

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  745005	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Center at Zaragoza, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12660 Pebble Hills Blvd. El Paso, TX 79938	

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)
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34486</p> <p>Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for three (Resident #35, Resident #89 and #192) of 12 residents reviewed for baseline care plans.</p> <p>The facility failed to ensure that Resident #35 ' s baseline care plan included her expressed preference for a vegetarian diet.</p> <p>The facility failed to ensure that Resident #89 ' s Baseline Care Plan addressed her Diabetes II.</p> <p>The facility failed to ensure that Resident #192 ' s baseline care plan included pressure reducing boots and that a copy was given to the resident and the resident ' s representative.</p> <p>These failures put residents at risk of not having their dietary needs and preferences met, not having their treatment needs associated with diabetes met and not receiving physician-ordered treatments.</p> <p>Findings included:</p> <p>Resident #35</p> <p>Record review of Resident #35 ' s face sheet, dated 04/18/2024, revealed she was [AGE] years old and was admitted to the facility on [DATE].</p> <p>Record review of Resident #35 ' s hospital history and physical, dated 03/27/2024, revealed she had severe osteoporosis (weak and brittle bones), a closed fracture of the left tibial plateau (broken left knee); fracture of humeral head, left, closed (broken left shoulder); closed fracture fibula, head (broken leg); and systematic lupus erythematosus (illness when the immune system attacks healthy tissue). Orders included that she was to have a vegetarian diet (page 45).</p> <p>Record review of Resident #35 ' s Baseline care plan, dated 03/29/2024, revealed Diet Order for regular diet, she was at risk for weight loss, with a nutritional goal of maintaining current weight. Preferences included that she liked to eat in her room. The Baseline care plan did not state that the resident followed a vegetarian diet.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #35 ' s Diet Order dated 03/29/2024 revealed she was to receive a regular diet. It stated ***PT [patient] IS VEGETARIAN***.</p> <p>Record review of Resident #35 ' s MAR for April 2024 revealed the words Vegetarian diet at the top of each page.</p> <p>Record review of Resident #35 ' s nursing progress notes dated 03/29/2024 through 04/18/2024 revealed no notes indicating she was receiving a vegetarian diet.</p> <p>In an interview on 04/16/24 at 04:28 PM Resident #35 revealed she was a vegetarian and wondered if a dietitian had looked at her diet. She expressed concern that she was not getting a balanced diet and said a family member brought in food to supplement her diet. She said she talked to staff, including dietary staff, about being a vegetarian but continued to be concerned that she was not getting good nutrition.</p> <p>In an interview and record review on 04/19/24 at 1:54 PM the Dietary Manager said he was aware that Resident #35 followed a vegetarian diet. He said he had assessed her dietary preferences, and the resident wrote him notes regularly on diet slips indicating what she wanted and how the food provided worked for her. Record review revealed seven dietary slips the Dietary manager had received from Resident #35 regarding preferences and concerns.</p> <p>In a telephone interview on 04/19/24 at 02:04 PM the Dietitian recalled working with a resident who was vegetarian. The Dietitian thought the dietary software used by the facility might have an algorithm to calculate dietary needs for a vegetarian. The Dietitian said she had talked with the Dietary Manager about Resident #35 ' s dietary needs and advised him that if there were animal proteins such as milk products in each meal the resident ' s diet should be adequate.</p> <p>In an interview on 04/19/24 at 03:33 PM the MDS Coordinator RN stated that Resident #35 ' s preference for a vegetarian diet should be care planned under preferences. The reason this should be done was so the facility could follow vegetarian guidelines. The risk to resident of not having her vegetarian dietary preferences on the baseline was that the facility might not follow through on her vegetarian diet preferences. The MDS Coordinator RN stated that she did not know if there were risks to a person following a vegetarian diet but that they might lack certain vitamins that are found in meat but not in vegetables, and result in vitamin deficiency.</p> <p>Resident #89</p> <p>Closed record review of Resident #89 ' s face sheet dated 04/18/2024 revealed she was [AGE] years old and was admitted to the facility on [DATE]. It indicated she had diagnoses including Type 2 Diabetes Mellitus with Other Diabetic Kidney Complication.</p> <p>Closed record review of Resident #89 ' s electronic census record revealed she was discharged on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Closed record review of Resident #89 ' s hospital history and physical dated 10/21/2023 revealed she had a medical history including Type 2 diabetes with renal (kidney) complications. The plan for diabetes was to have her on low dose sliding scale insulin (amount of insulin given depends on her blood sugar test). Discharge instructions included monitoring her blood sugar and stated that her health care provider would set individualized treatment goals for her to maintain blood glucose levels within specified ranges.</p> <p>Closed record review of Resident #89 ' s Admission MDS dated [DATE] revealed her diagnoses included diabetes mellitus. She was not receiving hypoglycemic (medicine to treat diabetes) medications. The CAA triggered the care area of nutritional status and indicated that a decision about care planning needed to be made about her nutritional status.</p> <p>Closed record review of Resident #89 ' s physicians orders from 11/13/2023 through 12/09/2023 revealed no orders for medications or for monitoring of diabetes mellitus.</p> <p>Record review of Resident #89 ' s baseline care plan dated 11/13/2023 revealed no care plans related to diabetic management.</p> <p>In an interview on 04/18/24 at 01:33 PM Resident #89 ' s family member revealed that the resident had been taking insulin when she was still living at home, but the family member did not remember if the resident was being given insulin in the facility.</p> <p>In an interview on 04/18/24 at 02:15 PM RN A revealed that she had worked with Resident #89 on several occasions and that there were no orders to check her blood sugar. The RN stated she was not aware Resident #89 had diabetes.</p> <p>In an interview on 04/19/24 at 03:32 PM the MDS Coordinator RN revealed she was unaware that Resident #89 had a diagnosis of diabetes. She said that if a resident had a diagnosis of diabetes, it should be on the baseline care plan because it was important to monitor for symptoms even if the resident was not receiving medications for the diagnosis.</p> <p>Resident #192</p> <p>Record review of Resident #192 ' s face sheet dated 04/18/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE].</p> <p>Record review of Resident #192 ' s wound management dated 04/12/2024, revealed physician orders for pressure reducing boots.</p> <p>Record review of Resident #192 ' s Baseline care plan dated 04/11/2024 revealed the following:</p> <p>Patient and Representative did not sign or attend the baseline care plan.</p> <p>Resident did not have pressure reducing boots included in the baseline careplan.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 04/16/24 at 10:20 AM Resident #192 revealed that he has been wearing pressure reducing boots from the hospital. He stated that he is supposed to wear them whenever he is in bed. Resident #192 stated that he was not given a copy of the baseline care plan nor was he asked any questions concerning his care.</p> <p>In an interview and record review on 04/17/24 at 3:00 PM, the DON said she was aware that Resident #192 was to wear pressure reducing boots to upload the pressure from his heels while he was in bed. She stated that she was made aware that residents and their representatives were not being included in the baseline care plan process or receiving a copy of it after completion. She revealed that the pressure reducing boots should have been completed in the baseline care plan. She stated that they did a regional audit and were trying to correct the issue. She stated that this failure could place residents at risk of not being included in the admission process. She said she was going to start a new process where it would be part of the admission packet and had to be signed with the other paperwork. She revealed that it was the LVN ' s that was admitting the resident to complete the baseline care plan, but she was responsible for checking for accuracy and completion.</p> <p>Record review of the facility policy Baseline Care Plan revised 06/30/2022 revealed that the facility must develop and implement a baseline care plan for each resident that includes instructions needed to provide effective and person-centered care of the resident that reflects the resident ' s goals and objectives and includes interventions that address the resident ' s current needs.</p> <p>45437</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486</b></p> <p>Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that describes the services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being for 3 of 16 residents (Resident #11, Resident #35 and Resident #89) reviewed for Comprehensive Care Plans.</p> <p>The facility failed to ensure that Resident #11 ' s Comprehensive care plan addressed her Tracheostomy (a surgical opening in the throat to allow for breathing).</p> <p>The facility failed to ensure that Resident #35 ' s Comprehensive Care Plan addressed her preference for a vegetarian diet.</p> <p>The facility failed to ensure that Resident #89 ' s Comprehensive Care Plan addressed her Diabetes II.</p> <p>This failure by the facility places current and future residents at risk of not receiving care that is thoughtful, planned, and relevant to their condition(s) which could lead to complications in resident health and quality of life and care.</p> <p>Findings include:</p> <p>Record review of resident face sheet dated 04/16/2024 revealed that Resident #11 was a [AGE] year-old female, admitted to the facility on [DATE].</p> <p>A record review of Resident #11 ' s MDS, dated [DATE], revealed the following:</p> <p>-Section I (Active Diagnosis)- stroke (damage to the brain from interruption of its blood supply), Diabetes Mellitus 2 (a long term condition in which the body has trouble controlling blood sugar and using it for energy), respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide), dysphasia (difficulty swallowing), hydrocephalus (a buildup of fluid in the cavities deep within the brain), aphasia (difficulty talking) and acute respiratory failure with hypoxia (a condition where you don't have enough oxygen in the tissues in your body).</p> <p>-Section O (treatments and Special Procedures)- Resident had a Tracheostomy while a resident.</p> <p>Record review of Resident #11 ' s Comprehensive care plan dated 03/26/2024 revealed that her Tracheostomy was not care planned.</p> <p>In an interview on 04/16/2024 at 1:05 PM., Resident #11 stated that she has had the tracheostomy for a few months.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #11 ' s orders revealed an order for a Tracheostomy and Trach Care: Stoma (opening): Cleanse stoma area with NS, apply new drain sponge (no woven gauze) secure in place with new trach tie. Monitor for s/sx of breakdown around stoma every shift, Start date: 12/03/2023.</p> <p>In an interview on 4/19/2024 at 2:46 PM the DON said Comprehensive Care plans were not completed accurately because they had not been trained in them yet. She stated it was MDS Coordinator ' s responsibility to complete them accurately. She was going to start making a schedule to help her more with care plans. She revealed this failure causes them to not identify care areas.</p> <p>In an interview on 04/19/2024 at 4:24 PM MDS Coordinator #1 revealed that for Resident #11 ' s care plan, she missed putting the Tracheostomy on it. She stated that it would have triggered the CAAS and she should have included it. She stated that this failure could result in the resident ' s care areas not being identified by staff.</p> <p>Resident #35</p> <p>Record review of Resident #35 ' s face sheet dated 04/18/2024 revealed she was [AGE] years old and was admitted to the facility on [DATE].</p> <p>Record review of Resident #35 ' s hospital history and physical dated 03/27/2024 revealed she had severe osteoporosis (weak and brittle bones), a closed fracture of the left tibial plateau (broken left knee); fracture of humeral head, left, closed (broken left shoulder); closed fracture fibula, head (broken leg); and systematic lupus erythematosus (illness when the immune system attacks healthy tissue). Orders included that she was to have a vegetarian diet (page 45).</p> <p>Resident #35 ' s MDS from her admission was requested but was not received prior to exit.</p> <p>Record review of Resident #35 ' s Comprehensive Care plan initiated 03/29/2024 revealed a care plan to address maintaining her nutrition. It did not address that she used a vegetarian diet. Her care plan dated 03/29/2024 stated that the facility would honor her preferences but did not mention her preference for a vegetarian diet.</p> <p>Record review of Resident #35 ' s Diet Order dated 03/29/2024 revealed she was to receive a regular diet. It stated ***PT [patient] IS VEGETARIAN***.</p> <p>Record review of Resident #35 ' s MAR for April 2024 revealed the words Vegetarian diet at the top of each page.</p> <p>Record review of Resident #35 ' s nursing progress notes dated 03/29/2024 through 04/18/2024 revealed no notes indicating she was receiving a vegetarian diet.</p> <p>In an interview on 04/16/24 at 04:28 PM Resident #35 revealed she was a vegetarian and wondered if a dietitian had looked at her diet. She expressed concern that she was not getting a balanced diet and said a family member brought in food to supplement her diet. She said she talked to staff, including dietary staff, about being a vegetarian but continued to be concerned that she was not getting good nutrition.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview and record review on 04/19/24 at 1:54 PM the Dietary Manager said he was aware that Resident #35 followed a vegetarian diet. He said he had assessed her dietary preferences, and the resident wrote him notes regularly on diet slips indicating what she wanted and how the food provided worked for her. Record review revealed seven dietary slips the Dietary manager had received from Resident #35 regarding preferences and concerns.</p> <p>In a telephone interview on 04/19/24 at 02:04 PM the Dietitian recalled working with a resident who was vegetarian. The Dietitian thought the dietary software used by the facility might have an algorithm to calculate dietary needs for a vegetarian. The Dietitian said she had talked with the Dietary Manager about Resident #35 ' s dietary needs and advised him that if there were animal proteins such as milk products in each meal the resident ' s diet should be adequate.</p> <p>In an interview on 04/19/24 at 03:33 PM the MDS Coordinator RN stated that Resident #35 ' s preference for a vegetarian diet should be care planned under preferences. The reason this should be done was so the facility could follow vegetarian guidelines. The risk to resident of not having her vegetarian dietary preferences on the comprehensive care plan was that the facility might not follow through on her vegetarian diet preferences. The MDS Coordinator RN stated that she did not know if there were risks to a person following a vegetarian diet but that they might lack certain vitamins that are found in meat but not in vegetables, and result in vitamin deficiency.</p> <p>Resident #89</p> <p>Closed record review of Resident #89 ' s face sheet dated 04/18/2024 revealed she was [AGE] years old and was admitted to the facility on [DATE]. It indicated she had diagnoses including Type 2 Diabetes Mellitus with Other Diabetic Kidney Complication.</p> <p>Closed record review of Resident #89 ' s electronic census record revealed she was discharged on [DATE].</p> <p>Closed record review of Resident #89 ' s hospital history and physical dated 10/21/2023 revealed she had a medical history including Type 2 diabetes with renal (kidney) complications. The plan for diabetes was to have her on low dose sliding scale insulin (amount of insulin given depends on her blood sugar test). Discharge instructions included monitoring her blood sugar and stated that her health care provider would set individualized treatment goals for her to maintain blood glucose levels within specified ranges.</p> <p>Closed record review of Resident #89 ' s Admission MDS dated [DATE] revealed her diagnoses included diabetes mellitus. She was not receiving hypoglycemic (medicine to treat diabetes) medications. The CAA triggered the care area of nutritional status and indicated that a decision about care planning needed to be made about her nutritional status.</p> <p>Closed record review of Resident #89 ' s physicians orders from 11/13/2023 through 12/09/2023 revealed no orders for medications or for monitoring of diabetes mellitus.</p> <p>Record review of Resident #89 ' s Comprehensive Care plan initiated 11/13/2023 revealed care plans indicating that she was at risk for skin breakdown due to diabetes, and that she was at risk of inability to maintain her nutrition due to diabetes. There were no care plans to monitor her blood glucose.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 04/18/24 at 01:33 PM Resident #89 ' s family member revealed that the resident had been taking insulin when she was still living at home, but the family member did not remember if the resident was being given insulin in the facility.</p> <p>In an interview on 04/18/24 at 02:15 PM RN A revealed that she had worked with Resident #89 on several occasions and that there were no orders to check her blood sugar. The RN stated she was not aware Resident #89 had diabetes.</p> <p>In an interview on 04/19/24 at 03:32 PM the MDS Coordinator RN revealed she was unaware that Resident #89 had a diagnosis of diabetes. She said that if a resident had a diagnosis of diabetes, it should be care planned because it was important to monitor for symptoms even if the resident was not receiving medications for the diagnosis.</p> <p>In an interview on 04/19/2024 at 2:57 PM the DON revealed that Resident #89 ' s diagnosis of diabetes should be on her care plan. The DON said this was important because the facility needed to make sure they had medications on hand for the resident in case she should need them. She said the diagnosis should be care planned so staff would know to monitor for signs and symptoms of diabetic issues such as hypo- or hyperglycemia (low or high blood sugar).</p> <p>Record review of a facility policy titled; Care Area Assessments taken from the facility ' s Nursing Services Policy and Procedure Manual, 2001 MED-PASS, Inc (Revised December 2011) revealed the following:</p> <p>Policy Statement</p> <p>Care Area Assessments (CAAs) will be used to help analyze data obtained from the MDS and to develop individualized care plans. CAAs are the link between assessment and care planning.</p> <p>Policy Interpretation and Implementation titled Care Plan Policy, dated 03/14/2024 was received and revealed the following:</p> <p>The care plan will identify priority problems and needs to be addressed by the interdisciplinary team, and reflect the patient's strengths, limitations, and goals. The care plan will be specific and appropriate to the individual needs for each resident. The interdisciplinary care plan will be developed through collaborative efforts of the IDT and other healthcare professionals. The care plan will be patient centered emphasizing the resident ' s and/or family ' s goals.</p> <p>Procedure: the [facility] will develop, implement, and provide care in accordance with the comprehensive person-centered care plan for the residents consistent with regulatory requirements. The care plan is to include measurable objectives and timeframes to meet a resident ' s medical, nursing, psychosocial, and functional needs identified with completion of the comprehensive assessment. To the extent that is practical, the resident and/or family will be involved in the development of their care plan. The care plan will be modified when needed to meet the resident ' s current needs, problems, and goals. Any revision, additions, or deletions to the plan of care will be dated and initialed.</p> <p>45437</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486</b></p> <p>Based on observation, interview and record review the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #35) of 12 residents reviewed for quality of care.</p> <p>The facility failed to ensure that Resident #35 received care for a wound to her left inner knee from 03/30/2024 to 04/09/2024.</p> <p>This failure could result in residents not receiving care needed for wounds.</p> <p>Findings included:</p> <p>Record review of Resident #35 ' s face sheet dated 04/18/2024 revealed she was [AGE] years old and was admitted to the facility on [DATE].</p> <p>Record review of Resident #35 ' s hospital history and physical dated 03/27/2024 revealed she had severe osteoporosis (weak and brittle bones), a closed fracture of the left tibial plateau (broken left knee); fracture of humeral head, left, closed (broken left shoulder); closed fracture fibula, head (broken leg); and systematic lupus erythematosus (illness when the immune system attacks healthy tissue). She had swelling around her left knee and was at risk for wound healing complications infections. It was recommended that she keep her knee in a knee immobilizer until the fracture healed.</p> <p>Record review of Resident #35 ' s Baseline care plan dated 03/29/2024 revealed she had a left tibial and humeral head fracture (broken left knee and leg). She was alert, oriented and able to communicate. The baseline care plan did not identify any skin conditions including abrasions, lacerations, skin tears, pressure injuries, ulcerations, or surgical wounds at the time of admission. The resident was at risk of skin breakdown due to impaired mobility.</p> <p>In an interview on 04/18/2024 at 4:49 PM with the Administrator, Resident #35 ' s admission MDS was requested but it was not provided prior to exit.</p> <p>Record review of Resident #35 ' s nursing admission progress note dated 03/29/2024 revealed the resident had swelling to her left leg, had an immobilizer on her left leg.</p> <p>Record review of Resident #35 ' s Daily Skilled Nurse ' s Note dated 03/30/2024 revealed the resident had swelling to her left leg and had an immobilizer on her left leg and a small wound to the inner side of the left knee.</p> <p>Record review of Resident #35 ' s Daily Skilled Nurse ' s Note dated 03/31/2024 revealed the resident had swelling to her left leg and had an immobilizer on her left leg and a small wound to the inner side of the left knee.</p> <p>Record review of Resident #35 ' s Daily Skilled Nurse ' s Note dated 04/01/2024 revealed the resident had a wound to the inner side of the left knee.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #35 ' s Daily Skilled Nurse ' s Note dated 04/02/2024 revealed the resident had a wound to the inner side of the left knee.</p> <p>Record review of Resident #35 ' s Daily Skilled Nurse ' s Note dated 04/04/2024 revealed the resident had a wound to the inner side of the left knee.</p> <p>Record review of Resident #35 ' s Daily Skilled Nurse ' s Note dated 04/05/2024 revealed the resident had a wound to the inner side of the left knee.</p> <p>Record review of Resident #35 ' s Daily Skilled Nurse ' s Note dated 04/07/2024 at 1:06 PM revealed the resident had a wound to the inner side of the left knee.</p> <p>Record review of Resident #35 ' s Daily Skilled Nurse ' s Note dated 04/07/2024 at 2:56 PM revealed she had an open area to the left lateral (outer) side of left knee.</p> <p>Record review of Resident #35 ' s Daily Skilled Nurse ' s Note dated 04/08/2024 revealed the resident had a wound to the inner side of the left knee.</p> <p>Record review of Resident #35 ' s physician ' s order dated 04/08/2024 and discontinued 04/16/2024 revealed the resident ' s left inner and outer knee were to be cleansed with normal saline, patted dry, that bacitracin (anti-bacterial) ointment was to be applied and covered with a dressing once a day and as needed.</p> <p>Record review of Resident #35 ' s Comprehensive Care Plan initiated 04/09/2024 revealed the resident had partial thickness ulcers to her left medial (inside) knee. Wound care was to be provided as ordered and documented.</p> <p>Record review of Resident #35 ' s active physician ' s order dated 04/16/2024 revealed the residents left inner knee was to be cleansed with normal saline, patted dry, bacitracin (anti-bacterial) ointment was to be applied and covered with a dressing once a day and as needed.</p> <p>Record review of Resident #35 ' s March MAR revealed that on 04/09, 04/10, 04/13, 04/14, and 04/18/2024 wound care was not provided because the resident was asleep.</p> <p>In an interview and observation on 04/16/24 at 04:35 PM Resident #35 was seated in a wheelchair with her left leg elevated and in a brace. The resident stated she had developed a wound under her left leg brace and the facility did not look at it until the physical therapist took her knee brace off and said she needed wound care. The resident stated she did not get treatment for the wound on her left knee the first week she was in the facility. She said that the wound care nurse would come in to dress the wound if she [the nurse] could find her. The resident stated she continued to receive treatment for the wound to her left knee.</p> <p>In an interview on 04/19/24 at 02:57 PM the DON revealed she was not able to explain why there was a delay in provision of wound care to Resident #35 ' s left knee. She stated she would have to ask the wound care nurse why there was a delay in starting treatment. The DON said that the risk to Resident #35 of a delay in treating the wound to her knee was that the wound could get worse, and the resident might be at increased risk of infection to the wound.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility policy Nursing Comprehensive revised 02/08/2024 revealed that skin evaluation and examination for any ulcerations or alterations in skin would be completed as part of the nursing comprehensive evaluation. In addition, the nurse would describe and document full evaluation of the skin, a Skin Evaluation would be scheduled weekly, and nurses were to follow treatment order as prescribed.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486</b></p> <p>Based on observation, interview and record review the facility failed to ensure that a resident who is fed by enteral means receives the appropriate treatment and services to prevent complications of enteral feeding for one (Resident #91) of 6 residents reviewed for appropriate treatment and services to prevent complications of enteral feeding.</p> <p>The facility failed to ensure Resident #91 ' s enteral feeding formula bag was labeled with her name, type of feeding, frequency, time and date administration started.</p> <p>This failure could put residents at increased risk of receiving incorrect feeding formula and/or incorrect quantity of formula.</p> <p>Findings included:</p> <p>Record review of Resident #91 ' s face sheet dated 04/16/2024 revealed she was [AGE] years old and admitted to the facility on [DATE].</p> <p>Record review of Resident #91 ' s hospital History and Physical dated 04/05/2024 revealed she had diagnoses including diabetes and was assessed with intractable (not easily treated or managed) nausea and vomiting.</p> <p>Record review of Resident #91 ' s admission assessment dated [DATE] revealed she was receiving enteral feedings (tube into the stomach to deliver nutritional formula) and was to receive nothing by mouth. The nutritional formula she was to receive was Jevity 1.2 (a brand and particular concentration of feeding formula). She was confused.</p> <p>Record review of Resident # 91 ' s Baseline Care Plan dated 04/16/2024 revealed she was receiving enteral feedings.</p> <p>Record review of Resident #91 ' s nursing progress note dated 04/16/2024 revealed the resident had a g-tube (tube into the stomach to deliver nutritional formula).</p> <p>Record review of Resident #91 ' s physician ' s order dated 04/16/2024 revealed she was to receive nothing by mouth and have continuous feedings with Jevity 1.2 until she was evaluated by speech therapy.</p> <p>Record review of Resident #91 ' s MAR for April 2024 revealed that the morning of 04/16/2024 she was administered Jevity 1.2 60 ML per hour via gtube per pump for 22 hours a day.</p> <p>(continued on next page)</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In observation and interview on 04/16/24 at 09:08 AM Resident #91 was in bed. A feeding formula bag that was mostly full of feeding formula and a water bag were observed hanging from a pole beside the resident ' s bed, with tubes running from the bags into a feeding pump. A tube ran from the feeding pump into the resident ' s side. It was observed that there were no labels on the formula or the water bag. Present in the room were Resident #91 ' s family members who were not able to state when the tube feeding formula had been hung.</p> <p>In an interview on 04/16/2024 at 09:12 AM LVN B revealed that the feeding formula bag tube should have a label on it. She stated that feeding formula bag was probably hung by the night nurse (name not known) and that the bag should have a label on it indicating the resident's name, type of feeding, rate of feeding, how often it was to be placed and the time and date placed. The LVN stated that the risk to the resident of not having the bag of feeding formula labeled was that there was no way to be sure if the resident was getting the correct formula. She said that could put the resident at risk of not getting the nutrition she needed.</p> <p>In an interview on 04/19/2024 at 2:57 PM the DON the policy on labeling of enteral tube feeding bags was requested. The DON asked if this was for the resident [unidentified] whose tube feeding formula bag label was found on the floor. Surveyor C told the DON that no information regarding a tube feeding bag label being found on the floor had been received and asked which resident the DON was referring to. The DON was not able to supply a resident ' s name. Surveyor C requested documentation regarding the tube feeding bag label found on the floor. A policy on labeling of enteral feeding bags and information about a resident whose enteral feeding bag label was found on the floor were not received before exit.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49854</p> <p>Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety for 1 of 1 kitchen reviewed for dietary services.</p> <p>A. Food containers had accumulations of dried drippings and residue on them.</p> <p>B. Food preparation areas had items with accumulation of dust, encrusted grease deposits, and other soiled accumulations.</p> <p>C. Food in refrigerator with expired dates.</p> <p>D. Bananas were stored next to a dirty trash bin.</p> <p>E. The Dietary Manager entered the kitchen without a beard guard.</p> <p>This failure places residents who eat food prepared by the facility at risk of food borne illnesses.</p> <p>The findings include:</p> <p>During an observation on [DATE] at 8:21 AM, revealed one red 1 Gallon plastic bottle that contained dressing that had liquid build up and it was sticky to the touch; a bottle of 1 Gallon Soy Sauce had liquid residual and dried dripping on sides of bottle. A container with soup had residue on the lid. A clear plastic container had 3 1-gallon Ziplock bags containing expired vegetables. Bag #1 was labeled as salad mix with a date of [DATE] with an expiration date of [DATE]. Bag # 2 was labeled with the date of [DATE] with an expiration date of [DATE]. Bag #3 was labeled with a date of [DATE] with an expiration date of [DATE].</p> <p>During an interview on [DATE] at 8:25 AM, Dietary Aide said residues on bottles could lead to risk of contamination of the plastic containers and bacteria could build up on them. The Dietary Aide also said that storing expired vegetables could lead to illness for the residents in the facility if they were used or if they contaminated other foods in the refrigerator.</p> <p>During an observation on [DATE] at 8:30 AM, revealed plastic containers with Paprika, Parsley Flakes, Ground [NAME] Pepper, Lemon and Pepper Seasoning Salt and Black Pepper had powder residues on the side of the bottle and on the lid. A cooking oil plastic bottle was sitting on top of a paper towel soaked in oil.</p> <p>During observation and interview on [DATE] at 8:35 AM, A box of bananas was next to a dirty trash bin. Interview with the Dietary Aide revealed the bananas should not be next to the trash can and kitchen staff store them on the opposite side of the counter, but she did not know why they were there or who left them there.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation on [DATE] at 8:37 AM, Water stains were observed on the walls and on the pantries. The wall towards the back of the deep fryer had white calcium build-up and water stains.</p> <p>During observation and interview on [DATE] at 8:40 AM, the Dietary Manager entered the kitchen without a beard guard, and after a short time said, Excuse me and stepped out of the kitchen, returning wearing a beard guard, although it was not covering his mustache. The Dietary Manager stated that he started working at the facility around February of 2024. Observation of a small refrigerator revealed there were expired flour tortillas with a Preparation date of [DATE] and a Use by date of [DATE]. Interview with Dietary Manager revealed using the flour tortillas on a meal with the use-by date of [DATE] could pose a risk of bacteria growing on the tortillas and that it could result in digestive infections to the residents.</p> <p>During observation and interview on [DATE] at 8:45 AM, Dietary Manager revealed there was a plastic trashcan with a white trash bag inside that was placed in between the grill and the griddle. The trash can had visible signs of food on the lid, and it looked dirty. The grill was dirty and grimy as well as the griddle with signs of grease and dry residues. The Dietary Manager stated that the griddle and the grill were cleaned every week. The Dietary Manager stated that there was no tracking system in place to record when these items were being cleaned. The Dietary Manager stated he did not see issues with the trashcan being near or in between the griddle and the grill.</p> <p>During observation and interview on [DATE] at 8:48 AM, Dietary Manager revealed the deep fryer was dirty with food residues and grease. The back of the fryer had food residues and the oil was dark in color. The Dietary Manager stated the used oil is disposed of weekly and that the fryer is cleaned every week. The Dietary Manager stated that there was no tracking system to record when the fryer has been cleaned.</p> <p>During observation and interview on [DATE] at 9:04 AM, Dietary Manager on the dish washing area revealed the drain at the back of the room where the kitchen floor mats are washed was dirty and clogged with trash and debris.</p> <p>Record review of facility's policy and procedure on Food Storage Policy Dated [DATE] and revised on [DATE] documented in part:</p> <p>Purpose: Food items within the building are to be stored properly to ensure they are optimal for safe consumption by patients and staff. Storing food properly helps to prevent foodborne illness and maintain their food 's peak qualities such as flavor, texture, color, and aroma. These factors contribute to a positive and enjoyable dining experience.</p> <p>Policy: the same day that food products are delivered to the facility, they are to be inspected for safety and quality. Each item is to be accurately dated upon receipt. When items are opened or in use, Use-by-date are to be labeled upon them followed by storing the item in the proper area such as the refrigerator, freezer, or dry storage area located in the kitchen. All outdated, expired, or damaged food products are to be discarded immediately. Proper food sanitation guidelines are to be followed.</p> <p>Involved Personnel:</p> <p>Food items belonging to the facility may be handled by the dietary department.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procedure:</p> <p>Facility food storage: refrigerated, frozen, and dry storage items.</p> <p>Refrigerated items: storing foods in the refrigerator slows bacterial growth and can help prevent foodborne illness.</p> <p>All items requiring refrigeration should be stored at temperatures of 36 - 41 F or below and are to be dated properly.</p> <p>The FIFO method (first in first out method) is to be used with all items to ensure proper rotation.</p> <p>Fresh fruits and vegetables should be placed in bins, cartons, or bags to promote freshness.</p> <p>Expired or damaged foods are to be discarded and not consumed.</p> <p>Review of facility's policy and procedure on Use of Gloves/Hairnets/Covering of food, dated [DATE] and revised on [DATE] revealed in part:</p> <p>Hair nets are to be used when cooking or preparing food. Hair nets are not required when delivering food. Ex: cooking food such as stirring pots or assembling ingredients.</p> <p>Policy &amp; Procedure Manual.</p> <p>General Sanitation of Kitchen.</p> <p>Policy: food and nutrition services staff will maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule.</p> <p>Procedure:</p> <p>Cleaning and sanitation tasks for the kitchen will be outlined in a written cleaning schedule.</p> <p>Tasks will be assigned to be the responsibility of specific positions.</p> <p>Frequency of cleaning for each task will be defined.</p> <p>Methods and materials/cleaning compounds to be used for cleaning/sanitizing will be written for each task.</p> <p>Employees will be trained on how to perform cleaning tasks.</p> <p>On the cleaning schedule, employees will initial and date tasks when completed. (Refer to chapter 5: cleaning instructions for sample cleaning schedule and sample cleaning forms.)</p> <p>Employees will wear rubber gloves and an apron to protect hands and clothing while cleaning the kitchen. Protective eyeglasses will be worn as appropriate.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The safety data sheets (SDS) will be available for all chemicals used by the food and nutrition services staff. Employees will be in-service on the proper use of chemical and SDS Sheets.</p> <p>Resource:</p> <p>OSHA Quick Card. Hazard Communication Safety Data Sheets, <a href="https://www.osha.gov/Publications/HazComm QuickCard SafetyData.html">https://www.osha.gov/Publications/HazComm QuickCard SafetyData.html</a>.</p>