorations. LVN H revealed that there were several residents on her hall where Resident #19 lived but that Resident #19 was not one of them. In an observation on 07/09/24 05:31 PM Resident #19 was noted to have trimmed, clean nails on both hands. In an interview on 07/10/24 at 11:45 AM ADM revealed that he expects that residents are to have their ADL's attended too, with long fingernails they can scratch themselves and it is a dignity issue, the residents could feel bad about themselves and it could make them depressed. Details such as residents being resistive to particular care areas need to be reflected in the care plan. In an interview on 07/10/24 at 01:32 PM DON revealed that she expects nails to be trimmed and clean, but residents can also have their own preferences about their nails, but that should be documented in their care plans. Dirty long nails could also pose an infection control issue. There could also be a psychological issue if the resident did want to have their nails trimmed and clean but were not given those services. Review on 07/10/24 at 3:33 PM of the nail care policy was requested, and none was provided prior to exit.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44021 Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 of 5 residents (Resident #19) reviewed for quality of care when: A. On 07/08/24 at 9:47 AM CNA J failed to note that Resident #19 had superficial scratches to his forehead that had been observed earlier that day. B. On 07/08/24 at 1:47 PM LVN H failed to assess he superficial scratches to Resident #19's forehead after being notified about the superficial scratches. This failure placed facility residents at risk for worsening stasis and venous ulcers, Cellulitis (skin infection), Osteomyelitis (infection of the bone), Sepsis (infection of the blood) severe pain, and loss of limbs. Findings included: A review of Resident # 19's face sheet dated 06/04/24 reflected a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted to the facility on [DATE], with the following diagnosis: Dementia (impaired ability to remember, think, or make decisions), and Anxiety. A review Resident #19's Quarterly Minimum Data Sheet (MDS), dated [DATE] reflected Resident #19 was assessed to with a Brief Interview for Mental Status (BIMS) score of 04 indicated that he had severe cognitive impairment. Rejection of Care - Presence and Frequency indicated a score of 0, indicating that the behavior was not exhibited. The MDS also indicate under Functional Status that Resident #19 requires extensive assistance with ADL's. A review of Resident #19's Comprehensive Care Plan, dated 06/04/24 reflected a focus area of The resident has an ADL self-care performance deficit with and intervention area that reflected Personal hygiene: The resident requires total assistance by 1 staff with personal hygiene and oral care. Further review of Resident #19's Comprehensive Care Plan reflected a focus area of The resident is on anticoagulant therapy (aspirin) related to Disease process HTN/Hyperlipidemia (high blood pressure and too much fat in the blood), with and intervention area that reflected Daily skin inspection. Report Abnormalities to the nurse. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 07/08/24 at 9:47 AM Resident #19 was observed supine, covered in a sheet. The resident's skin appeared mottled, and his face was covered in large whitish/yellow flakes covered his scalp line, were observed to be embedded in his beard and covered his cheeks. The residents' nails were noted to be 1/2 inch to 3/4 inch long and were yellowish in color with areas beneath the nails that appeared brown, black, and dark red. The resident was noted to have two superficial scratches to his forehead The scratches were approximately 2.5 inches long running in a vertical pattern with what appeared to be dried blood at the boarders of the scratches. The other scratch was approximately 1 in long and was orientated vertically with the other scratch at approximately a 30-degree angle intersecting with the longer scratch making a y symbol. The area where the scratches intersected appeared to have dried blood at that spot. The resident stated that he tries to get out of bed every day, but the staff must have been running late that day. In an interview on 07/08/24 at 11:53 AM CNA M revealed that Resident #19 gets his showers regularly and that he was non-combative and that Resident #19's skin just pills up like that. She revealed that she had told LVN H about the flaking skin and the scratches on Resident #19's forehead. Review of Resident #19's progress notes on 07/08/24 at 1:35 PM from 06/08/24 to 07/08/24 revealed no notations of Resident #19's skin condition or scratches on his forehead. In an observation and interview on 07/08/24 at 1:47 PM LVN H was observed pushing Resident #19 in a wheelchair towards his room. Resident #19 was dressed in clean clothes and wearing a ball cap. No flakes were noted on Resident#19's face. LVN H revealed that Resident #19 had just had a shower, all of the dead skin had been washed off and his skin had been moisturized. She stated that [Resident #19] did not have any scratches on his head. In an observation and interview on 07/08/24 at 2:00 PM Resident #19 was observed seated in a wheelchair in his room watching TV. When asked if he still had the scratches on his forehead, he took off his ball cap and pointed to his forehead and stated Yes. The scratch was observed in the center of the resident's forehead, there was no dried blood, the shape was still in a y shape and the skin had been visibly moisturized. Resident #19 stated that he had felt much better after having a shower. In an interview on 07/08/24 at 2:05 PM LVN H revealed that CNA J was the staff that recently gave Resident #19 his shower. She revealed that she did not have time to see the scratches on Resident #19's forehead and that she had to finish her end of shift report with another nurse. Record review on 07/08/24 at 2:21 PM of the bath sheets for Resident #19's hall revealed a bath sheet signed by CNA J that did not note any scratches on Resident #19's forehead. Further record review of the facilities incident accident report from 07/07/24 to 07/08/24 revealed notation for Resident #19. Record review of the facility's 24-hour report revealed no notes regarding Resident #19. In an interview on 07/08/24 at 3:17 PM RN K revealed that the staff use the 24-hour reports to list any hospitalization s, transfers, new admissions, lab and X-Ray results and any change in condition. Scratches would be considered a change in condition. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/08/24 at 3:25 PM RN I revealed that if a resident had even a very small scratch that was not there before he would immediately assess it, consult a physician about it and carry out the orders of that physician to treat it. He stated that the scratches would be reported on the incident accident report and reflected in the 24-hour report to make sure that all nursing staff is aware. In an interview on 07/08/24 at 3:29 PM CNA L revealed that if she saw a scratch that hadn't been there before she would report it to a nurse immediately, she would bring a nurse directly to the resident. She stated that if she saw a scratch while giving a shower or care she would notate where the scratch was on the shower sheet. She stated that the staff do that to make sure that nursing staff are aware. In an interview on 07/08/24 at 4:12 PM DON revealed that if a CNA sees a change in condition either in the resident or the skin the staff are to report it to the charge nurse no matter the acuity of the wound or abrasion. Staff do have to note it on the shower sheet and tell the charge nurse. Once the charge nurse has been informed or made aware of the wound or change in condition the nurse needs to go observe and assess the wound and that needs to be logged in the 24-hour report either in the paper log or in the electronic health record system. The nurse was responsible for assessing any change in condition. If residents are not assessed promptly and properly it cause a possible risk to the residents' health and well-being. In an interview on 07/09/24 at 1:41 PM CNA J revealed that she had been the CNA that gave Resident #19 a shower the previous day and that had been the first time she had ever interacted with Resident #19. She stated that she had scrubbed Resident #19 very well and had applied lotion to his skin. She stated that she did not note any scratches on him. Review of the facility's policy Skin and Wound Care Assessment Protocol Dated 7/2018 reflected Facility Acquired Wounds or Skin Condition Discovery during Skin Checks, personal care or incident/injury .Report via incident report .Assess in Wound Module .Nurse's note performed and/or documentation added to note section in wound/rounds .to elaborate on new Dietary, Physician and RP contact and therapy referral per policy.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070 Based on observations, interviews, and record reviews the facility failed to ensure Food and drink that is palatable, attractive, and appetizing temperature for 1 (Residents #14) of 6 residents reviewed for food and nutrition. The facility failed to serve the resident food that was the appropriate temperature and fully cooked. This failure could place residents at risk for decreased quality of life. Findings included: Review of Resident #14's undated face sheet revealed she was a [AGE] year-old-female admitted to the facility on [DATE] with diagnoses that included: Cardiovascular accident (stroke), seizures (nerve disorder), depression (mental illness), diabetes (increased blood sugar), and bipolar disorder (mental illness). Also listed on the face sheet was the following: Allergen Milk, Chocolate, & Tomato. Review of Resident #14's quarterly MDS assessment, dated 05/21/24, revealed she had a BIMs score of 14: cognitively intact. The resident had the ability to understand, with clear speech, and required extensive assistance of one staff member to complete activities of daily living. An interview and observation with Resident #14 on 07/08/24 at 8:30 a.m. revealed Resident #14's breakfast tray was on the hall cart covered. LVN D served the breakfast tray to Resident #14 and did not offer to get a warm meal or heat it up. Resident #14 tried to eat the eggs and cream of wheat, but he eggs were cold and the cream of wheat was a large cold clump. An interview on 07/08/24 at 11:00 a.m. with LVN D stated she had served the breakfast tray to Resident #14. LVN D stated she did not even think about offering to get some warm food for Resident #14, she does not eat well anyway. LVN D stated the resident said nothing to her about the food being cold or asked for anything else when she served it this morning. Observation on 07/08/24 at 12:10 p.m. revealed Resident #14 in the dining room. The resident had been served a baked potato that was half cooked. The resident had told the CNA that she could not eat that, the CNA offered to get her something else, but she stated no she had ordered a baked potato early this morning for lunch and the kitchen could not even cook it right. There was no milk on the table or offered to the resident. After the resident left the table, the potato was cut and it was hard on one end with various clumps of potato that was cooked (the resident had eaten). In a confidential group meeting on 07/08/24 at 1:00 p.m. with ten residents revealed the food was cold when served on the hall carts for all meals and the food was not as tasty as it used to be. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 07/10/24 at 11:53 a.m. with the Administrator revealed the ordering of the food products was the dietary mangers responsibility to order the items that are needed. The Administrator stated if there was a grievance given to him by the resident like food, then it would be discussed with the department manager, and expectation that the manager would take care of the issue. The ADM did not necessarily follow-up with the manager I would make them responsible to correct the problem unless there was another complaint. The Administrator stated he had grievances concerning cold food and he has spoken to the dietary manager. The Administrator stated it was very important for the residents for socializing and keeping the spirit of the resident up. Review of the Nex. Grievance dated 06/20/24 (as the date the grievance was reported) revealed a grievance (effective date) 06/20/24 by Resident #14 concerning cold food being served at meals. A summary of the pertinent findings and conclusions revealed: the grievance was given to the dietary manager on 06/21/24. Further review revealed the corrective action will be taken to prevent recurrence: to have meeting with Resident #14. In an interview on 07/10/24 at 1:30 p.m. with Resident #14 revealed the food was very tasty, and the food was hot that was served at lunch time. That is the way all the meals should be. Record review of the facility's policy titled Resident Rights with a revised date of April 2017 revealed .c. Be assured choice opportunity to act autonomously e. Receive care and services that are adequate, appropriate, and in compliance with .relevant federal and state laws, rules and regulations I expect and receive a prompt response regarding request . from the director and/or staff .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070 Based on observations, interviews, and record reviews the facility failed to ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferencesfor 1 (Residents #14) of 6 residents reviewed for resident rights. The facility failed to facility's failure to provide lactose free milk to Resident #14. The resident had an allergy to milk products and the facility failed to keep the product in the facility. The facility failed to serve the resident food that was the appropriate temperature and fully cooked. This failure could place residents at risk for decreased quality of life. Findings included: Review of Resident #14's undated face sheet revealed she was a [AGE] year-old-female admitted to the facility on [DATE] with diagnoses that included: Cardiovascular accident (stroke), seizures (nerve disorder), depression (mental illness), diabetes (increased blood sugar), and bipolar disorder (mental illness). Also listed on the face sheet was the following: Allergen Milk, Chocolate, & Tomato. Review of Resident #14's quarterly MDS assessment, dated 05/21/24, revealed she had a BIMs score of 14: cognitively intact. The resident had the ability to understand, with clear speech, and required extensive assistance of one staff member to complete activities of daily living. Review of Resident #14's Plan of Care dated 07/03/24 reflected, 1. [Resident #14] Focus: 1. I AM AT RISK FOR COMPLICATIONS R/T: allergic to chocolate, milk and milk products, and tomato products. Goals: 1. I WILL NOT HAVE COMPLICATIONS SECONDARY TO ALLERGIES/SENSITIVITIES THROUGH NEXT REVIEW, Interventions: NOTIFY DIETARY AND ACTIVITIES OF FOOD ALLERGIES WHEN APPLICABLE 5. OBSERVE ME FOR S/S OF ADVERSE REACTION Review of the dietary meal ticket dated 07/08/24 for Resident #14 reflected: Diet: Regular thin liquids & Allergen Milk, Chocolate, & Tomato. This information was documented on the diet ticket and on the face sheet since admission (05/29/22). (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and observation with Resident #14 on 07/08/24 at 8:30 a.m. revealed Resident #14's breakfast tray was on the hall cart covered. There was no milk on the tray. Resident #14 stated she had problems with the dietary staff serving her the appropriate milk. Resident #14 stated that the dietary manager did not respond when she asked her about it, the dietary aides would tell her it had not been delivered on the truck. That has been going on for months. The kitchen has not offered me any other kind of lactose free milk. When the state was here about 2 months ago the administrator went out and got some lactose free milk. Resident #14 said she had an allergy to all milk and dairy products, regular milk gives me gas, indigestion, and a belly ache. The resident stated she has not had any milk since. The resident stated sometimes I do get so hungry for cereal, I will ask for regular milk , so I can have cereal, and I will pay the price by having a belly ache later. Resident #14 stated there are times I also eat ice cream because I'm just hungry for it and I will have belly ache later. The resident said the Administrator knows, he has been given grievances about the cold food and no lactose free milk available, but nothing has happened. An interview on 07/08/24 at 11:00 a.m. with LVN D stated she had served the breakfast tray to Resident #14. The LVN stated the resident had ask for lactaid milk in the past several times, but the kitchen always told us they did not have any. In a confidential group meeting on 07/08/24 at 1:00 p.m. with ten residents revealed they did get served what was on their meal ticket. One resident in the meeting stated they did not get what was on their meal ticket served most of the time, due to the allergy to milk products. An interview and observation on 07/10/24 at 9:15 a.m. Dietary Aide D stated the kitchen did have lactose free milk. Dietary Aide D opened the refrigerator and showed a gallon of lactaid milk. The Dietary aide stated Resident #14 ask for the lactose free milk all the time. We do not always have it and she get upset. We have some now because the administrator went and got some yesterday (07/09/24). Dietary aide D stated he had not seen any in the kitchen since he/she had been here. An interview on 07/10/24 at 11:53 a.m. with the Administrator revealed that he anticipated and expected the dietary manager to serve special requested needs for the residents such as if they are allergic to a certain food, they should always have it all available in the kitchen. Administrator stated the ordering of the food products was the dietary mangers responsibility to order the items that are needed. The Administrator stated if there was a grievance given to him by the resident like food, then it would be discussed with the department manager, and expectation that the manager would take care of the issue. The ADM did not necessarily follow-up with the manager I would make them responsible to correct the problem unless there was another complaint. Review of the Nex. Grievance dated 05/25/24 (as the date the grievance was reported) reflected a grievance (effective date) 05/25/24 by Resident #14 concerning no available lactose free milk to be served at meals. A summary of the pertinent findings and conclusions revealed: the grievance was given to the dietary manager on 05/25/24. Further review revealed the corrective action will be taken to prevent recurrence: to provide the product. In an interview on 07/10/24 at 1:30 p.m. with Resident #14 revealed the food was very tasty, and the food was hot that was served at lunch time. That is the way all the meals should be. Resident #14 stated she sure hope it stayed that way and she was very glad to have received lactose free milk at breakfast and lunch, it tastes so good. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled Resident Rights with a revised date of April 2017 revealed .c. Be assured choice opportunity to act autonomously e. Receive care and services that are adequate, appropriate, and in compliance with .relevant federal and state laws, rules and regulations I expect and receive a prompt response regarding request . from the director and/or staff .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46525 Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen, reviewed for food safety. 1. The facility failed to ensure the ice machine chute guard was clean. 2. The facility failed to ensure food items in the refrigerators, freezer and dry storage room were labeled with the item description (handwritten or manufacturer's label), had the received by date, the opened date and or the consume by or expiration by dates (if opened, 72 hours per the facility's policy or the manufacturer's expiration date); stored in accordance with the professional standards for food service. 3. The facility failed to discard opened items stored in refrigerator, freezers and dry storage that were not properly labeled with the opened or prepped by date and or past the 'best buy', consume by or manufacturer's expiration dates. 4. The facility failed to ensure multiple food items stored in a bin/container were each clearly identifiable. 5. The facility failed to ensure the staff were executing proper hand hygiene and use of PPE (masks and gloves). 6. The handwashing sink #1's garbage receptacle had items other than paper towels. 7. The facility failed to have a separate area for dented cans and housed dented cans with the undented cans. These failures could place residents at risk for food-borne illness and cross contamination. Findings included: Observation of the Kitchen on 07/08/24 at 08:12 AM revealed the following: - Handwashing sink #1 has a couple of gray smudges inside the back and left sides of the sink bowl as well as a few small food item particles in it. -The ice machine's ice chute guard had a light pink stain across the length of the bottom of the ice chute guard. -On prep table next to the reach-in refrigeration, had red liquid running off of the drink gun attachment and connector onto the prep table. Observations of the Reach-in refrigerator on 07/08/24 at 08:20 AM revealed the following: (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Right side door: -On top shelf, approximately 12-4 oz. chocolate supplemental shakes in a box dated 07/01/24 and 07/15/24. The shake container did not have a manufacturer's expiration date and the two dates listed did not indicate if they were the received by, opened or consume by or expiration dates. -Bottom of refrigerator, 2 trays with a total of 15-4 oz. clear plastic cups with lids containing red liquid and 1-4 oz. clear plastic cup with lid containing clear liquid, all labeled N on the lids; there were no label of item description, no prep date and no consume by or expiration date. - Left side door: -On top shelf, -2 medium zip top bags containing sandwiches cut in-half, wrapped in plastic wrap, a pack of graham crackers, bottled water with no received by date, and a container of applesauce, plastic cutlery, napkin and some condiment packets: -1 bag was labeled Dialysis 07/01/24 and the other bag was labeled June 27, there was no label of item descriptions on or inside the bag, no name for the resident it was prepared for, no consume by or expiration date. -2 clear square plastic to-go containers with a sandwich & chips, there was no label of item description, no prep date, no consume by or expiration date. -1-46 oz. mildly thickened cranberry cocktail juice no receive by date, the manufacturer best by date was illegible. 1-46 oz moderately thickened cranberry cocktail juice, received by date 05/14/24, opened 06/25/24, manufacturer expiration 04/12/24. -Bottom: 2 trays with 35-4 oz. clear plastic cup with lids of various colored liquids, there was no label of item description, no prep date and no consume by or expiration date. Observations of the Walk-in refrigerator on 07/08/24 at 08:39 AM, revealed the following: -Left side: -1 Large zip top bag with tortillas dated 07/06/24 left open to air, there was no consume by or expiration date. -1-5 lbs. package (160 slices) of Swiss cheese manufacturer PKD 05/15/24, no received by date noted. -1 Large zip top bag with shredded Parmesan cheese, left opened to air, no opened date, no consumed by date or expiration date. - 1-5 lbs. plastic bag of shredded mozzarella, received by date illegible (had smudged off), manufacturer expiration date 09/26/24. -1 Large zip top bag with tortillas dated 07/06/24, no label of item description, no consume by or expiration date. 2-5 lbs. clear containers with lids of mustard potato salad, dated 06/27/24, manufacturer used by date 07/05/24. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1 Large clear cylindrical container with lid labeled Apple Jelly dated 07/02/24, no consume by expiration date. -1 Large clear cylindrical container with lid with shredded yellow cheese, labeled cheese dated 06/30/24 no consumed by or expiration date. Observations of the Dry Storage Room on 07/08/24 at 08:58 AM revealed the following: -Right front shelf: -4 Large zip top with approximately 10 envelopes, each dated 06/21/24, no consume by or expiration date. -1 Large zip top bag with grits dated 07/04/24, no consume by or expiration date. -1-28 oz. bag creamy wheat dated 07/04/24, no consume by or expiration date. -1-2.5 lbs. Chocolate cookie pieces, previously opened, dated 06/22/24 no consume by or expiration date. -1 Large zip top bag with approximately 50 small round cookies, previously opened packages, labeled cookies, dated 07/07/24, bag left open to air. -Right back shelf: -1-6 lbs. 6 oz. can of tomatoes & zucchini sliced in juice dented at top of can. -1-12 oz. can evaporated milk received by 06/20/24 dented at top back and bottom side. -Left back shelf: -1 -3 lbs. 2 oz. can cream of mushroom soup dated 06/20/24 manufacturer expiration date 04/04/25, dented at the bottom of the can. -1-6 lbs. 10 oz. can of pineapple tidbits in juice date 06/06/24, manufacturer expiration date 07/28/25, small dent at top side. -1-6 lbs. 10 oz. can of pineapple tidbits in juice, no received by date, large dent on bottom a top. -1-6 lbs. 9 oz. can of medium sliced carrots, dated 06/28/24, manufacturer expiration date 05/14/24, there was a large dent on front of can. -1 Large zip top bag with 5 lbs. of brownie mixed opened date illegible, received by date 05/30/24. Observations of the Reach-in refrigerator on 07/10/24 at 09:48 AM, revealed the following: -Vent, located at the bottom outside of the refrigerator, had dust and a small black stain/particle on it. Observation of the Kitchen on 07/10/24 at 09:50 AM, revealed the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Handwashing sink #1's garbage receptacle had other items in the trash. There was product boxes and red liquid noted amid paper towels. Observations of the Kitchen on 07/10/24 at 11:40 AM, revealed the following: -Cook F was wearing gloves and assisting [NAME] E behind the steam table in preparing meal trays for the hall carts. [NAME] F walked off from behind the steam table to the other side. He did something then came back behind the steam table without washing his hands or changing gloves. [NAME] F then left from behind the steam table wen to get some plastic wrap and came back to behind the steam table without changing his gloves or washing his hands. He left once more and went off to complete do something else and then return behind the steam table without changing his gloves or washing his hands. Observations of the Kitchen on 07/10/24 at 11:57 AM, revealed the following: -Dietary Aide D was wearing gloves, he opened the kitchen door touching the inside of the door, exiting the kitchen. He then came back into the kitchen without changing his gloves or washing his hands, -Dietary Aide D, still wearing the same gloves, went into the walk-in refrigerator and got a gallon of 2% milk. He took a cup and opened the milk as he was walking and started to pour the milk while moving toward the kitchen door again. He sat the cup down, opened the kitchen door, touching the inside of the door; standing at kitchen entryway he then reached back in and grabbed the cup of milk and took it out to the dining room. Observations of the Kitchen on 07/10/24 at 11:58 AM, revealed the following: -After survey intervention, [NAME] F came out of the dish room and washed his hands, went behind the steam table and picked up some gloves but as he was walking away, he grabbed his mask with his clean left hand and started to pull it up over his nose, he sneezed in his hand as he was pulling up the mask. He then walked over to the prep table next to the reach-in refrigerator and grabbed 3 zip top bags he had recently brought out of the walk-in refrigerator, without washing his hands or putting on the gloves in his right hand. Observation of the Kitchen on 07/10/24 at 12:10 PM, revealed the following: -Dietary Aide D was noted standing in the doorway, touching the inside of the kitchen door (it was ajar) with his bare hands. He then entered the kitchen, grabbed a clean clear plastic pitcher with lid, walked over to handwashing sink #1 and began filling up the pitcher with water. He did not wash his hands upon re-entering the kitchen, before picking up the pitcher or after to take out to the dining room nor did he put on gloves. In an interview on 07/08/24 at 08:58 AM with the DM, she stated the facility had a milk person that delivers to them and when he delivered, he brought some whole milk and 2% milk. The DM stated most of the recipes (provided by corporate) required 2% milk. She said, I don't have anyone with a gluten allergy but I had one resident who preferred lactaid (lactose free milk) but ate regular ice cream. She stated they had soy milk which was dairy-free. The DM stated she attempted to offer the soy milk to the resident but she did not like it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/10/24 at 09:48 AM with the DM, she stated they keep opened/leftover items in the refrigerator for 72 hours and in the dry storage, they mark the opened date on the item then the opened items are kept until expiration date. The DM stated if there was no manufacturer's expiration date then they go by policy and if they are uncertain of a date they toss it. She stated food gets placed on the steam table about 1 hour prior to service. The DM stated to monitor routinely monitor temperature on steam table they calibrate the thermometer prior to service. When asked how food was tested for doneness, the DM said, for example chicken had to be 165 degrees [Fahrenheit], if it's not then they reheat until 135 degrees [Fahrenheit] then we know it's done. In an interview on 07/10/24 at 09:53 AM with the dietary staff, Dietary Aide G stated the harm to residents if food was raw or not cooked to doneness was food poison leading to illness. In an Observation and Interview on 07/10/24 at 11:42 AM with the DM, who attempted to turn on the metal plate charger (helps the meal plate stay warm) but it did not turn on. The metal plates were being placed under the meal plates, but they were not heated. The DM stated they have a new metal plate charger coming. In an interview on 07/10/24 at 01:41 PM with DM, she stated she did not notice the hand hygiene concerns the surveyor mentioned to her regarding the staff during meal service. She stated there would be some in-services given. Review of the facility's Nutrition Services Food Storage Policy, Date Revised December 2020, reflected Policy: Safe and sanitary conditions shall be maintained in storage, preparation, and distribution of food. Procedure: Storage: General Requirements: Staff shall be instructed to know where items belong and to know that any stored food must show an identifying label. Storage of Food Items: Items are immediately moved to the appropriate storage area designated for dry goods or the cooler/freezer items after they are received. All containers must be legibly and accurately labeled. All foods shall be dated with the month and year received and shall be rotated on the first in/first out basis upon receipt. Oldest items are to be moved to the front to be used first. Food shall be purchased in quantities which can be stored properly. Frozen products purchased in larger quantities than needed are divided into appropriate quantities, wrapped, and labeled with the description of the product, the date it was wrapped and placed in the freezer. Perishable foods such as meat, poultry, fish, and dairy products must be refrigerated to ensure nutritive value and quality. Appropriately store foods requiring refrigeration as follows: Place in freezer, refrigerator, or cooler immediately upon delivery. Cooked or prepared foods stored as leftovers shall be stored in covered containers or wrapped carefully and securely. Each item shall be clearly labeled and dated before being refrigerated. Leftover food shall not be kept in the refrigerator longer than three days and should be used, frozen, or discarded within that time. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the U.S. FDA Food Code 2022 reflected: Chapter 3 . section 3-201.11 Compliance and Food Law: . C. Packaged Food shall be labeled as specified in Law, including 21 CFR 101 Food Labeling [* .(b) A food which is subject to the requirements of section 403(k) of the act shall bear labeling, even though such food is not in package form. (c) A statement of artificial flavoring, artificial coloring, or chemical preservative shall be placed on the food or on its container or wrapper, or on any two or all three of these, as may be necessary to render such statement likely to be read by the ordinary person under customary conditions of purchase and use of such food. The specific artificial color used in a food shall be identified on the labeling when so required by regulation in part 74 of this chapter to assure safe conditions of use for the color additive.], 9 CFR 317 Labeling, [*(a) When, in an official establishment, any inspected and passed product is placed in any receptacle or covering constituting an immediate container, there shall be affixed to such container a label .Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. Section 3-302.12 Food Storage Containers, Identified with Common Name of Food: Except for containers holding FOOD that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food. Section 3-501.17 . Commercial processed food: Open and hold cold . B. 1. The day the original container is opened in the food establishment shall be counted as Day 1. 2. The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. C. 2. Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (A) of this section. 3. Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section. Definitions 3. Food Receiving and Storage - When food, food products or beverages are delivered to the nursing home, facility staff must inspect these items for safe transport and quality upon receipt and ensure their proper storage, keeping track of when to discard perishable foods and covering, labeling, and dating all PHF/TCS foods stored in the refrigerator or freezer as indicated. www.fda.gov eCFR- Code of Federal Regulations are indicating within the text by an *- www.ecfr.gov

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44021 Based on interviews and record review the facility failed to maintain clinical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident #19) of 5 residents reviewed for accuracy and completeness of clinical records. The facility failed to accurately document Resident #19 ' s superficial scratches on his forehead in his medical records. A. On 07/08/24 at 9:47 AM CNA J failed to note that Resident #19 had superficial scratches to his forehead that had been observed earlier that day. B. On 07/08/24 at 1:47 PM LVN H failed to assess he superficial scratches to Resident #19's forehead after being notified about the superficial scratches. C. On 07/09/24 at 1:41 PM CNA J revealed that she had been the CNA that gave Resident #19 a shower the previous day and that she that she had not noted any scratches on Resident #19. This failure placed facility residents at risk for worsening stasis and venous ulcers, Cellulitis (skin infection), Osteomyelitis (infection of the bone), Sepsis (infection of the blood) severe pain, and loss of limbs. Findings included: A review of Resident # 19's face sheet dated 06/04/24 reflected a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted to the facility on [DATE], with the following diagnosis: Dementia (impaired ability to remember, think, or make decisions), and Anxiety. A review Resident #19's Quarterly Minimum Data Sheet (MDS), dated [DATE] reflected Resident #19 was assessed to with a Brief Interview for Mental Status (BIMS) score of 04 indicated that he had severe cognitive impairment. Rejection of Care - Presence and Frequency indicated a score of 0, indicating that the behavior was not exhibited. The MDS also indicate under Functional Status that Resident #19 requires extensive assistance with ADL's. A review of Resident #19's Comprehensive Care Plan, dated 06/04/24 reflected a focus area of The resident has an ADL self-care performance deficit with and intervention area that reflected Personal hygiene: The resident requires total assistance by 1 staff with personal hygiene and oral care. Further review of Resident #19's Comprehensive Care Plan reflected a focus area of The resident is on anticoagulant therapy (aspirin) related to Disease process HTN/Hyperlipidemia (high blood pressure and too much fat in the blood), with and intervention area that reflected Daily skin inspection. Report Abnormalities to the nurse. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 07/08/24 at 9:47 AM Resident #19 was observed supine, covered in a sheet. The resident's skin appeared mottled, and his face was covered in large whitish/yellow flakes covered his scalp line, were observed to be embedded in his beard and covered his cheeks. The residents' nails were noted to be 1/2 inch to 3/4 inch long and were yellowish in color with areas beneath the nails that appeared brown, black, and dark red. The resident was noted to have two superficial scratches to his forehead The scratches were approximately 2.5 inches long running in a vertical pattern with what appeared to be dried blood at the boarders of the scratches. The other scratch was approximately 1 in long and was orientated vertically with the other scratch at approximately a 30-degree angle intersecting with the longer scratch making a y symbol. The area where the scratches intersected appeared to have dried blood at that spot. The resident stated that he tries to get out of bed every day, but the staff must have been running late that day. In an interview on 07/08/24 at 11:53 AM CNA M revealed that Resident #19 gets his showers regularly and that he was non-combative and that Resident #19's skin just pills up like that. She revealed that she had told LVN H about the flaking skin and the scratches on Resident #19's forehead. Review of Resident #19's progress notes on 07/08/24 at 1:35 PM from 06/08/24 to 07/08/24 revealed no notations of Resident #19's skin condition or scratches on his forehead. In an observation and interview on 07/08/24 at 1:47 PM LVN H was observed pushing Resident #19 in a wheelchair towards his room. Resident #19 was dressed in clean clothes and wearing a ball cap. No flakes were noted on Resident#19's face. LVN H revealed that Resident #19 had just had a shower, all of the dead skin had been washed off and his skin had been moisturized. She stated that [Resident #19] did not have any scratches on his head. In an observation and interview on 07/08/24 at 2:00 PM Resident #19 was observed seated in a wheelchair in his room watching TV. When asked if he still had the scratches on his forehead, he took off his ball cap and pointed to his forehead and stated Yes. The scratch was observed in the center of the resident's forehead, there was no dried blood, the shape was still in a y shape and the skin had been visibly moisturized. Resident #19 stated that he had felt much better after having a shower. In an interview on 07/08/24 at 2:05 PM LVN H revealed that CNA J was the staff that recently gave Resident #19 his shower. She revealed that she did not have time to see the scratches on Resident #19's forehead and that she had to finish her end of shift report with another nurse. Record review on 07/08/24 at 2:21 PM of the bath sheets for Resident #19's hall revealed a bath sheet signed by CNA J that did not note any scratches on Resident #19's forehead. Further record review of the facilities incident accident report from 07/07/24 to 07/08/24 revealed notation for Resident #19. Record review of the facility's 24-hour report revealed no notes regarding Resident #19. In an interview on 07/08/24 at 3:17 PM RN K revealed that the staff use the 24-hour reports to list any hospitalization s, transfers, new admissions, lab and X-Ray results and any change in condition. Scratches would be considered a change in condition. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/08/24 at 3:25 PM RN I revealed that if a resident had even a very small scratch that was not there before he would immediately assess it, consult a physician about it and carry out the orders of that physician to treat it. He stated that the scratches would be reported on the incident accident report and reflected in the 24-hour report to make sure that all nursing staff is aware. In an interview on 07/08/24 at 3:29 PM CNA L revealed that if she saw a scratch that hadn't been there before she would report it to a nurse immediately, she would bring a nurse directly to the resident. She stated that if she saw a scratch while giving a shower or care she would notate where the scratch was on the shower sheet. She stated that the staff do that to make sure that nursing staff are aware. In an interview on 07/08/24 at 4:12 PM DON revealed that if a CNA sees a change in condition either in the resident or the skin the staff are to report it to the charge nurse no matter the acuity of the wound or abrasion. Staff do have to note it on the shower sheet and tell the charge nurse. Once the charge nurse has been informed or made aware of the wound or change in condition the nurse needs to go observe and assess the wound and that needs to be logged in the 24-hour report either in the paper log or in the electronic health record system. The nurse was responsible for assessing any change in condition. If residents are not assessed promptly and properly it cause a possible risk to the residents' health and well-being. In an interview on 07/09/24 at 1:41 PM CNA J revealed that she had been the CNA that gave Resident #19 a shower the previous day and that had been the first time she had ever interacted with Resident #19. She stated that she had scrubbed Resident #19 very well and had applied lotion to his skin. She stated that she did not note any scratches on him. Review of the facility's policy Skin and Wound Care Assessment Protocol Dated 7/2018 reflected Facility Acquired Wounds or Skin Condition Discovery during Skin Checks, personal care or incident/injury .Report via incident report .Assess in Wound Module .Nurse's note performed and/or documentation added to note section in wound/rounds .to elaborate on new Dietary, Physician and RP contact and therapy referral per policy.