STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676486	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lbj Medical Center	206 Haley Rd. Johnson City, TX 78636

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure residents received services in the facility with reasonable accommodations of resident's needs and preferences except when to do so would endanger the health and safety of the resident or other residents for 2 of 7 residents (Resident #18 and #22) reviewed for resident rights. The facility failed to ensure Resident's #18's and Resident #22's call light was within reach on 03/31/25. This failure could place residents at risk of needs not being met. Findings included: Record Review of Resident #22's undated face sheet reflected the resident was a [AGE] year-old male admitted on [DATE]. His diagnoses included acute respiratory failure with hypoxia (a serious condition where the lungs fail to adequately oxygenate the blood, leading to low blood oxygen levels), diabetes (a group of diseases that result in too much sugar in the blood), atherosclerotic heart disease of native coronary artery (coronary artery disease) (heart disease involving the reduction of blood flow to the cardiac muscle due to a buildup of atheromatous plaque in the arteries of the heart), and chronic obstructive pulmonary disease (COPD) (a lung disease characterized by chronic respiratory symptoms and airflow limitation). Record Review of Resident #22's Quarterly MDS dated [DATE] reflected Resident #22 was independent for eating, required partial or moderate assistance for toileting, required supervision or touching assistance for bathing, and was dependent on staff for personal hygiene. The MDS reflected Resident #22' had a BIMS score of 08 which indicated Resident #22 was moderately cognitively impaired. Record review of Resident #22's care plan dated 03/18/25 reflected: Resident was at risk for falling R/T Chronic pain syndrome. Goal: Resident #22 would remain free from injury. Interventions included: Keep call light in reach at all times. Record review of Resident #22's care plan dated 03/18/25 reflected: Resident had moderately impaired, vision R/T Nonexudative age-related macular degeneration, bilateral. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Goal: Resident #22 would not experience negative consequences of vision loss as evidenced by remaining physically safe and participating in social and self-care activities. Interventions included: Keep call light in reach at all times. In an interview and observation on 03/31/25 at 11:03 AM, Resident #22 stated things were fine and staff treated him well. Observed Resident #22's call light on the floor on the right side of the residents bed and on the other side of the residents bedside table, and out of the residents reach. He stated he has used his call light to call for staff and they responded immediately. He stated he usually had his call light close to him or attached to his bed, but where it was at that time, he would have had to roll off of the bed to get it. He stated he guessed it fell off when the last person was in there. Record Review of Resident #18's undated face sheet reflected the resident was a [AGE] year-old male admitted on [DATE]. His diagnoses included dementia (a general name for a decline in cognitive abilities that impacts a person's ability to perform everyday activities), diabetes (a group of diseases that result in too much sugar in the blood), aphasia (inability to use spoken language), and cerebral aneurysm (a weakness in the blood vessels in the brain that balloons and fills with blood). Record Review of Resident #18's Quarterly MDS dated [DATE] reflected Resident #18 required substantial or maximal assistance for eating and was dependent on staff for toileting, bathing, and personal hygiene. The MDS reflected Resident #18's BIMS score was left blank due to Resident #18 was rarely/never understood and was not able to answer questions. Record review of Resident #18's care plan dated 03/18/25 reflected: Resident was at risk for falling R/T hemiplegia. Unsafe self-transfers. Resident does not call for assistance. Staff anticipates resident's needs. Goal: Resident #18 would remain free from injury. Interventions included: Give resident verbal reminders to call for assistance with ADLs. In an observation on 03/31/25 at 11:27 AM, Resident #18 was lying in bed with his call light out of reach and wrapped around his overhead light fixture. Resident #18 had garbled speech and was not able to communicate with the state surveyor. The resident appeared clean and groomed and showed no signs of pain or distress. The resident was not able to demonstrate if he could or could not reach his call light. In an interview on 03/31/25 at 11:13 AM, CNA B stated all residents call lights should be within their reach at all times. She stated Resident #22 regularly put himself to bed and she thought he had just gotten into bed. She stated she usually clipped it to the side of his bed, where his call light was in reach. She stated Resident #22 could not have reached the call light where it was laying when the state surveyor saw it. She stated she had been in-serviced on call light placement and if a call light was out of reach it could cause a fall or the resident would not have been able to call for help. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/31/25 at 11:34 AM, LVN A stated Resident #18's call light should be in reach and all residents call lights should be in reach at all times. She stated she was trained on call light placement. She stated if a residents call light was out of their reach, they could have been injured or been in distress, could not get to staff if they needed something, and their needs may not have been met. She stated Resident #18 understood when he was spoken to but could not always answer back correctly due to having a diagnosis of aphasia. In an interview on 04/02/25 at 10:19 AM, the DON stated it was her expectation that all residents call lights should be within reach at all times. She stated staff have been trained on call light placement. She stated if a residents call light was out of reach, it could have inhibited them from getting the care or requests they may have needed. In an interview on 04/02/25 at 10:32 AM, the ADM stated it was her expectation that all residents had their call lights within reach at all times. She stated staff had been trained on call light placement. She stated if a resident could not reach their call light they could not notify the team if they needed assistance. Record review of the facility policy titled Answering the Call Light and dated 2001 (revised March 2021) reflected Purpose: The purpose of this procedure is to ensure timely responses to the resident's requests and needs. General Guidelines: 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure individuals with mental health disorders were provided an accurate Preadmission Screening and Resident Review (PASRR) Level 1 Screening for 1 of 2 residents (Resident #14) reviewed for PASRR. The facility failed to ensure Resident #14 had an accurate PASRR Level 1 Screening indicating a diagnosis of mental illness on 03/03/2025. This failure could place residents at risk of not receiving needed individualized care, and specialized services to meet their needs. Findings included: Record review of Resident #14's face-sheet, dated 04/01/2025, revealed a [AGE] year-old female, admitted on [DATE]. Her diagnoses included metabolic encephalopathy (confusion, memory loss, and loss of consciousness due to an underlying condition affecting metabolism), bipolar disorder (a chronic mood disorder that causes intense shifts in mood, energy levels, and behavior), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), type 2 diabetes mellitus (a condition that affects how the body uses sugar as a fuel), dependent personality disorder (a personality disorder characterized by a person's need to be taken care of and a fear of having to take care of themselves), avoidant personality disorder (a personality disorder characterized by poor self-esteem, an intense fear of rejections, and extreme shyness), anxiety disorder (a mental health condition characterized by excessive fear), and muscle weakness. Record review of Resident #14's admission MDS, dated [DATE], Section C (Cognitive Patterns) revealed a BIMS score of 14 indicating intact cognition. Section I (Active Diagnoses) revealed anxiety disorder, depression, and bipolar disorder. Record review of Resident #14's care plan, dated 05/23/2023 and revised on 03/18/2025, revealed Resident is at risk for changes in mood R/T anxiety disorder, bipolar disorder, depression, and dependent personality disorder. Record review of Resident #14's history and physical, dated 03/15/2025, revealed active medical problems that included: bipolar disorder, major depressive disorder, dependent personality disorder, and avoidant personality disorder. Record review of Resident #14's PASRR Level 1 Screening, dated 03/03/2025, section C0100, revealed no evidence or indicators Resident #14 was an individual that has a mental illness. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/02/2025 at 11:33 AM with the MDS, she stated she was responsible for PASRR documentation. She stated she received the PASRR from acute care facilities prior to the resident's admission. She stated if a PASRR assessment was incorrect then she was responsible for contacting the previous facility for a correct PASRR. She stated she didn't have any PASRR's under review for correction at that time. She stated a resident with diagnoses that included anxiety disorder, bipolar disorder, depression, and dependent personality disorder should have a positive PASRR Level 1 Screening. The MDS stated if a PASRR Level 1 screening was incorrectly indicated as negative then the resident wouldn't receive care and services available from the state. During an interview on 04/02/2025 at 11:43 AM with the DON, she stated the MDS was responsible for receiving and ensuring the accuracy of PASRR Level 1 Screenings. She stated she wasn't aware of any PASRR Level 1 screenings that were incorrect. The DON stated a resident with anxiety disorder, bipolar disorder, depression, and dependent personality disorder should be positive. She stated if PASRR screenings were incorrect the resident wouldn't have access to needed resources. During an interview on 04/02/2025 at 12:35 PM, the ADM stated the MDS and case management were responsible for the accuracy of PASRR Level 1 Screenings. She stated if the resident was admitted with a PASRR Level 1 screening that was incorrect then the acute care facility should have been contacted for a correction. She stated a resident wouldn't have access to available resources if the PASRR Level 1 Screening was completed incorrectly. Requested the facility policy related to PASRR Level 1 Screenings on 04/01/2025 at 1:10 PM from the ADM. No policy received prior to exit.

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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** Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, which included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for 2 of 7 residents (Resident's #30 and #14) reviewed for care plans. The facility failed to include the resident was a smoker and the resident had a diagnosis of acute gastritis with bleeding in Resident #30's comprehensive care plan. The facility failed to ensure Resident #14's care plan was updated to reflect their current ADL functional status. This failure could place residents at risk for not receiving necessary care and services or having important care needs identified and met. Findings included : Record review of Resident #30's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #30 had diagnoses which included acute gastritis with bleeding (a condition where the stomach lining becomes inflamed and bleeds), Alzheimer's disease (a neurodegenerative disease that usually starts slowly and progressively worsens), dysphagia (difficulty in swallowing), and fibromyalgia (a functional somatic medical syndrome with symptoms of chronic widespread pain, accompanied by fatigue, sleep disturbance including awakening unfreshed, and cognitive symptoms). Record review of Resident #30's admission MDS assessment dated [DATE], reflected that Resident #30 was using tobacco. Record review of Resident #30's Quarterly MDS assessment dated [DATE], reflected that Resident #30 had a BIMS score of 06 which reflected the resident was severely cognitively impaired. Resident #30's Quarterly MDS assessment reflected the resident required supervision or touching assistance with eating, toileting, and personal hygiene, and partial to moderate assistance with bathing. Resident #30's Quarterly MDS reflected resident had a diagnosis of acute gastritis with bleeding. Record review of Resident #30's care plan reflected Resident #30 was not care planned for being a smoker or having a diagnosis of acute gastritis with bleeding. Record review of Resident #30's safe smoking evaluation, dated 01/21/25, reflected the resident had demonstrated ability to safely smoke. In an interview on 03/31/25 at 11:47 AM Resident #30 stated everything was good and the staff treated her good. She stated she did not usually need to use her call light because she mostly did thing's for herself. She stated she had been living in the facility for about a year and she wanted to go home. She stated she was going to talk to the staff about it and she had no concerns. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #14's face-sheet, dated 04/01/2025, revealed a [AGE] year-old female, admitted on [DATE]. Her diagnoses included metabolic encephalopathy (confusion, memory loss, and loss of consciousness due to an underlying condition affecting metabolism), bipolar disorder (a chronic mood disorder that causes intense shifts in mood, energy levels, and behavior), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), type 2 diabetes mellitus (a condition that affects how the body uses sugar as a fuel), dependent personality disorder (a personality disorder characterized by a person's need to be taken care of and a fear of having to take care of themselves), avoidant personality disorder (a personality disorder characterized by poor self-esteem, an intense fear of rejections, and extreme shyness), anxiety disorder (a mental health condition characterized by excessive fear), and muscle weakness. Record review of Resident #14's admission MDS, dated [DATE], Section C (Cognitive Patterns) revealed a BIMS score of 14 indicating intact cognition. Section GG (Functional Abilities) revealed resident required Substantial/maximal assistance (Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for toileting hygiene: the ability to maintain perineal (genital) hygiene, adjust clothes before and after voiding or having a bowel movement. Section H- Bladder and Bowel revealed resident was frequently incontinent of bowel and bladder. Review of Resident # 14's care plan, dated 05/23/2023 and revised 03/18/2025, revealed Resident experiences occasional bowel and bladder incontinence R/T impaired mobility with approaches that included Resident toilets self independently. During an interview on 04/02/2025 at 10:32 AM, Resident #14 stated she was unable to sit up independently and required assistance to go to the bathroom because of her weakness. In an interview on 04/02/25 at 10:19 AM, the DON stated it was a collaborative effort as far as who completed the care plans. She stated the baseline care plan was done by nursing administration within 48 hours and then the MDS nurse and herself updated the care plans for acute changes. She stated the MDS nurse mostly did the comprehensive care plans and then as a team, they updated them as needed. She stated they had all been trained on completing the care plans accurately. She stated if a resident was a smoker, and all of their diagnoses should be care planned, including acute gastritis with bleeding. She stated she was not aware Resident #30 was not care planned for being a smoker or having the diagnosis of acute gastritis with bleeding. She stated Resident #30 was not smoking when she first admitted to the facility, but had smoked prior to admitting, and she started back smoking after about a month or so. She stated she was going to correct Resident 30's MDS. She stated if a resident was not care planned for being a smoker or having a diagnosis of acute gastritis with bleeding, it would not be a whole reflection of the resident and that was how staff were made aware of residents continuity of care. In an interview on 04/02/25 at 10:26 AM, the MDS nurse stated the ADON was responsible for baseline care plans. She stated when she completed the MDS assessments it triggered the CAA's and then as a collaborative team, they care planned things as they came along. She stated she had been trained on completing the care plans accurately. She stated if a resident was a smoker, it should be care planned and all diagnoses should be care planned, including acute gastritis with bleeding. She stated she was not aware that Resident #30 was not care planned for being a smoker or for having a diagnosis of acute gastritis with bleeding. She stated if a resident was not care planned for smoking she was not sure what it could cause but if they were not care planned for having acute gastritis with bleeding, it could have possibly interrupted the resident's nursing care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/02/25 at 10:32 AM, the ADM stated it was a combination of the MDS nurse and nursing administration that completed the care plans and they had all been trained on completing care plans accurately. She stated she was aware Resident #30 was a smoker. She stated she was not aware that Resident #30 was not care planned for being a smoker or for having a diagnosis of acute gastritis with bleeding. She stated if a resident was not care planned for being a smoker or for having all of their diagnoses, including acute gastritis with bleeding, the residents needs may not have been met. During an interview on 04/02/2025 at 10:51 AM, CNA C stated she utilized the care plans to determine the needs of the residents. She stated the DON, and the charge nurse were responsible for updating the care plans. CNA C stated if the care plans were current and correct then the resident might not receive the care they need. She stated Resident #14 required assistance to get up to the bathroom. During an interview on 04/02/2025 at 11:11 AM, RN D stated the nurses, and the case manager were responsible for starting and revising care plans. She stated if the care plan was not correct then the resident might not get the care they required. She stated Resident #14 required assistance to get out of bed and to the toilet. During an interview on 04/02/2025 at 11:33 AM, the MDS stated the DON was responsible for updating care plans related to ADL's. She stated the care plans were used by the staff providing care and if not updated they might not get the care they required. During an interview on 04/02/2025 at 11:43 AM, the DON stated the CNA's used the care plan for determining resident needs. She stated she was responsible for baseline care plans. She stated the resident might not get the help they need if the care plan wasn't correct. During an interview on 04/02/2025 at 12:35 PM, the ADM stated the MDS, and nursing administration were responsible for ensuring care plans were correct. She stated the care plans were utilized by staff providing care. She stated the resident might not get the care they needed if the care plan wasn't correct. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy revised on 01/26/2024 titled Comprehensive Care Plans revealed Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the resident's comprehensive assessment. Policy Explanation and Compliance Guidelines: 1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma-informed. 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment and by Day 21 of the patient's stay. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the care plan. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the care plan. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 7. The physician, other practitioner, or professional will inform the resident and/or resident representative of the risks and benefits of proposed care, of treatment, and treatment alternatives/options. The facility will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record, including discussions with the resident and/or resident representative. 8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. 9. The services provided or arranged by the facility, as outlined in the comprehensive care plan, will meet professional standards of quality, and will be provided by qualified persons in accordance with each resident's written plan of care .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety in 1 of 1 kitchen and 1 of 1 nourishment room reviewed for kitchen and food sanitation. 1. The facility failed to ensure food in the refrigerator was properly sealed from air-borne contamination. 2. The facility failed to ensure food in the dry storage area was properly sealed from air-borne contamination. 3. The facility failed to maintain a sanitary open front refrigerator/freezer in the nourishment room. 4. The facility failed to label, date, and discard expired food items in the side-by-side refrigerator in the kitchen. 5. The facility failed to label, date, and discard expired food items in the nourishment room refrigerator and freezer. These failures could place residents at risk for food contamination and food-borne illness. Findings included: Observation on 04/01/2025 at 09:52 AM of the side-by-side refrigerator revealed an open a box of thawed bacon labeled with a date of 03/13/2025, that was not properly sealed, and the bacon was exposed to the elements. The box was located on the bottom shelf. There were 23 containers of individual yogurt labeled with a date of 02/27/2025 that had a manufacture's date of 03/26/2025. There was a label on the side of the shelf that listed bread, dated 03-13-2025 that contained four loaves of white bread that were dated 03/20/2025. There was one open container of thickened sweetened tea dated 02-13-2025. The manufacturing instructions revealed, Directions: Refrigerator prior to serving .After opening, may be kept up to 7 days under refrigeration. Observation on 04/01/2025 at 09:57 AM of the walk-in pantry revealed an open bag of potato chips that was not properly sealed. The bag was open at one end and exposed to the elements. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 04/01/2025 at 10:52 AM in the kitchen revealed four loaves of bread were sitting in their packaging out on a cart and had not been disposed of. Observation on 04/01/2025 at 11:53 AM in the kitchen revealed three loaves of bread in their original packaging sitting out on a cart. The trash can had the container of tea, the yogurts, and the open bag of chips. The open box of bacon was in the refrigerator. Observation on 04/01/2025 at 12:03 PM revealed one open bag of bread on the counter dated 03/20/2025. Half of the bread had been served and the CK opened the bag to get out more bread. Observation on 04/01/2025 at 01:15 PM of the nourishment room revealed a sign on the outside of the refrigerator that reflected, As always, please remember to check all expirations of items in this refrigerator and discard if items are not properly labeled and/or expired. A sign on the freezer door reflected, Residents Refrigerator Only. Date and Name Required. Items will be eliminated for expiration day. Every Friday Housekeeping will clean out frig. The refrigerator contained a bowl of dry cereal covered in plastic wrap, an open soda bottle, a bottle of Gatorade, and a bottle of juice all of which were not labeled with a resident's name nor dated. The inside bottom shelf was dirty with brown stains and the pull-out drawer was dirty with hair, food crumbs, and light sticky residue. Observation of the inside freezer shelf was dirty with red residue stains. Five frozen food items in freezer were not labeled with resident's names and four of the items were not dated. There was one container of expired yogurt with a manufacture date of 03/07/2025 and a box of popsicles with a best buy date of January 2025. Observation on 04/02/2025 at 11:31 AM of the nourishment room revealed the refrigerator contained a bowl of dry cereal covered in plastic wrap, a bottle of Gatorade, and a bottle of juice all of which were not labeled with a resident's name nor dated. The inside bottom shelf was dirty with brown stains and the pull-out drawer was dirty with hair, food crumbs, and light sticky residue. Observation of the inside freezer shelf was dirty with red residue stains. Five frozen food items in freezer were not labeled with resident's names and four of the items were not dated. There was one container of expired yogurt with a manufacture date of 03/07/2025 and a box of popsicles with a best buy date of January 2025. In an interview on 04/01/2025 at 10:00 AM, the DA stated she had worked at the facility for 3 years. She had received training on labeling, dating, and storing food and handling expired food from the dietitian that came once a month. The DA stated all food must be covered or properly sealed in a plastic bag and labeled with an open date. All open food must be used or thrown away within 7 days or within the manufacture's used by date. All expired food must be thrown away, otherwise it would be bad for a resident to consume expired food. She stated the bread in the side-by-side refrigerator had been previously frozen and was dated with the date it was pulled out of the freezer and should be used or thrown away within 7 days. She stated all kitchen staff were responsible for checking food for proper labeling, storage, and dating and checking for expired food. (continued on next page)

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	676486	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lbj Medical Center	206 Haley Rd. Johnson City, TX 78636

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 04/01/2025 at 10:04 AM, the CK stated she had worked at the facility since 1992. She had received training on labeling, dating, and storing food and handling expired food from the dietitian that came once a month. The CK stated that all food must be covered or properly sealed in a bag, labeled with an opened date, and expired date. She stated all opened or cooked food must be used or thrown away within 7 days. If the food was not sealed properly, the CK stated that it could cause cross contamination from chemicals and could make residents sick. She stated all expired food must be thrown away, otherwise it could make residents sick. She stated the bread in the side-by-side refrigerator had been previously frozen, was dated with the date it was pulled out of the freezer, and it should be used or thrown away within 7 days. She stated all kitchen staff were responsible for checking food for proper labeling, storage, and dating and checking for expired food, which she did each morning. In an interview and observation on 04/01/2025 at 10:07 AM, the DM stated he had worked at the facility for about 1 ½ years and did not really have any experience. The DM stated he had received training on labeling, dating, and storing food. He had not received any training on handling expired food. The DM stated all food must be sealed in a bag, labeled with a received date, and an opened date. He stated all opened or cooked food must be used or thrown away within 7 days. If the food was not sealed properly, the DM stated that would be cross contamination and food not properly sealed should be thrown out. He stated all expired food must be thrown away, otherwise it could be dangerous and make the residents sick. He stated he was responsible for checking food for proper labeling, storage, and dating and checking for expired food. The DM stated the bread in the side-by-side refrigerator had been previously frozen and was dated with the date it was pulled out of the freezer and should be used or thrown away within 7 days. The state surveyor showed the DM the concerns in the kitchen. The DM stated he had no concerns about the box of bacon being left open. He stated the date of 03/13/2025 was when the bacon was received, not when it was opened. He thought it had been opened about 5 days ago and had no concern it was not labeled. He stated he planned to serve the bacon tomorrow morning for breakfast. The DM stated the bread was expired, and he planned to throw them out. The DM was observed placing two of the loaves of bread on the counter but did not throw them away. The DM stated the yogurt was expired and he planned to throw it away. He left the yogurt in the refrigerator. The DM stated he did not think the container of thickened sweetened tea had been opened and was not concerned. The state surveyor showed him the container had been opened. The DM was not sure what he would do. After reading the directions, he stated he would throw it away and took it out of the refrigerator and sat the container on the kitchen counter. He stated the bag of chips should have been sealed in a plastic bag and should be thrown away. The DM stated the food not being properly sealed, labeled, and dated, and the expired food did not meet his expectations. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview and observation on 04/01/2025 at 12:14 PM, the ADM stated her expectation was that kitchen staff follow their policy for food labeling and storage. She stated all food must be dated with an opened date, received date, labeled, and tightly sealed in plastic bag and used by the manufacture's guideline or within 7 days. The ADM stated there was a sign in the kitchen that listed when food needed to be used or thrown away for safety and they follow the recommended guidelines. She stated expired food needed to be thrown away to avoid residents getting salmonella, sick, and foodborne illnesses. The ADM stated the open box of bacon in the refrigerator would not meet her expectations and was observed throwing it away. The ADM stated she had no way of knowing how long it had been in the refrigerator. She stated if her kitchen staff stated the bread was expired, then it should be thrown out and serving it would not meet her expectation. She was observed telling the DM to throw out the bread. The DM stated he thought the bread was good and denied telling the state surveyor tit was expired, or he would throw it away. In an interview on 04/02/2025 at 04:00 PM, the RDN stated she visited the facility about once a month. She stated during that time she toured the kitchen and went over the Quality Assurance Checklist. She stated all her concerns were listed on the monthly checklist. The RDN stated her expectations for food storage were based off the facility policies. She stated all opened food was to be used within 7 days or it should have been disposed of. She stated manufacturers guidelines should have been followed and any items should have been thrown out by the manufacturers date. She stated any opened item in the refrigerator should have been sealed to prevent exposure. She stated the bacon and yogurt should have been discarded. The RDN stated consumption of expired or opened unsealed food items could lead to food that was subpar in quality or food-borne illness. In an interview on 04/02/2025 at 12:24 PM, HSK stated she had worked at the facility for two months. She received orientation training on cleaning duties. She stated she cleaned the nourishment room and cleaned the outside and inside of the refrigerator and freezer once every two weeks. She stated the refrigerator and freezer were last cleaned on 03/31/2025. She stated she also cleaned out and threw away food once a week by the use by date or expired date. She stated all food must be labeled with the resident's names and dated. In an interview on 04/02/2025 at 12:31 PM, CNA C stated all food in the resident's refrigerator in the nourishment room must be labeled with resident's name, room number, and dated. She stated everyone was responsible for doing that. She stated she had not used the nourishment refrigerator since it was moved recently and was not responsible for cleaning it. She stated not labeling it could lead to a resident not getting their prescribed diet and make them sick. In an interview on 04/02/2025 at 12:35 PM, RN E stated all food in the resident's refrigerator in the nourishment room must be labeled with the resident's name and dated so staff could identify whose food it was to avoid potential reactions due to residents with food restrictions, allergies, or textured diets. RN E stated nurses were supposed to check daily for expired food and dates. She stated food without a resident's name or date would be discarded to avoid residents getting sick from spoiled food. RN E stated the residents do not have access to that room. She stated she did not know who was responsible for cleaning the inside of the refrigerator or freezer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 04/02/2025 at 12:45 PM the DON stated she did not know the facility's policy on resident's personal food or food in the nourishment room, but stated all food should be labeled with the resident's name and dated. The DON stated all staff were responsible for labeling and dating the room and could access the nourishment room for the residents. She stated the residents did not have access to the nourishment room. The DON stated she did not know who was responsible for checking and throwing out expired food or food that was not labeled and dated, but it was an administrative task. She stated it was important to label and date all food items to avoid residents getting an illness or being harmed due to expired food. She stated it would not meet her expectations to have expired food or food without labels and dates. The DON stated that housekeeping was responsible for cleaning the refrigerator and freezer, but she did not know how often that occurred. Review of the facility's Kitchen/Food Service observations dated 10/15/2024, 11/20/2024, and 12/18/2025 completed by the RDN reflected: Section: 5: Food storage Refrigerators/Freezers All leftovers and open food covered, labeled, and dated with a use by date. All other food items covered, labeled, and dated. Received dates present on all items. Food not expired or soiled. Section 6: Meal Service Observation Nourishment room: clean, no out of date foods, temps logs in use. RDN's comments dated 10/15/2024 regarding the nourishment room reflected, encouraged staff to label and date pt (residents) items discarding s/p 3 days; spill/dirty fridge needing addressing. RDN's comments dated 11/20/2024 regarding the nourishment room reflected, encouraged staff to label and date pt (residents) items discarding s/p 3 days . RDN's comments dated 12/18/2024 reflected, To work on - hazardous food storage, labeling/dating . and nourishment room Missing labels/date on food, spill in fridge needs cleaning. Review of the QA/Monitor Report dated 03/19/2025 completed by the registered dietitian reflected, No for nourishment room being clean, and no out of date foods. Review of the DM's certificate reflected the DM had completed the Food Manager Certification Program on 01/18/2023. Review of the facility's undated policy titled Food Storage reflected: Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes and HACCP guidelines. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procedure: 1. Dry storage rooms d. To ensure freshness, store opened and bulk items in tightly covered containers. All containers must be labeled and dated. 2. Refrigerators d. Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage. e. Use all leftovers within 72 hours. Discard items that are over 72 hours old .