STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676422	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palomino Place	3160 Gus Thomasson Road Mesquite, TX 75150

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35747 Based on observation, interview, and record review, the facility failed to ensure residents had a right to personal privacy that included accommodations for one (Resident #153) of nine residents reviewed for resident rights. The facility failed to ensure Resident #153 was provided with privacy when receiving tracheostomy care. This failure placed residents at risk for their privacy being violated and a decrease in their quality of life. Findings included: Review of Resident #153's Face Sheet, dated 08/22/24, reflected she was a [AGE] year-old female who admitted to the facility on [DATE]. Review of Resident #153's MDS Assessment, dated 08/20/24, reflected she had diagnoses including cancer (a disease in which abnormal cells divide uncontrollably and destroy body tissue) and pulmonary disease (a disease that affects the lungs and other parts of the respiratory system). Resident #153 had a BIMS score of 7, indicating she had severe cognitive impairment. Review of Resident #153's Care Plan, dated 08/22/24, reflected Resident #153 had a tracheostomy and was at-risk for increased secretions/congestion and infections. Goals included for any secretions/congestion to be relieved within five minutes of suctioning and for no infections to occur within a 90-day timeframe. Observation of Resident #153 from the hallway on 08/20/24 at 11:56AM revealed she was receiving tracheostomy care by two staff members (Speech Therapist I and LVN J). Resident #153's bedroom door was open, and no privacy curtain was in place/in use. During an interview with Resident #153 on 08/20/24 at 12:05PM, she stated facility staff typically closed her bedroom door when providing care. She said she was not sure why the door was not closed when she received her most recent tracheostomy care. She reported typically, she preferred for her door to remain open throughout the day. (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Speech Therapist I on 08/20/24 at 12:09PM, she stated she did not offer privacy for Resident #153 when providing her most recent tracheostomy care. She stated facility staff typically closed residents' doors when providing care; she was not sure why the door was not closed during Resident #153's most recent tracheostomy care. During an interview with LVN J on 08/20/24 at 12:13PM, she stated she did not offer privacy for Resident #153 when providing her most recent tracheostomy care. She explained that Resident #153 typically preferred for her door to be open, which was why she did not offer to close the door when providing care. During an interview with the DON on 08/22/24 at 3:36PM, she stated the expectation for staff was to provide privacy for residents during personal care. She stated the risk of not providing privacy for residents during personal care included the potential for dignity issues. Review of the facility's Dignity policy, dated 02/2021, reflected, .Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem . and .Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37028 Based on observation, interview, and record review, the facility failed to provide the necessary services for residents who were unable to carry out activities of daily living to maintain good grooming and personal hygiene for 1 (Resident #203) of 8 residents reviewed for quality of life. The facility failed to ensure Resident #203's hair was washed while she was at the facility. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity and a decreased quality of life. Findings include: 1. Record review of Resident #203's Admission MDS assessment dated [DATE], reflected Resident #203 was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included Parkinson's disease and diabetes. Resident #203 had a BIMS score of 9 which indicated Resident #203's cognition was moderately impaired. Resident #203 was totally dependent on staff for bathing/showering. Review of Resident #203's Comprehensive Care Plan, dated 08/09/24, reflected the resident required the shower chair and assistance of one staff for grooming. An observation and interview on 08/20/24 at 9:57 AM with Resident #203 revealed she was seated in her wheelchair in her room. Her hair looked oily. She said she had not received a shower since she arrived on 08/09/24 and her hair had not been washed. She said staff would clean her body, but not wash her hair. A follow-up observation and interview 08/22/24 at 10:47 AM with Resident #203, revealed she still had not had her hair washed. She said her hair felt oily and itchy. An interview on 08/22/24 at 11:07 AM with CNA A revealed she said she showered Resident #203 on 08/21/24 and her bathing schedule was Monday, Wednesday, and Friday. She said the resident did not ask for her to be washed and she forgot to ask her. CNA A said she did not wash the resident's hair. She said the resident could get lice if she did not get her hair washed. CNA A said the resident had a care plan but it did not include washing the resident's hair. An interview on 08/22/24 at 12:33 PM with the ADON revealed hair washing during bathing was to be completed if the resident wanted it . The ADON said she did not know that Resident #203 had not had her hair washed since she was admitted on [DATE]. She said Resident #203 had a shower in her room. Record review of the facility policy, Bath-Shower, not dated, reflected: Procedure o Wash your hands, gather equipment. o Explain procedure to patient and provide privacy. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o Adjust temperature of water before placing Patient under shower. Check temperature; water should not be above 105-110 degrees F. o Encourage Patient to do as much of his/her own care as possible; supervise and assist Patient as necessary. o Wash face and shampoo hair; rinse well.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observation, interview and record review, the facility failed to ensure fluid intake to maintain proper hydration for two (Resident #1 and Resident #45) of four residents reviewed for hydration status and maintenance was available. 1. The facility failed to offer fluids that were accessible for Resident #1 and the facility failed to offer extra fluids at mealtime for Resident #1 as indicated in the resident's comprehensive plan of care. 2. The facility failed to offer fluids that were accessible for Resident #45 and the facility failed to offer extra fluids at mealtime for Resident #45 as indicated in the resident's comprehensive plan of care. These failures could increase the resident's risk for dehydration, skin breakdown and weight loss. Findings Include: Record Review of Resident #1's Quarterly MDS with an ARD of 06/28/2024 revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #1's active diagnoses included: Dysphagia (Condition with difficulty in swallowing food/liquid) and Hemiplegia and Hemiparesis (one-sided paralysis) affecting the right dominant side. Resident #1 had a BIMS score of 2 indicating a severe cognitive impairment. Resident #1 had no potential indicators of psychosis. Resident #1 required set up assistance for eating, Resident #1's Quarterly MDS revealed the definition for eating was, The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. Resident #1's Quarterly MDS revealed that Resident #1 required partial/moderate assistance for chair/bed-to-chair transfers (The ability to transfer to and from a bed to a chair (or wheelchair). Record Review of Resident #1's physician order revealed an order for, Honey Thickened Liquids with an order date of 08/1/2023 and status as active (current). Record Review of Resident #1's comprehensive plan of care dated, 08/21/2024 revealed the following: Problems: [Resident #1] is at risk for dehydration related to impaired cognition and honey thick liquids. Status: Active (Current) Interventions: Extra Fluids on Tray, Status: Active (Current) Disciplines: Nutrition Services Director, Nursing. Observation of Resident #1's room on 08/20/24 at 2:15PM revealed Resident #1 was sitting in his wheelchair, in his room, watching television. Observation of Resident #1's room revealed there was no accessible fluids anywhere in Resident #1's room. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of Resident #1's room on 08/21/24 at 9:46AM revealed Resident #1 was not in his room at this time. Observation of Resident #1's room revealed there was no accessible fluids anywhere in Resident #1's room. Observation of Resident #1's room on 08/21/24 at 1:48PM revealed Resident #1 was sitting in his wheelchair, in his room, watching television. Observation of Resident #1's room revealed there was no accessible fluids anywhere in Resident #1's room. Observation of Resident #1 during lunch service in the facility's dining room on 08/20/24 from 12:20PM-1:00PM revealed Resident #1 independently utilized utensils to independently consume food and liquids. During the observation of Resident #1 during mealtime revealed Resident #1 consumed 1 glass of honey thickened tea, no additional fluids were offered or given to Resident #1 during his meal. Resident #1 exited the dining room at 1:00PM. Record Review of Resident #1's lunch meal ticket for 08/21/24 revealed Resident #1 was on a Regular-Puree diet with honey thickened liquids. The meal ticket did not reveal Resident #1's care planned intervention of extra fluids on tray. Interview with Resident #1 on 08/22/24 revealed Resident #1 was unable to answer surveyor questions. 2. Record review of Resident #45's quarterly MDS assessment, dated 07/25/24, revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: non-Alzheimer's dementia and diabetes. Resident #45 had severely impaired cognition and was completely dependent on staff for eating. Resident 45 had a BIMS score of 3 indicating a severe cognitive impairment. Record Review of Resident #45's Comprehensive Care Plan, not dated, reflected: Resident #45 was at risk for dehydration. Facility interventions included: Offer appropriate fluids during activities and care. Extra fluids on tray An observation and interview on 08/20/24 at 2:00PM revealed Resident #45 was lying in bed and she said she was thirsty. Observation revealed no fluids available anywhere in the room. LVN E entered the room and said the resident was able to drink independently and she went to get the resident water. An observation on 08/21/24 at 9:56 AM revealed Resident #45 was lying in bed. The resident's lips were dry. The resident did not have fluids available at the bedside. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview on 08/21/24 at 1:20 PM revealed CNA D was feeding Resident #45 lunch. The only fluids in the resident's room/tray was approximately 1/2 glass of tea. CNA D said periodically staff would give the resident fluids. She said she gave the resident lemonade about 45 minutes earlier. The ticket on the tray did not say extra fluids. An interview on 08/22/24 at 12:25 PM with ADON H revealed she gave Resident #45 water when she asked for it. She said she did not know the resident's care plan said she was supposed to get extra fluids on her tray. An interview on 08/22/24 at 1:17 PM with LVN G revealed staff passed water every shift and as needed to the residents to keep them hydrated. LVN G said Resident #45 could drink fluids by herself and had to be dependently fed. LVN G said she did not know why the resident did not have fluids available on 08/21/24 or 08/22/24. She said she did not know why the resident did not receive extra fluids on her tray. She said the resident was at risk for dehydration if she did not have access to fluids. Interview with LVN A on 08/22/24 at 1:18PM revealed that she was the nurse for Resident #1 and Resident #45 and worked the 6am-2PM shift. LVN A revealed that direct care staff would pass ice and hydration at the beginning of each shift per the resident's needs and physician orders. LVN A revealed that if residents required thickened liquids per physicians orders, the facility staff would access the thickened liquids in the facility's nutrition room as thickened liquids were not kept in the resident's rooms. LVN A revealed that the facility nutrition room was only accessible by staff. LVN A revealed that residents who had thickened liquid orders would have to ask staff to access the fluids or fluids would be given routinley during med pass and meal times. LVN A revealed that Resident #1 was able to hydrate and feed himself independently while Resident #45 requires assistance for hydration and meals. Observation of the Facility Nutrition Room on 08/22/24 at 1:45PM revealed the door was locked and inaccessible to those without a key or code. An interview on 08/21/24 at 2:00 PM with the DON revealed Resident #45 was supposed to have fluids available at the bedside. She said extra fluids on the tray ticket would require a physician's order. Interview with CNA Q on 08/22/24 at 4:05PM revealed that it was the responsibility of the CNA's in the facility to pass ice, ensure hydration and ensure resident's have accessible fluids in their rooms. CNA Q revealed that any staff member could pass ice and get the resident's a form of hydration, but it was the CNA's who primarily ensure that there was some sort of hydration in the resident's room accessible to them. CNA Q revealed that resident's should have accessible fluids in their rooms at all times. CNA Q revealed that Resident #1 could hydrate and access fluids, if in reach and at bedside, independently. CNA Q revealed that Resident #45 could hydrate and access fluids independently, if in reach and at bedside, but did require cues and set-up assistance. CNA Q revealed a risk to resident's who did not have access to fluids or hydration is an increased risk of dehydration. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with ADON H on 08/21/24 at 3:30PM revealed that all residents were supposed to always have hydration in their rooms unless clinically contradictory. ADON H revealed that she was unsure of the facility's protocol or procedure for resident's on thickened liquids and keeping their hydration needs accessible at bedside as she has only been employed at the facility for one week. ADON H was unsure of Resident #1 or Resident #45's functional abilities. ADON H revealed that a risk to the resident's who have inaccessible hydration is an increased risk of hydration. Interview with MDS Nurse A on 08/22/24 at 2:12PM revealed that she was the MDS nurse responsible for all comprehensive care plans. MDS Nurse A revealed that all staff had access to the resident's plan of care and the plan of care should have been followed. MDS Nurse A revealed that resident's who had a care planned focus of risk for dehydration would also have care planned interventions to correspond including, extra fluids. MDS Nurse A revealed she was unaware Resident #1 and Resident #45's care plan for extra fluids on tray during meals was not being followed. MDS Nurse A revealed it is the responsibility of all direct care staff and facility management to ensure all interventions are being followed per the resident's plan of care. MDS Nurse A revealed a risk to resident's who had inaccessible hydration or insufficient hydration needs would be an increased risk for dehydration. Interview with the Dietician on 08/22/24 at 10:49AM revealed that resident's with thickened liquids orders did not have to have direct access to fluids at their bedside as clinical staff would offer fluids during mealtime and med pass. The Dietician revealed that resident's who did not have modified liquid orders should have had a water pitcher at bedside with their choice of fluids. Resident's who had order restrictions such as NPO (nothing by mouth) or fluid restrictions may not have fluids accessible at bedside at all times. The Dietician was not aware Resident #1's or Resident #45's care planned intervention for extra fluids on tray at meals was not being followed. The Dietician revealed that these recommendations or interventions made by nursing staff should have been relayed to the dietary staff so the resident's meal tickets could have been updated to reflect their current needs. The Dietician revealed a risk to resident's who have inaccessible hydration or insufficient hydration needs would be an increased risk of dehydration and skin breakdown. Interview with DON on 08/21/24 at 3:30PM revealed that direct care staff would distribute hydration to resident's during med pass, hydration/snack rounds and mealtimes. The DON revealed it was the responsibility of all nursing staff to ensure hydration needs are met for all resident's no matter their dietary orders regarding hydration. The DON revealed that all resident's had the right to have hydration that is accessible to them at all times, unless the resident is NPO (Nothing by Mouth). The DON revealed that if resident's cannot independently feed or hydrate themselves then it is the responsibility of the nursing staff to frequently encourage and offer fluids to ensure hydration needs are being met. The DON revealed that Resident #1 could hydrate and feed himself independently and Resident #45 needed cues and set-up assistance for meals and hydration, but does require staff assistance at times. The DON revealed that she was not aware Resident #1's or Resident #45's care plan indicated an intervention for extra fluids on tray during meals. The DON revealed that all resident's plan of care should have been followed and accurately reflected their current needs. The DON revealed a risk to resident's who have inaccessible hydration or insufficient hydration needs would be an increased risk of dehydration. Record Review of the facility's policy titled, Hydration Protocol dated February 2022 revealed that, Water pitchers must be filled with fresh ice water frequently and placed at the bedside of each Patient/Resident, unless otherwise ordered . Beverages must be made available to the Patients/Residents during Nutrition Services off-hours.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observation, interviews, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 (Resident #45) of 8 residents reviewed for pharmacy services. The facility failed to document on the Medical Administration Record and Treatment Administration Record for August 2024 that Resident #1 was receiving Hydrocodone 10 mg-acetaminophen 325 mg (pain medicine). These failures could place residents at risk for medication errors, ineffective relief from pain medication, and drug diversion of controlled substances. Findings included: Record review of Resident #45's quarterly MDS assessment, dated 07/25/24, revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: non-Alzheimer's dementia and diabetes. Resident #45 had severely impaired cognition. Resident #45 was receiving scheduled pain medicine with no documentation of pain. Review of Resident #45's Care Plan, not dated, reflected: Resident #45 had risk for pain. Facility interventions included: Assess level of comfort/discomfort and identify comfort goal. Assess and monitor pain medications are adequately managing pain and signs/symptoms of complications. Review of Resident #45's August 2024 Physician Orders, reflected: Hydrocodone 10 mg-acetaminophen 325 mg tablet every six hours as needed for pain. There was not an order for Hydrocodone 7.5 mg-acetaminophen 325 mg every six hours as needed for pain. Review of Resident #45's August 2024 Medication Administration Records and Treatment Administration Records reflected there were no documented doses of Hydrocodone 10 mg-acetaminophen 325 mg or Hydrocodone 7.5 mg-acetaminophen 325 mg tablet. There was also no documentation that the resident had any pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and record review of Resident #45's August 2024 Narcotic Count Record Sheet reviewed on 08/22/24 with the DON reflected: Hydrocodone 10 mg-acetaminophen 325 mg: 08/10/24 7:00 PM - Unknown Nurse 08/11/24 8:00 AM, 2:00 PM, 8:00 PM - Unknown Nurse 08/12/24 - Unable to read time. - LVN E 08/13/24 - Unable to read time - LVN E 08/14/24, Unable to read time, Unable to read time - Unknown Nurse 08/15/24 7:00 PM - LVN E 08/16/24 Unable to read time - LVN E 08/17/24 8:00 AM, 2:00 PM, 8:00 PM - Unknown nurse 08/18/24 8:00 AM, 2:00 PM, 8:00 PM - Unknown nurse 08/19/24 5:00 PM - LVN E 08/20/24 2:00 PM - LVN E 08/21/24 9:00 PM - Unknown Nurse 08/22/24 9:00 AM - LVN G Hydrocodone 7.5 mg-acetaminophen 325 mg: 08/01/24 9:00 PM - LVN E 08/09/24 4:00 PM - LVN E 08/10/24 5:00 AM - Unknown Nurse 08/10/24 1:00 PM - Unknown Nurse Narcotic Count Record sheet reflected that the narcotic medication was signed out on that document to be administered to the resident. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 08/22/24 at 10:20 AM of Resident #1 revealed she was seated in her wheelchair at the nurse station. Resident #1 complained of abdominal pain and told ADON F that she was hurting. The ADON said she would get her nurse. The resident said, They never help me. My stomach hurts bad. I'm hurting right here. Resident pointed to right side of abdominal pain. LVN G approached the resident and said she medicated her not even 2 hours ago. The resident was pushed to her room. The ADON assessed her and said the plan was to call the physician. An interview on 08/22/24 at 2:45 PM with LVN E revealed she medicated Resident #1 anytime she complained of pain because she had an order for Hydrocodone. LVN E said she only documented the medication administration on the narcotic count log. LVN E said she assessed the resident for pain when she administered the medication but did not document it because she only documented on the narcotic count log. The narcotic count on the cart was correct . An interview on 08/22/24 at 3:26 PM with the DON revealed Resident #1 received pain medication the morning of 08/22/24. She said she was not aware that staff did not document the administration of the hydrocodone on the MAR/TAR or progress notes. The DON said she did not know why the resident had a narcotic count log for a 10 mg dose of hydrocodone and a 7.5 mg dose of hydrocodone. She said there was a risk to the resident if she was only receiving a 7.5 mg dose of hydrocodone because she would not be getting the full ordered dose. The DON said the nurse was supposed to document on the MAR/TAR and progress note if they administered a dose of medication , but she did not know they were not documenting it. The DON looked at the narcotic count log and said she recognized LVN E's name and she planned to talk to her. An interview on 08/22/24 at 3:57 PM with the Physician revealed Resident #1 was new to his caseload and he had not reviewed her medical records yet. He said the nurses should not be administering hydrocodone 7. 5mg because there was no order for it. The Physician said the resident was at risk if she did not receive the ordered dose of the medication and if staff did not document the dose they were administering. He said she could be double-dosed and staff might not document side effects from the medication. Review of the facility policy, Medications, dated November 2017, reflected: 2. The details of administration of each PRN medication for a Patient/Resident, including the time of administration, must be noted along with the reason for giving the medication and the effectiveness of the medication.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193 Based on interview and record review, the facility failed to ensure, based on the comprehensive assessment of a resident, residents who had not used psychotropic drugs were not given these drugs unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record for 1 of 5 residents (Resident #44) reviewed for unnecessary psychotropic medications. The facility failed to provide an appropriate diagnosis for Resident #44's use of Olanzapine (Atypical antipsychotic used to treat schizophrenia and bipolar disorder). These failures could put residents at risk of receiving unnecessary psychotropic medications. Findings included: Record review of Resident #44's Quarterly MDS assessment, undated, revealed the resident was a [AGE] year-old male who admitted to the facility on [DATE]. The resident's cognition was moderately impaired. The resident had diagnoses including anxiety disorder, depression (other than bipolar). The resident did not have a diagnosis of schizophrenia or bipolar. Record review of Resident #44's care plan revealed he had a care plan for the antipsychotic medication but not specific for schizophrenia or bipolar disorder. Record review of Resident #44's Order Summary Report, dated August 2024, reflected: Olanzapine 7.5 mg tablet oral, for anxiety disorders, order date 04/18/24. Record review of Resident #44's consultant pharmacist's medication regimen review dated 4/28/24 - 4/29/24 reflected, Olanzapine 7.5 mg for anxiety is not supported in our setting. Please change to appropriate DX to support med order with non-pharmacological interventions first or TAPER TO QOD FOR 3 DAYS THEN DC. For review on 6/26/24 and 6/27/24 reflected add supportive documentation including appropriate diagnosis assessments and file for Olanzapine med order In an interview on 08/22/24 at 02:40 PM with ADON B she stated she was responsible with the other ADON to follow up with the pharmacy recommendations. Regarding Resident #44, ADON B stated she did not follow up with resident's pharmacy recommendations because he was being seen by an outside psychiatric doctor. ADON B stated the DON did a follow up with the psychiatric doctor. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/22/24at 03:24 PM with the DON she stated she did a follow up with Resident's #44's psychiatric doctor, but she was not able to remember when and she did not document. The DON stated she was aware Resident #44 was taking Olanzapine, and when she talked with the resident's psychiatric doctor regarding the pharmacy recommendation for the right diagnosis for the medication, the psychiatric doctor stated he was not going to change the diagnosis because the resident had bipolar. The psychotic doctor did not give the rationale in writing to indicate the right diagnosis for the medication (psychiatric office was closed when contacted). When the DON was asked what the policy regarding right diagnosis for psychotropic medication was, she stated she did not know. The facility did not have a policy for the right diagnosis for psychotropic medications use.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 37028 Based on observations, interviews, and record review, the facility failed to ensure that menus were followed for the lunch meal served on 08/21/24 to meet the nutritional needs for 7 of 24 regular diet plates served. 1.The facility failed to serve 7 of 24 observed lunch trays with the appropriate and sufficient serving of chicken for lunch on 08/21/24. These failures could place residents at risk of decreased food intake, weight loss and an increased risk of aspiration. Interview on 08/21/24 beginning on 11:00AM during a confidential resident group meeting with 7 facility residents revealed that residents are served inadequate portions. The confidential resident group meeting revealed that several resident's were concerned with the portion sizes they are served as they are still hungry after they finish their meal and have to ask for more food or a snack after they finish their meals. The residents revealed that each plate looks different when compared to other resident's, even though each meal could be the same. Observation and record review of the facility's lunch food line service on 08/21/24 at 11:35AM revealed [NAME] E was serving and preparing each ticket for delivery to either the dining room or to the facility's hall trays for delivery. [NAME] E revealed that the facility prepared the residents' choice meal for lunch. [NAME] E revealed that before serving dietary staff would ensure the right scoops were in each food item for serving by checking the meal extensions on the menu posted for that day. Observation of the food service line revealed two documents were at the beginning of the service line which assisted staff in accurately serving each food item and they revealed the following: Record review of the facility's document titled Cycle 18 not dated, revealed the food item and portions for the served items for lunch on 08/21/24. Patient Meal of the Month- 3 ounces Vegetable of the day- 1/2 cup Bread of Choice- 1/2 cup Record review of the facility's document titled Cyle 18 did not reveal specific portions or scoops to use for the meal served for lunch on 08/21/24 for dietary staff to follow to ensure residents were receiving sufficient and adequate portions. Observation of the facility's lunch food line service on 08/21/24 at 11:40AM revealed the following items on the service line: Spring Mix- Served with a black scoop. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Shredded Chicken- Served with a black scoop. Diced tomatoes- Served with a yellow scoop. Shredded Carrots- Served with a white scoop. Shredded Cheese- Served with a black scoop. Mechanical Ground Chicken- Served with a grey scoop. Diced Onion- Served with a black scoop. Sliced Cucumber- Served with a yellow scoop. Hard boiled eggs, cut in half- One per plate, served with tongs. Record Review of facility's document titled, Portion Control, no date indicated, revealed the following: Scoop Color/Sizes Black- 1/8 cup Red- 1/6 cup Yellow- 7/32 cup Blue- 1/4 cup Green- 1/3 cup Ivory- 3/8 cup Gray-1/2 cup White- 2/3 cup Observation of lunch food line service from 11:40AM-12:15PM revealed that 7 out of 24 regular diet chef salads were served inadequate and insufficient portions of chicken. Observation on 08/21/24 at 11:43AM revealed [NAME] E did not fill the scoop and placed a half scoop of shredded chicken on the plate and continued down the service line. Observation on 08/21/24 at 11:46AM [NAME] E did not fill the scoop and placed a half scoop of shredded chicken on the plate and continued down the service line. Observation on 08/21/24 at 11:55AM [NAME] E did not fill the scoop and placed a half scoop of shredded chicken on the plate and continued down the service line. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/21/24 at 11:59AM [NAME] E did not fill the scoop and placed a half scoop of shredded chicken on the plate and continued down the service line. Observation on 08/21/24 at 12:01PM [NAME] E did not fill the scoop and placed a quarter scoop of shredded chicken on the plate and continued down the service line. Observation on 08/21/24 at 12:05PM [NAME] E did not fill the scoop and placed a half scoop of shredded chicken on the plate and continued down the service line. Observation on 08/21/24 at 12:10PM [NAME] E did not fill the scoop and placed a quarter scoop of shredded chicken on the plate and continued down the service line. Interview with [NAME] E on 08/21/24 at 12:20Pm revealed that she was nervous during observation and realized her mistake when the Dietary Manager told her to use full scoops. [NAME] E revealed she should have used a full scoop of chicken, leveled the scoop out and placed the portion on the plate. Interview with the Dietary Manager on 08/22/24 at 11:15AM revealed that food was portioned based on the facility meal extensions and that dietary staff had access to the meal extensions at all times during their shift. The Dietary Manager revealed a risk to serving insufficient portions to residents would be weight loss. In an interview with the Dietician on 08/22/24 at 10:49AM revealed that all dietary staff were in-serviced on portions and where to access the facility's meal extensions guide. The Dietician revealed that a risk to the residents when served incorrect portions or in the correct consistent form could result in weight loss or skin breakdown from inadequate nutrition. Review of the facility's policy titled, Portion Control dated of November 3rd, 2004 revealed that, The menu should list the specific portion size for each food item. Menus should be posted at the tray line for staff to refer to for proper portioning of servings for each diet .servings too small of portions results in the Residents not receiving the nutrients needed

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observation, interview and record review the facility failed to provide food that was palatable, appetizing and served at safe temperatures for 1 (08/20/24-Lunch) of 2 meals reviewed for temperature, taste and palatability. 1.The facility failed to serve food that was palatable and appetizing for Resident #3 for lunch on 08/20/24. 2. The facility failed to ensure desserts served during lunch service on 08/21/24 were tested for safe serving temperatures before serving to residents. These failures could place residents at risk for weight loss, altered nutritional status and food borne illnesses. Findings Included: 1. Record Review of Resident #3's Admission MDS with an ARD of 08/16/24 revealed an [AGE] year-old male who admitted to the facility on [DATE]. Resident #3's active diagnoses included: Dysphagia (Difficulty Swallowing) and Urinary tract infection. Resident #3's had a BIMS score of 7, indicating a severe cognitive impairment. Resident #3 had no indicators of psychosis. Record Review of Resident #3's comprehensive care plan, dated for 08/20/24 revealed the following: Problems: [Resident #3] has a history of CVA (Cerebral Vascular Accident, Stroke) with dysphagia Interventions: Serve Diet as Ordered, Active (Current), Monitor for aspiration, Active (Current) Disciplines: Nutrition Services Record Review of a document titled, [Company Name] Spring/Summer 2024 revealed the menu for 08/20/24 and revealed the following to be served for lunch on 08/20/24: Country Style Ribs Baked Potato Steamed Carrots Bread of the Day Margarine Pineapple Upside Down Cake Beverage of Choice (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of Resident #3 on 08/20/24 at 12:20PM during lunch in the facility's dining room revealed Resident #3 sitting in his wheelchair, fork placed on plate and looking around the room. Record Review of Resident #3's meal ticket on 08/20/24 at 12:22PM revealed that he was on a puree diet with nectar thickened liquids. Resident #3's lunch plate revealed: 1 scoop of mashed potatoes, 1 scoop of a tan colored food which revealed to be puree bread of the day, 1 scoop of an orange-colored food, which revealed to be puree sliced carrots and 1 scoop of a brown colored food with dark sauce on top which revealed to be puree baby back ribs with barbeque sauce. In front of Resident #3 appeared two cups. One cup contained a clear congealed liquid with a label that stated, [Resident #3]- 08/20/24- Nectar Thickened Liquids. The other cup contained a thin brown liquid, which revealed to be tea. Interview with Resident #3 on 08/20/24 at 12:36PM revealed that he did not enjoy the food he was eating. Resident #3 revealed that the only thing good on the plate was the mashed potatoes. Resident #3 proceeded to taste and describe every item on his plate for the surveyor. Resident #3 revealed that pureed baby back ribs with sauce had no flavor, the pureed carrots had no flavor and the pureed bread of the day was sticky and hard to place on his spoon. Resident #3 picked the pureed bread from the plate onto his spoon and attempted to eat the item, but a majority of the pureed bread stuck to the spoon. Resident #3 revealed that the food was always served luke warm. Resident #3 revealed that he hated eating this, baby food and wished he could eat a hamburger. Record review of a facility document titled, Cycle 18, not dated, revealed the menu for lunch served at the facility on 08/21/24: Patient Meal of the Month Starch of Choice (No specific food item listed) Vegetable of the Day (No specific food item listed) Bread of Choice (No specific food item listed) Margarine Dessert of the day (No specific food item listed) Beverage of Choice. Record Review of the document titled, [Facility Name] August Resident Choice Special Menu revealed the following items: Soup and Salads: [Employee Name] Beef Soup Sides: Baked Potato with fixings and Breadsticks Main Course: Grilled Chicken Chef Salad or Select Choice Menu (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dessert: Peach Cobbler Beverage: Tea, Water or Fruit Punch Interview with the Dietary Manager on 08/21/24 at 11:40AM revealed that the vegetable of the day was green beans, and the bread of choice was wheat bread. Observation on 08/21/24 at 1:14PM revealed the lunch test tray for the puree diet was tasted by two state surveyors. The pureed lunch test tray was served on one plate with four scoops. The pureed chicken was covered in a brown gravy sauce, both the gravy and chicken had no flavor, the pureed mashed potatoes were covered in brown gravy, the flavor resembled mashed potatoes, but did not resemble a baked potato as indicated on the menu. The pureed wheat bread was served hard and sticky, consistency did not resemble pudding and it stuck to the spoons. The pureed green beans had no flavor, the pureed peach cobbler was gritty and tasted like thickener. The pureed beef soup was served cold. Observation on 08/21/24 at 1:29PM revealed the lunch test tray for the puree diet was tasted by the Dietary Manager. The Dietary Manager revealed that the puree mashed potatoes with gravy was not overly salted and resembled the product, the pureed wheat bread tasted like bread and was sticky due to the production process, the pureed vegetables were well seasoned and resembled green beans, the puree dessert had the flavor of peach cobbler. The Dietary Manager revealed that the pureed dessert tasted like thickener because that is what was added to the dessert. The puree chicken with gravy tasted like the product. 2. Record Review of the document titled, [Facility Name] August Resident Choice Special Menu revealed the facility was serving peach cobbler for dessert. Observation of the facility dining room on 08/21/24 at 12:35PM revealed the Dietary Manager passing out peach cobber to residents in the dining room. Interview with the Dietary Manager on 08/21/24 at 12:41PM revealed that he did not take temperatures of the desserts before serving them as he forgot to do so. The Dietary Manager revealed that he or a member of the dietary staff would ensure that the desserts are stored at the proper temperature, temperatures taken and then served if appropriate, to the facility's residents. The Dietary Manager revealed that temperatures could not be taken as all the desserts have been served to the resident's either in the dining room or on the hall trays sent to resident's who eat in their rooms. The Dietary Manager revealed that the facility has no reported food borne related illnesses. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Dietary Manager on 08/22/24 at 11:15AM revealed that all cooks were tasked with all puree food items for the facility and it was his expectation that all food items were tasted before being served. The Dietary Manager revealed that the puree bread was made from bread, milk and then would be pureed to a pudding-like consistency. The Dietary Manager revealed that puree bread would be sticky due to the gluten in the bread. The Dietary Manager revealed that all puree items should have been easy for resident's to eat and the food should not have stuck to their spoons. The Dietary Manager revealed that all puree food should be made to a pudding-like consistency. The Dietary Manager revealed that all dietary staff were in-serviced and educated on hire and throughout their employment on how to make and maintain all pureed items consistency. The Dietary Manager revealed that he and his staff would be alerted of a resident's preference or care plan through diet communication forms from either therapy or nursing staff. The Dietary Manager did not reveal any issues or concerns with the food tray he tested from lunch served on 08/21/24. In an interview with the Dietician on 08/22/24 at 10:49AM revealed that the cooks and dietary aides were all tasked with making the puree food items. The dietician revealed that it was her expectation for the pureed food items to be tasted before they were served to the resident's. The Dietician revealed that the puree bread should be made with the bread item and pureed with milk for the base and should be made to a pudding-like consistency. The pureed bread could be made before the meal was served and placed in the hot food item holder before serving. The Dietician revealed the puree bread should be a pudding consistency and tends to result in a sticky consistency. The Dietician revealed that the pureed bread should not have stuck to a resident's spoon or be difficult for the resident to consume. The Dietician revealed that dietary staff were in-serviced and educated on hire and throughout their employment on how to make and maintain pureed items consistency. The Dietician revealed that it was her expectation that all food served at the facility was appetizing, palatable and served within safe temperatures. Record Review of the facility's document titled, Nutrition Services Director Job Description, dated July 2018 revealed that it was the overall purpose of the Nutrition Services Director to . [be] responsible for food service standards, policy and procedure, dining staff while providing the highest quality of food service for patients.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observation, interview and record review, the facility failed to ensure food was prepared and served according to the resident's assessment, plan of care, and in a form designed to meet the resident's needs for two (08/20/24- Lunch and 08/21/24- Lunch) of three meals reviewed for resident's needs. 1.The facility failed to follow Resident #3's physician order for nectar thickened liquids on 08/20/24. 2. The facility failed to provide pureed wheat bread in a smooth, palatable and pudding-like consistency on 08/20/24 and 08/21/24 3. The facility failed to serve 7 of 24 observed lunch trays with the appropriate and sufficient serving of chicken for lunch on 08/21/24. These failures could place residents at risk of decreased food intake, weight loss and an increased risk of aspiration. Findings Include: Record Review of Resident #3's Admission MDS with an ARD of 08/16/24 revealed an [AGE] year-old male who admitted to the facility on [DATE]. Resident #3's active diagnoses included: Dysphagia and Urinary tract infection. Resident #3's had a BIMS score of 7, indicating a severe cognitive impairment. Resident #3 had no indicators of psychosis. Record Review of Resident #3's comprehensive care plan, dated for 08/20/24 revealed the following: Problems: [Resident #3] has a history of CVA (Cerebral Vascular Accident, Stroke) with dysphagia Interventions: Serve Diet as Ordered, Active (Current), Monitor for aspiration, Active (Current) Disciplines: Nutrition Services Record Review of a document titled, [Company Name] Spring/Summer 2024 revealed the menu for 08/20/24 and revealed the following to be served for lunch on 08/20/24: Country Style Ribs Baked Potato Steamed Carrots Bread of the Day (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Margarine Pineapple Upside Down Cake Beverage of Choice Observation of Resident #3 on 08/20/24 at 12:20PM during lunch in the facility's dining room revealed Resident #3 sitting in his wheelchair, fork placed on plate and looking around the room. Record Review of Resident #3's meal ticket on 08/20/24 at 12:22PM revealed that he was on a puree diet with nectar thickened liquids. Resident #3's lunch plate revealed: 1 scoop of mashed potatoes, 1 scoop of a tan colored food which revealed to be puree bread of the day, 1 scoop of an orange-colored food, which revealed to be puree sliced carrots and 1 scoop of a brown colored food with dark sauce on top which revealed to be puree baby back ribs with barbeque sauce. In front of Resident #3 appeared two cups. One cup contained a clear congealed liquid with a label that stated, [Resident #3]- 08/20/24- Nectar Thickened Liquids. The other cup contained a thin brown liquid, which revealed to be tea. Interview with Resident #3 on 08/20/24 at 12:20PM revealed that he requested tea and this was what they served him, pointing to the cup containing a thin brown liquid which revealed to be tea. Resident #3 revealed that he did not enjoy the food he was eating. Resident #3 revealed that the only thing good on the plate was the mashed potatoes. Resident #3 proceeded to taste and describe every item on his plate for the surveyor. Resident #3 revealed that pureed baby back ribs with sauce had no flavor, the pureed carrots had no flavor and the pureed bread of the day was sticky and hard to place on his spoon. Resident #3 picked the pureed bread from the plate onto his spoon and attempted to eat the item, but a majority of the pureed bread stuck to the spoon. Resident #3 revealed that he hated eating this, baby food and wished he could eat a hamburger. Interview with the Dietary Manager on 08/20/24 at 12:31PM revealed that Resident #3 had the incorrect tea in front of him per the physician's orders as indicated on Resident #3's meal ticket. The Dietary Manager went back to the kitchen and brought back a cup, with a brown liquid and several ice cubes. The Dietary Manager added three sugar packets to the cup and stirred the liquid, the liquid still appeared to be thin. Interview with the Director of Rehabilitation on 08/20/24 at 12:39PM revealed that the tea served by the Dietary Manager was still not in the correct consistency per Resident #3's current physician orders of nectar thickened liquids and should not contain ice as it can alter the consistency of the thickened liquids. The Director of Rehabilitation proceeded back to the kitchen and came back to Resident #3 with a cup containing a brown liquid which was revealed to be tea. The Director of Rehabilitation stirred the liquid and the liquid appeared to be thicker than the previous offered liquids. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #3'document titled, Speech Pathology Report dated 08/20/24 revealed that Resident #3 was seen by [Company Name] consultants for a MBSS (Modified Barium Swallow Study) on 08/20/24 for diet upgrade. Review of the document revealed that Resident #3's current diet was puree and current liquids was nectar thick. Review of the document revealed that the recommended solids after the MBSS was for mechanical soft and recommended liquids was for honey thick liquids with no restrictions or thin liquids by tsp/5cc or nectar thick liquids by tsp/5cc. Document revealed to be signed by MD B on 08/20/24 at 11:08AM. 2.Record review of a facility document titled, Cycle 18, not dated, revealed the menu for lunch served at the facility on 08/21/24: Patient Meal of the Month Starch of Choice (No specific food item listed) Vegetable of the Day (No specific food item listed) Bread of Choice (No specific food item listed) Margarine Dessert of the day (No specific food item listed) Beverage of Choice. Record Review of the document titled, [Facility Name] August Resident Choice Special Menu revealed the following items: Soup and Salads: [Employee Name] Beef Soup Sides: Baked Potato with fixings and Breadsticks Main Course: Grilled Chicken Chef Salad or Select Choice Menu Dessert: Peach Cobbler Beverage: Tea, Water or Fruit Punch Interview with the Dietary Manager on 08/21/24 at 11:40AM revealed that the bread of choice was wheat bread. Observation on 08/21/24 at 1:14PM revealed the lunch test tray for the puree diet was tasted by two state surveyors. The pureed wheat bread was served hard and sticky, consistency did not resemble pudding and it stuck to the spoons. Observation on 08/21/24 at 1:29PM revealed the lunch test tray for the puree diet was tasted by the Dietary Manager. The Dietary Manager revealed that the pureed wheat bread tasted like bread and was sticky due to the production process (continued on next page)

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	676422	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palomino Place	3160 Gus Thomasson Road Mesquite, TX 75150

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Interview on 08/21/24 beginning on 11:00AM during a confidential resident group meeting with 7 facility residents revealed that residents were served inadequate portions. The confidential resident group meeting revealed that several residents were concerned with the portion sizes they are served as they are still hungry after they finish their meal and have to ask for more food or a snack after they finish their meals. The residents revealed that each plate looks different when compared to other resident's, even though each meal could be the same. Observation and record review of the facility's lunch food line service on 08/21/24 at 11:35AM revealed [NAME] E was serving and preparing each ticket for delivery to either the dining room or to the facility's hall trays for delivery. [NAME] E revealed that the facility prepared the residents' choice meal for lunch. [NAME] E revealed that before serving dietary staff would ensure the right scoops were in each food item for serving by checking the meal extensions on the menu posted for that day. Observation of the food service line revealed two documents were at the beginning of the service line which assisted staff in accurately serving each food item and they revealed the following: Record review of the facility's document titled Cycle 18 not dated, revealed the food item and portions for the served items for lunch on 08/21/24. Patient Meal of the Month- 3 ounces Vegetable of the day- 1/2 cup Bread of Choice- 1/2 cup Record review of the facility's document titled Cyle 18 did not reveal specific portions or scoops to use for the meal served for lunch on 08/21/24 for dietary staff to follow to ensure residents were receiving sufficient and adequate portions. Observation of the facility's lunch food line service on 08/21/24 at 11:40AM revealed the following items on the service line: Spring Mix- Served with a black scoop. Shredded Chicken- Served with a black scoop. Diced tomatoes- Served with a yellow scoop. Shredded Carrots- Served with a white scoop. Shredded Cheese- Served with a black scoop. Mechanical Ground Chicken- Served with a grey scoop. Diced Onion- Served with a black scoop. Sliced Cucumber- Served with a yellow scoop. Hard boiled eggs, cut in half- One per plate, served with tongs. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of facility's document titled, Portion Control, no date indicated, revealed the following: Scoop Color/Sizes Black- 1/8 cup Red- 1/6 cup Yellow- 7/32 cup Blue- 1/4 cup Green- 1/3 cup Ivory- 3/8 cup Gray-1/2 cup White- 2/3 cup Observation of lunch food line service from 11:40AM-12:15PM revealed that 7 out of 24 regular diet chef salads were served inadequate and insufficient portions of chicken. Observation on 08/21/24 at 11:43AM revealed [NAME] E did not fill the scoop and placed a half scoop of shredded chicken on the plate and continued down the service line. Observation on 08/21/24 at 11:46AM [NAME] E did not fill the scoop and placed a half scoop of shredded chicken on the plate and continued down the service line. Observation on 08/21/24 at 11:55AM [NAME] E did not fill the scoop and placed a half scoop of shredded chicken on the plate and continued down the service line. Observation on 08/21/24 at 11:59AM [NAME] E did not fill the scoop and placed a half scoop of shredded chicken on the plate and continued down the service line. Observation on 08/21/24 at 12:01PM [NAME] E did not fill the scoop and placed a quarter scoop of shredded chicken on the plate and continued down the service line. Observation on 08/21/24 at 12:05PM [NAME] E did not fill the scoop and placed a half scoop of shredded chicken on the plate and continued down the service line. Observation on 08/21/24 at 12:10PM [NAME] E did not fill the scoop and placed a quarter scoop of shredded chicken on the plate and continued down the service line. Interview with [NAME] E on 08/21/24 at 12:20Pm revealed that she was nervous during observation and realized her mistake when the Dietary Manager told her to use full scoops. [NAME] E revealed she should have used a full scoop of chicken, leveled the scoop out and placed the portion on the plate. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Dietary Manager on 08/22/24 at 11:15AM revealed that ice could be served in modified liquids such as nectar and honey thick liquids if the resident requested it as it was the resident's rights. The Dietary Manager revealed that modified liquids came in either pre-packaged or the dietary staff would make the liquids to their consistency based on the resident's orders. The Dietary Manager revealed that staff who served in the dining room should have checked the resident's ticket to ensure they were served the correct food and hydration per the physicians orders. The Dietary Manager revealed that it was his expectation that all food items were tasted before being served. The Dietary Manager revealed that the cooks made the puree bread on 08/20/24 and 08/21/24 and no issues were reported to him. The Dietary Manager revealed that the puree bread was made from bread, milk and would then be pureed to a pudding-like consitency. The Dietary Manager revealed that puree bread would be sticky due to the gluten in the bread. The Dietary Manager revealed that all puree items should be easy for residents to eat and the food should not have stuck to their spoons. The Dietary Manager revealed that all puree food should be made to a pudding-like consistency. The Dietary Manager revealed that all dietary staff were in-serviced and educated on hire and throughout their employment on how to make pureed food items and how pureed items were maintained for consistency. The Dietary Manager revealed that he and his staff would be alerted of a resident's preference or care plan through diet communication forms from either therapy or nursing staff. The Dietary Manager revealed that food was portioned based on the facility meal extensions and that dietary staff had access to the meal extensions at all times during their shift. The Dietary Manager revealed a risk to serving insufficient portions to residents would be weight loss. The Dietary Manager revealed that a risk to serving residents liquids not ordered by their physician would be choking. In an interview with the Dietician on 08/22/24 at 10:49AM revealed that the cooks and dietary aides were all tasked with and made the puree food items. The dietician revealed that it was her expectation for the pureed food items to have been tasted before they were served to the resident's. The Dietician revealed that the puree bread should have been made with the bread item and pureed with milk for the base and should have been made to a pudding-like consistency. The pureed bread can be made before the meal it is served and placed in the hot food item holder before serving. The Dietician revealed the puree bread should have been a pudding-like consistency and tended to result in a sticky consistency. The Dietician revealed that the pureed bread should not have stuck to the resident's spoon or should not have been difficult for the resident to consume. The Dietician were in-serviced and educated on hire and throughout their employment on how to make pureed food items and how pureed items were maintained for consistency. The Dietician revealed that food should have been served by the dietary staff per the meal extensions breakdown as listed on the menu. The Dietician revealed that all dietary staff were in-serviced on portions and where to access the facility's meal extensions guide. The Dietician revealed that a risk to the residents when served incorrect portions or in the correct consistent form could result in weight loss or skin breakdown from inadequate nutrition. The Dietician revealed that a risk to resident's being served incorrect liquids not ordered by their physician would be aspiration. Review of the facility's policy titled, Portion Control dated of November 3rd, 2004 revealed that, The menu should list the specific portion size for each food item. Menus should be posted at the tray line for staff to refer to for proper portioning of servings for each diet .servings too small of portions results in the Residents not receiving the nutrients needed

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #45) of 8 residents observed for infection control. CNA B failed to perform hand hygiene or change her gloves after providing incontinence care for Resident #45. This failure could place residents at risk for healthcare associated cross contamination and infections. Findings included: Record review of Resident #45's quarterly MDS assessment, dated 07/25/24, revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: non-Alzheimer's dementia, diabetes, and neurogenic bladder (inability to control urine) . Resident #45 had severely impaired cognition was completely dependent on staff for toileting. Resident #45 was always incontinent of bladder and bowel. Review of Resident #45's Care Plan, not dated, reflected: Resident #45 had a self-care deficit with extensive assistance required with bathing, hygiene, dressing, and grooming related to impaired mobility and impaired cognition. An observation on 08/21/24 at 1:05 PM revealed resident #45 was lying in bed. CNA D and CNA B entered the resident's room. The resident's brief was on the floor. CNA B and CNA D positioned the resident in bed and gathered their supplies for incontinence care. CNA B performed hand hygiene and put on gloves. CNA B cleaned the resident and prepared to put a clean brief on the resident. CNA B did not perform hand hygiene or change her gloves after cleansing the resident. CNA B used her soiled gloves to put a clean brief on the resident. The resident was repositioned for comfort. An interview on 08/21/24 at 1:20 PM with CNA B revealed she said she was supposed to perform hand hygiene after cleaning the resident and before putting on a clean brief. She said it was important not to touch clean items with soiled gloves. An interview on 08/21/24 at 2:00 PM with the DON revealed staff were supposed to perform hand hygiene after cleaning for incontinence care and before putting on clean brief. She said that it was important to prevent infection. Record review of the facility policy, Infection Control, dated November 2017, reflected: 1. The facility must establish an infection prevention and control program (IPCP) that must include: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all patients . 37193