STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676378	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sorrento	2739 Babcock San Antonio, TX 78229

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42031 Based on observation, interview, and record review the facility failed to immediately notify, consistent with his or her authority, the resident representative(s) when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 of 5 residents (Resident #96), reviewed for resident rights. The facility failed to notify Resident #96's resident representative of facility acquired pressure ulcers to his left foot, left lateral leg, left heel, right lateral knee, and left flank From 7/10/24 through 7/22/24 (12 days). This failure could place residents at risk of delays in decision making, and could cause anxiety, grief, and a poor quality of care and life. The findings were: Record review of Resident #96's undated face sheet revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] from an acute care hospital. His diagnoses included stage 4 pressure ulcer to sacral region (area just above the tailbone with Full-thickness skin loss extends through the fascia with considerable tissue loss. There may be muscle, bone, tendon, or joint involvement.), Type 2 diabetes without complications (chronic condition that affects the way the body processes blood sugar), unstageable right heel pressure ulcer (pressure ulcer or injury in which staging is not possible either due to dead tissue obstructing the wound bed or where the skin is intact as in a deep tissue injury), and gastrostomy malfunction (malfunction of an opening into the stomach from the abdominal wall, made surgically for the introduction of food via a tube). The resident was a full code and discharged to the hospital on 7/23/24 at the request of the resident's representative. Record review of Resident #96's care plan with an effective date of 7/2/24 revealed a problem for the resident being at risk of pressure ulcers with a goal the resident will be free from further skin breakdown for the next 90 days. Another problem for the resident being at risk of skin breakdown with a goal the resident's skin would remain dry and intact and have no further breakdown over the next 90 days. Both had multiple interventions. Further review revealed a problem for potential for surgical site infection and interventions included to discuss with resident and family any concerns related to wound healing. A problem for the resident being a full code with interventions to notify the doctor and responsible party of a change in condition. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #96's admission MDS assessment undated with an observation end date of 7/7/24 revealed the resident had a BIMS score of 15 indicating the resident was cognitively intact. The resident had limited range of motion to bilateral upper extremities. The resident was dependent - helper did all of the effort. Resident did none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity for rolling left and right, sit to lying, lying to sitting and all transfers. The resident had an ostomy, indwelling foley catheter, and a gastrostomy tube for feedings. The resident had 1 stage 4 pressure ulcer on admission and no stage 1, 2, or 3 pressure ulcers. The resident had 2 unstageable deep tissue injuries on admission. Participation in assessment and goal setting were the resident and family with a goal to discharge to the community with active discharge planning already occurring for the resident to return to the community. The MDS was signed as completed on 7/16/24. Record review of Resident #96's hospital discharge paperwork with a print date of 7/1/24 detailed the resident diagnoses included multiple myeloma with metastasis to bone, was post chemotherapy and in remission, diverting colostomy on 5/24/24, stage 4 pressure ulcer with exposed bone, that had been debrided and now had a wound vac, history of left lower extremity deep vein thrombosis, and a slow healing surgical wound to the back of his neck. Record review of wound care list provided by facility dated 7/23/24 revealed Resident #96 had a stage 4 sacrum ulcer, an unstageable right heal deep tissue injury, and a right dorsal foot deep tissue injury, all present on admission. The right dorsal foot was resolved on 7/22/24. The facility acquired pressure ulcers were as follows: a left dorsal foot deep tissue injury, an unstageable left lateral leg, a left heel deep tissue injury, a right lateral knee, deep tissue injury, and a left flank deep tissue injury. Also documented on this form was the right heel and left lateral leg were changed to unstageable on 7/22/24. Record review of Resident #96's progress notes revealed a note by an unknown nurse dated 7/23/24 at 8:06 p.m. the resident's family had concerns with the sacral wound and new wounds and requested the resident be sent to the emergency room for evaluation and treatment. Record review of Resident #96's progress notes revealed a note by the SW dated 7/24/24 at 10:09 a.m. indicated the SW had met with the resident's family the night before and they were concerned with his condition due to the sacral wound getting worse and new wounds had developed. SW and wound care nurse had a difficult conversation with them last night about how he (the resident) is in skin failure. The note went on it was discussed that his decline is indicative of him transitioning. The Nurse Practitioner was contacted and agreed to do a direct admit to the hospital if the family wanted. The note further indicated They were very concerned they were not notified of his condition change. Wound care nurse and SW calmed them down and they agreed to send him to the hospital and have a palliative consult at the hospital. Record review of Resident #96's wound assessments all completed by RN C indicated the deep tissue injury to the left dorsal foot and right dorsal foot both developed on 7/10/24, the deep tissue injury to the left lateral leg developed on 7/15/24, and the deep tissue injuries to the left heel, right lateral knee, and left flank developed on 7/21/24. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #96's wound assessments revealed assessments completed and signed by RN C for the deep tissue injuries to the left and right dorsal feet dated 7/10/24 and under date family notified was 7/10/24. Further review revealed wound assessments for these same wounds dated 7/15/24 and under date family notified was 7/15/24. Record review of Resident #96's wound assessments revealed an assessment dated [DATE] completed and signed by RN C for a deep tissue injury to the left lateral leg with date of onset 7/15/24, under date family notified was 7/15/24. Record review of Resident #96's wound assessments revealed an assessments dated 7/22/24 completed and signed by RN C revealed a new documented left heel deep tissue injury to the left heel with a date of onset of 7/21/24 and a right lateral knee, deep tissue injury with a date of onset of 7/21/24 and under date family notified was documented 7/22/24 on both. In an observation and interview on 7/23/24 at 10:40 a.m. Resident #96 was lying in bed, watching tv, head of bed was flat, the resident stated he was pretty terrible at the moment because he was in pain and waiting for the pain meds to kick in, Tube feeding hanging on a pole with pump but was not hooked up or running. The resident had his remote and his call light in reach. The resident also had a Reacher-grabber at bedside. In an interview on 7/24/24 at 11:30am the Resident's representative family who was his durable and medical Power of Attorney stated they were never notified of his new wounds, or his sacral wound getting worse and was tearful and expressed anger and frustration and further stated the resident was supposed to be discharged back to his assisted living but now was told by the SW and wound care nurse at the facility basically hospice and end of life were his only options and she had him sent to the hospital. In an observation and interview on 7/24/24 at 4:00 p.m. the resident's representative family stated a friend of the family came to visit Resident #96 on 7/23/24 and called the RP and stated she was informed the resident was on end-of-life services and could not have visitors. Unsure of who had told the visitor this but stated she came to the facility and was at that time informed of the worsening sacral wound and new wounds by the SW and the wound care nurse and the RP stated she was angry, shocked, and hurt. The RP stated she insisted the resident be sent back to the hospital for evaluation and he was sent. The RP stated she had never been notified of any new wounds and thought everything was going well. The RP stated she visited and others at least once a week and she had been notified when the resident started antibiotics for an infection but never about the wounds or that the resident would need end of life services. The RP further stated Resident #96 was still in the emergency room waiting on a bed and was alert and oriented and the plan was to surgically debride the sacral wound tomorrow and the resident would be staying in the hospital. At this time, the RP facetime called the resident and put surveyor on with Resident #96 and the resident stated he was doing well and his pain was much better at this time and he remembered speaking with surveyor at the facility. Resident #96 stated he had made his family member his durable and medical power of attorney but no one had communicated with her and he asked this surveyor if he needed to fill out another one and asked if it expires. Surveyor explained we could not give advice but that it did not expire unless he revoked it. The resident then stated he wanted to do new ones now just in case. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 7/25/24 at 9:31 a.m. RN C stated she was not sure if the family had ever been notified of Resident #96's new wounds and stated she had apologized to the resident's family because she was not aware they did not know and she was not sure who was responsible for notifying the resident's family. In an interview on 7/25/24 at 9:55 a.m. the SW stated the wound care nurse came and got her when the family was upset prior to sending the resident to the hospital and together they explained the resident's decline and the family was upset they were not notified of the residents change of condition. The SW stated she was unsure who was responsible for notifying the resident's family and RP of his change of condition and confirmed she (SW) had not notified the resident's family. In an interview on 7/25/24 at 10:10 a.m. LVN D stated he was familiar with the resident and takes care of him. LVN C stated he had not notified the resident's family of his new wounds and thought it was basically if you find it and deal with it that you were responsible for notifying the family. LVN D stated he had called the RP and notified her when the lab results were abnormal and antibiotics were started. In an interview on 7/25/24 at 10:25 a.m. the ADON stated the nurse was ultimately responsible for notifying the family of changes in condition, even wounds. In an interview on 7/25/24 at 1:45 p.m. the DON stated the wound care nurse was responsible for notifying the family's of wound care changes of condition and the nurses were also responsible. In an interview on 7/25/24 at 4:30 p.m. RN C stated she did document the wound assessments and stated it was a general form and confirmed despite the documentation that she had notified the family, she had not. RN C stated sometimes she does not leave until 10:00 p.m. ensuring the wound care was completed and documented and she did not have time to notify the family. In an interview on 7/26/24 at 2:25 p.m. the DON stated possible consequences of the family not being notified of a resident's change of condition would be the family would be upset and the documentation of it being done when it was not could cause a possible miscommunication among staff. Review of the facility policy on change of condition revised January 2024 indicated a . a significant change in a resident's status is any acute or sudden change . examples included pressure injury .The licensed nurse will . 3. Document date, time provider, responsible party was notified of findings .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28619 Based on interviews and record reviews, the facility failed to ensure the assessment accurately reflected the resident's status for 1 (Resident#15) out of 24 residents reviewed for MDS assessments. Resident #15's quarterly MDS assessment with an ARD of 05/03/2024 inaccurately reflected he was ordered a therapeutic diet when he was ordered a regular diet. This failure could affect residents with MDS assessments and could result in inaccurate care. The findings included: Record review of Resident #15's EMR dated 07/25/2024 reflected he was admitted to the facility on [DATE]. His diagnoses included: anemia (a blood disorder that occurs when the body doesn't have enough red blood cells or red blood cells do not function properly), chronic kidney disease (kidneys are damaged and cannot filter blood the way they should), atrial fibrillation (a common type of irregular heart rhythm), and functional dyspepsia (a common gastrointestinal disorder defined by symptoms such as burning, pain and fullness). Record review of Resident #15's quarterly MDS assessment with an ARD of 05/03/2024 reflected he scored a 12 out of 15 on his BIMS which signified he was cognitively intact. He was on a therapeutic diet. Record review of Resident #15's comprehensive care plan (undated) inaccurately reflected he was on a therapeutic diet. Record review of Resident #15's diet orders dated 07/25/2024 and previous reflected he was ordered a regular NSOT on 02/15/2023. He was ordered a regular diet on 12/21/2023. Observation on 07/24/2024 at 1:00 pm of Resident #15 in his room revealed he had a regular meal for lunch. Interview on 07/24/2024 at 1:05 pm with Resident #15, he stated he was on a regular diet and ate what he wanted. Interview on 07/26/2024 at 12:30 pm with RN A who covered for the MDS nurse who was not available revealed that the NSOT was no longer the current diet and the MDS was inaccurate when it reflected Resident #15 was ordered a therapeutic diet. She stated the NSOT order was never taken out of the system, but the regular diet was ordered after and was the accurate diet. She stated it was important for the MDS to be accurate because it was based on an assessment of the resident and told staff what Resident #15's care needs were, and they could be overlooked. Interview on 07/26/2024 at 1:09 PM with the DON, she stated the order was not updated in the MDS and the care plan for Resident #15 and it was important for those to be accurate because it could result in missed care. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11, October 2023 reflected The RAI process has multiple regulatory requirements . (1) the assessment accurately reflects the resident's status.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28619 Based on observation, interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for 2 (Residents#35 and #71) of 24 residents reviewed for care plans. 1. Resident #35's supra-pubic (above the pelvic bone) indwelling urinary catheter (tube inserted into bladder through abdomen) was not reflected in her (current) (undated) comprehensive person-centered care plan. 2. Resident #71's PASRR services was not reflected in his (current) (undated) comprehensive person-centered care plan. These failures could affect residents who reside at the facility and require care and result in missed or inaccurate care. The findings included: 1.Record review of Resident #35's EMR reflected she was admitted to the facility on [DATE]. Her diagnoses included: dysphagia (difficulty swallowing), vascular dementia (a condition that affects the brain due to damaged blood vessels that disrupt blood flow and oxygen supply), and neuropathic bladder (lack of bladder control due to a brain, spinal cord, or nerve problem). Record review of Resident #35's quarterly MDS assessment with an ARD of 7/16/2024 reflected she had a catheter. She was not a candidate for a BIMS which signified she was severely cognitively impaired. Record review of Resident #35's comprehensive person-centered care plan (current) (undated) did not reflect she had a supra-public indwelling urinary catheter. Record review of Resident #35's physician orders active as of 07/25/2024 reflected she had a suprapubic catheter and it was active as of 02/08/2024. Observation of Resident #35 receive catheter care on 07/25/24 at 08:42 AM revealed she had a supra-pubic catheter. Interview on 07/26/2024 at 12:30 pm with RN A who covered for the MDS nurse who was not available revealed that when Resident #35's supra-pubic catheter was placed in February 2024, the comprehensive care plan was not updated to reflect the change. She stated the care plan needed to accurately reflect a resident's required care based on the assessment and observations, and care could be missed. Interview on 07/26/2024 at 1:09 PM with the DON, she stated Resident #35's care plan needed to reflect she had a supra-pubic catheter because it was a special part of the resident's care and could be missed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.Record review of Resident #71's EMR reflected he was admitted to the facility on [DATE]. His diagnoses included: heart disease (conditions that include diseased vessels, structural problems, and blood clots), disorders of the peritoneum (pain and discomfort in the area between the anus and genitals), atrial fibrillation (a heart condition that causes an irregular and often rapid heartbeat) and intellectual disability (a chronic neurodevelopmental disorder that affects a person's intellectual and adaptive functioning). Record review of Resident #71's admission MDS assessment dated [DATE] reflected under Preadmission Screening and Resident Review a yes related to intellectual disability and was PASRR positive with level II screening. Record review of Resident #71's comprehensive person-centered care plan (current) (undated) did not reflect he was PASRR positive or has an intellectual disability. Interview on 07/26/2024at 12:30 pm with RN A who covered for the MDS nurse who was not available revealed that Resident #71's comprehensive care plan needed to include his PASRR services. She stated it was important for the care plan to be accurate because it was based on an assessment of the resident and told staff what Resident #15's care needs were, and they could be overlooked. Interview on 07/26/2024 at 1:09 PM with the DON, she stated Resident #71's comprehensive care plan needed to reflect his PASRR services and intellectual disability because that was part of his care, and it could be missed. Record review of the facility policy and procedure titled Comprehensive Care Planning (undated) reflected The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28619 Based on observations, interviews, and record reviews the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments person-centered care plan to reflect the current condition for 2 of 12 residents (Resident #15 and Resident #70) reviewed for care plan revisions. 1.Resident #15's comprehensive person-centered care plan was not revised after his quarterly MDS assessment dated [DATE] to reflect he was ordered a regular diet instead of a therapeutic. 2.Resident #70's comprehensive person-centered care plan was not revised after his annual MDS assessment dated [DATE] to reflect he was on a therapeutic diet. This failure could affect residents with MDS assessments and could result in missed of required care. The findings included: 1. Record review of Resident #15's EMR dated 07/25/2024 reflected he was admitted to the facility on [DATE]. His diagnoses included: anemia (a blood disorder that occurs when the body doesn't have enough red blood cells or red blood cells do not function properly), chronic kidney disease (kidneys are damaged and cannot filter blood the way they should), atrial fibrillation (a common type of irregular heart rhythm), and functional dyspepsia (a common gastrointestinal disorder defined by symptoms such as burning, pain and fullness). Record review of Resident #15's quarterly MDS assessment with an ARD of 05/03/2024 reflected he scored a 12 out of 15 on his BIMS which signified he was cognitively intact. He was on a therapeutic diet. Record review of Resident #15's comprehensive care plan (undated) inaccurately reflected he was on a therapeutic diet. Record review of Resident #15's diet orders (current) and previous reflected he was ordered a regular NSOT on 02/15/2023. He was ordered a regular diet on 12/21/2023. Observation on 07/24/2024 at 1:00 pm of Resident 15 in his room revealed he had a regular meal for lunch. Interview on 07/24/2024 at 1:05 pm with Resident #15, he stated he was on a regular diet and ate what he wanted. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/26/2024 at 12:30 pm with RN A who covered for the MDS nurse who was not available revealed that the NSOT was no longer the current diet for Resident #15 and the MDS was inaccurate. She stated Resident #15's care plan was inaccurate, but his physician orders for a regular diet was dated 12/2023, so the care plan should have been revised to reflect Resident #15 was on a therapeutic diet after the MDS assessment. Interview on 07/26/2024 at 1:09 PM with the DON, she stated Resident #15's diet order was not updated in the MDS or the care plan for Resident #15. She stated not having an accurate MDS or care plan could result in missed care. 2. Record review of Resident #70's EMR reflected he was admitted to the facility on [DATE]. His diagnoses included: Down Syndrome, hypotension, hydrocephalus, and depression. Record review of Resident #70's annual MDS assessment dated [DATE] reflected he was on a therapeutic and mechanically altered diet. He was not able to complete the BIMS interview and was sometimes understood and sometimes understands. Record review of Resident #70's diet order dated 5/2/24 reflected Pureed LCS. Record review of Resident #70's diet order dated 12/20/23 reflected Nectar Thickened Liquids, Puree. Record review of Resident #70's comprehensive care plan (undated) reflected Problem, on a therapeutic diet as evidenced by Puree, regular, Nectar thickened liquids, interventions, serve diet per order. Observation on 07/26/2024 at 12:45 PM of Resident #70 reflected he had pureed fish, creamed corn, bread, okra, and cake. Record review of Resident #70's lunch meal ticket reflected LCS pureed. Interview on 07/26/2024 at 12:30 pm with RN A who covered for the MDS nurse who was not available revealed that Resident #70's diet was changed to LCS, and the care plan needed to be revised after the MDS assessment because care could be missed. Interview on 07/26/2024 at 1:09 PM with the DON, she stated Resident #70's care plan needed to be revised after his MDS assessment to reflect he was on a therapeutic diet. She stated missed care could occur or he could be given the wrong diet. Record review of the CMS MDS 3.0 Manual dated October 2023 revealed in section 2-44, Care plan completion based on the CAA process is required for OBRA-required comprehensive assessments. It is not required for non-comprehensive assessments (Quarterly, SCQA), PPS assessments, Discharge assessments, or Tracking records. However, the resident's care plan must be reviewed after each assessment, as required by S483.20, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 46677 Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were secured properly within 1 of 4 medication carts (med cart in hall 100) observed for medication storage. RN B pre-poured medication for Resident #13 then stored it in the top drawer of the medication cart in hallway 100. This failure could place residents at risk of not receiving the intended therapeutic benefit of the medications as ordered. The findings were: Observation of the medication cart on 100 hall on 07/26/2024 at 10:49 AM revealed a medication cup with one small yellow pill in the cup. Medication cup was not labeled and had no identifying markers to indicate what was within the cup. Medication cart was locked and secured. Interview with RN B on 07/26/2024 at 11:11 AM revealed RN B poured Resident #13's Eliquis 25 mg but when she attempted to pass the medication Resident #13 was sleeping. RN B stated she placed the medication in the medication cart planning to give the medication when the resident woke up for lunch at 11:30 AM. RN B stated that pre-pouring medications was not allowed, and she should have disposed of the medication when she was unable to give it to Resident #13. RN B stated the pre-pouring medications could result in resident's not getting their medications as prescribed or the wrong resident getting the medication. Record review of Resident #13's MAR on 07/26/24 revealed RN B did not document Resident #13's Eliquis 25 mg as being given to resident. Record review of facility policy named Storage of Medications dated April 2007 revealed Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47622 Based on observations, interview and record review the facility's Dietary Services failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. 1. The freezer in the kitchen had a packages of frozen foods that were opened and not sealed. 2. The ice machine had black substance that appeared to spread across in the area where ice was dispensed and hard water stains on the outside. 3. The ice machine in the nutrition room of the [NAME] Neighborhood had black substance on the hood of the unit where ice is dispensed. 4. The [NAME] neighborhood had food in the nutrition room in the freezer that was unlabeled. 5. In the dry storage area were gnats flying above the food. 6. There was a drainage trap with a plastic top for cups and paper near on the floor beneath the juice machines. This deficient practice could cause food borne illness for the residents that receive food from the kitchen. The findings included: During initial tour on 07/23/24 09:30 AM of the kitchen with the Nutritional Services Director (NSD) revealed the freezer had a package of frozen pork sausage patties and a package chicken nuggets that were opened and not sealed. During an interview 07/23/24 09:30 AM the NSD stated that the frozen bag of chickent nuggets and the frozen bag of pork sausage was supposed to be closed to prevent freezer burn and contamination and could cause food borne illness. During observation 07/23/24 09:30 AM there were gnats flying in the dry storage room. During an interview 07/23/24 09:30 AM the NSD stated,oh no. I will take care of this right away because that is not clean to have bugs anywhere around food. The NSD stated it may be due to the drains not being cleaned. During observation on 7/23/2024 09:30 AM There was a drainage trap with a plastic top for cups and paper that was underneath the juice machines. She stated the drains traps were cleaned once per week on Thursdays and that may be the reason there were gnats because it had not been cleaned. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observation 07/26/2024 09:30 AM the ice machine in the kitchen had black substance that appeared to spread across in the area where ice was dispensed and hard water stains on the outside of the machine. During observation on7/23/2024 at 9:55AM the Nutrition Room had food in the freezer unlabeled. The ice machine in the nutrition room had black substance that appeared to spread across in the area on the hood of the unit where ice was dispensed. During an interview 7/26/2024 at 10:03AM the Nutrition Services Director stated gnats may come because an area was not clean, maybe from the drains in the kitchen. She stated it would be due to improper cleaning. She stated when things are not cleaned properly in the kitchen, it could cause illness to the residents. She stated food in the freezer should be stored properly because of cross contamination, could become freezer burned, and could cause food borne illness to the residents. She stated it was important to keep the area around the dumpsters clean to prevent rodents and pests from entering the building. She stated she did not put the issue of gnats on the maintenance log because she did not know the gnats were there. She stated dietary was responsible for cleaning the fridges on the units' nutrition rooms daily in the morning and at night when they leave the evening snacks. She stated it had not been done. She stated the dietary was responsible for cleaning the ice machines as well and that the black substance that was spread across the hood of the ice dispenser in the kitchen and the nutrition room had not been cleaned. She stated the ice machines that were not cleaned could cause food borne illness. During an interview on 7/26/2024 at 10:24AM the Registered Dietician stated the ice machines should be kept clean to prevent food borne illnesses. She stated the gnats could get in the residents' food and cause food borne illnesses due to improper cleaning that may include the drains in the kitchen. She stated the kitchen should be kept clean to protect the residents from food borne illnesses. She stated improper food storage from dry to frozen foods could cause cross contamination and food borne illness and would be considered an infection control issue. Record review of dietary policy on 7/26/2024 at 8:30AM titled Sanitation of Dietary Department dated 11/3/2004 stated: The dietary staff shall maintain the sanitation of the Dietary Department through compliance with a written, comprehensive cleaning schedule. Record review of policy for ice machines on 7/26/2024 at 8:40AM titled Ice Machines and Ice Storage Chests dated revised 1/2012 stated: Ice machines and ice storage/distribution containers will be used and maintained to assure a safe and sanitary supply of ice. Policy Interpretation and Implementation stated: Ice making machines, ice storage chests/containers, and ice can all become contaminated by: a. unsanitary manipulation by employees, residents and visitors; b. waterborne microorganisms naturally occurring in the water source; c. colonization by microorganisms; and/or d. improper storage or handling of ice.

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 47622 Based on observations, interviews and record reviews the facility failed to dispose of garbage and refuse properly to ensure the residents were free from pests and rodents and to live in a safe and clean evironment. Garbage was observed on the ground with used incontinent briefs and other debris on the ground around the dumpsters. This deficient practice could cause the facility to have pests and rodents in and around the facility preventing a clean and safe homelike environment for the residents. The findings included: During an observation 7/23/2024 9:40 AM there was garbage outside around the dumpsters in the back of the building through doors leading from the kitchen with incontinent briefs and plates and other debris on the ground. During an interview 7/23/2024 9:40 AM the NSD stated there was an overflow of garbage in the dumpsters and when the garbage truck dumped the garbage, it fell out on the ground. The NSD stated when she saw the garbage on the ground before the morning meeting that started at 8:00 AM and she did not clean it because she did not want to be late to the morning meeting. She agreed it could bring pests and rodents if garbage is left on the ground. The NSD stated Dietary Services was responsible of making sure the area around the dumpsters were clean and free from garbage on the ground. During an interview 7/26/2024 at 10:24 AM the RD stated that the garbage dumpster should be free from debris on the ground to prevent pests and rodents from entering the building. Record review 7/26/2024 at 10:00AM of policy titled: Dumpster Protocol dated 12/2023 stated Dumpster area perimeter should remain free of debris; Director of Maintenance/designee should make daily rounds to check for debris; Any facility staff should report observations of debris to the Executive Director/Director of Maintenance / designee.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42031 Based on observation, interview, and record review the facility failed to, in accordance with accepted professional standards and practices, maintain medical records on each resident that were accurately documented for 1 of 5 residents (Resident #96), reviewed for administration. Wound assessments for Resident #96 were documented as the family was notified when they were not. This failure could result in confusion, decreased continuity of care, and result in anger, frustration, poor quality of life and a delay in decision making. The findings were: Record review of Resident #96's undated face sheet revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] from an acute care hospital. His diagnoses included stage 4 pressure ulcer to sacral region (area just above the tailbone with Full-thickness skin loss extends through the fascia with considerable tissue loss. There may be muscle, bone, tendon, or joint involvement.), Type 2 diabetes without complications (chronic condition that affects the way the body processes blood sugar), unstageable right heel pressure ulcer (pressure ulcer or injury in which staging is not possible either due to dead tissue obstructing the wound bed or where the skin is intact as in a deep tissue injury), and gastrostomy malfunction (malfunction of an opening into the stomach from the abdominal wall, made surgically for the introduction of food via a tube). The resident was a full code and discharged to the hospital on 7/23/24 at the request of the resident's representative. Record review of Resident #96's care plan with an effective date of 7/2/24 revealed a problem for the resident being at risk of pressure ulcers with a goal the resident will be free from further skin breakdown for the next 90 days. Another problem for the resident being at risk of skin breakdown with a goal the resident's skin would remain dry and intact and have no further breakdown over the next 90 days. Both had multiple interventions. Further review revealed a problem for potential for surgical site infection and interventions included to discuss with resident and family any concerns related to wound healing. A problem for the resident being a full code with interventions to notify the doctor and responsible party of a change in condition. Record review of Resident #96's admission MDS assessment undated with an observation end date of 7/7/24 revealed the resident had a BIMS of 15 indicating the resident was cognitively intact. The resident had limited range of motion to bilateral upper extremities. The resident was dependent - helper did all of the effort. Resident did none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity for rolling left and right, sit to lying, lying to sitting and all transfers. The resident had an ostomy, indwelling foley catheter, and a gastrostomy tube for feedings. The resident had 1 stage 4 pressure ulcer on admission and no stage 1, 2, or 3 pressure ulcers. The resident had 2 unstageable deep tissue injuries on admission. Participation in assessment and goal setting were the resident and family with a goal to discharge to the community with active discharge planning already occurring for the resident to return to the community. The MDS was signed as completed on 7/16/24. (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 7/23/24 at 10:40 a.m. Resident #96 was lying in bed, watching tv, head of bed was flat, the resident stated he was pretty terrible at the moment because he was in pain and waiting for the pain meds to kick in, Tube feeding hanging on a pole with pump but was not hooked up or running. The resident had his remote and his call light in reach. The resident also had a Reacher-grabber at bedside. Record review of Resident #96's progress notes revealed a note by an unknown nurse dated 7/23/24 at 8:06 p.m. the resident's family had concerns with the sacral wound and new wounds and requested the resident be sent to the emergency room for evaluation and treatment. Record review of Resident #96's progress notes revealed a note by the SW dated 7/24/24 at 10:09 a.m. indicated the SW had met with the resident's family the night before and they were concerned with his condition due to the sacral wound getting worse and new wounds had developed. SW and wound care nurse had a difficult conversation with them last night about how he (the resident) is in skin failure. The note went on it was discussed that his decline is indicative of him transitioning. The Nurse Practitioner was contacted and agreed to do a direct admit to the hospital if the family wanted. The note further indicated They were very concerned they were not notified of his condition change. Wound care nurse and SW calmed them down and they agreed to send him to the hospital and have a palliative consult at the hospital. Record review of Resident #96's wound assessments all completed by RN C indicated the deep tissue injury to the left dorsal foot and right dorsal foot both developed on 7/10/24, the deep tissue injury to the left lateral leg developed on 7/15/24, and the deep tissue injuries to the left heel, right lateral knee, and left flank developed on 7/21/24. Record review of Resident #96's wound assessments revealed assessments completed and signed by RN C for the deep tissue injuries to the left and right dorsal feet dated 7/10/24 and under date family notified was 7/10/24. Further review revealed wound assessments for these same wounds dated 7/15/24 and under date family notified was 7/15/24. Record review of Resident #96's wound assessments revealed an assessment dated [DATE] completed and signed by RN C for a deep tissue injury to the left lateral leg with date of onset 7/15/24, under date family notified was 7/15/24. Record review of Resident #96's wound assessments revealed an assessments dated 7/22/24 completed and signed by RN C revealed a new documented left heel deep tissue injury to the left heel with a date of onset of 7/21/24 and a right lateral knee, deep tissue injury with a date of onset of 7/21/24 and under date family notified was documented 7/22/24 on both. In an interview on 7/25/24 at 4:30 p.m. RN C stated she did document the wound assessments and stated it was a general form and confirmed despite the documentation that she had notified the family, she had not. RN C stated sometimes she does not leave until 10:00 p.m. ensuring the wound care was completed and documented and she did not have time to notify the family. In an interview on 7/26/24 at 2:25 p.m. the DON stated possible consequences of the documentation of the notification being done when it was not could cause a possible miscommunication among staff. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy on charting and documentation revised July 2017 indicated . 7. Documentation of procedures and treatments will include care-specific details, including: . f. Notification of family, physician, or other staff, if indicated; .

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47622 During observations, interviews, and record reviews, the facility failed to maintain an effective pest control program so that the facility is free of pests and rodents. In the dry storage area of the kitchen, about 5 gnats were observed flying around the food on the top shelf near packages of pasta and dry foods. This deficient practice could put residents at risks of food borne illness due infection control for the residents eating food from the kitchen. The findings were: During observation 07/23/24 09:30 AM gnats were in the dry storage room flying around foods on the top shelf. During an interview 07/23/24 09:30 AM the NSD stated ,oh no. I will take care of this right away because that is not clean to have bugs anywhere around food. She stated she had not requested for pest control services on the maintenance log for the gnats. During an interview 7/26/2024 at 10:03AM the NSD stated gnats may come because an area was not clean, maybe from the drains in the kitchen. She stated it would be due to improper cleaning. She stated when things are not cleaned properly in the kitchen, it could cause illness to the residents. During an interview on 7/26/2024 at 10:24AM the Registered Dietician stated the gnats could get in the residents' food and cause food borne illnesses due to improper cleaning that may include the drains in the kitchen. She stated the kitchen should be kept clean to protect the residents from food borne illnesses. Record review of policy for pest control on 7/26/2024 at 8:50AM titled Pest Control dated 11/3/2004 stated: If pests are seen in the kitchen, the Dietary Services Manager, or designee and Managed Director are informed in writing, describing where the pest was seen and when. The Procedure stated: 1. The Dietary Services Manager or designee informs the maintenance Director and the administrator. During an interview on 7/26/2024 at 1:46PM Maintenance Supervisor stated [NAME] Pest Control would come monthly and as needed with a response time within 24 hours. He stated he was not aware of the gnats in the kitchen until today. He stated had he been told sooner, he would have called for [NAME] to come out and eradicate the gnats.