STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745022	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ware Memorial Care Center	1510 S. Van Buren St. Amarillo, TX 79101

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813 Based on observation, interview and record review, the facility failed to ensure residents had the right to be informed in advance if the risks and benefits of proposed care, or treatment and treatment alternatives or treatment options and to chose the alternative or options he or she prefers for 5 of 19 residents (Resident #13, #15, #47, #70, and #75) and 5 residents interviewed during an anonymous interview reviewed for self-determination. The facility failed to ensure Resident #13, #15, #47, #70, and #75 and 5 anonymous residents received requested bedrails for 10 days or more after requested by the resident or family. This failure could cause residents to feel uncomfortable and disrespected leading to feeling of anxiety, anger, isolation, and deterioration in general health conditions. Findings include: Resident #13 Record review of Resident #13's clinical record revealed a [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses to include epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), Alzheimer's (a progressive disease that destroys memory and other important mental functions), diabetes (a chronic condition that affects the way the body processes blood sugar (glucose), osteoarthritis(a type of arthritis that occurs when flexible tissue at the ends of bones wears down), chronic respiratory failure(a long-term condition that occurs when the body's respiratory system can't exchange oxygen and carbon dioxide properly), and muscle weakness (a lack of muscle strength). Record review of Resident #13's last MDS revealed a quarterly assessment completed on 9-1-2024 with a BIMS of 15 indicating he was cognitively intact, and he had a functionality of requiring substantial/maximal assistance with chair/bed-to-chair transfers and rolling left and right. Record review of the care plan with admitted [DATE] for Resident #13 revealed the following: (continued on next page)

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Problem: [Resident #13] requires assistance from staff with performance of daily living and functional abilities related to HTN (hypertension-a condition in which the force of the blood against the artery walls is too high), DM (diabetes-a chronic condition that affects the way the body processes blood sugar (glucose), HLD (hyperlipidemia-a condition in which there are high levels of fat particles in the blood), Seizures (sudden, uncontrolled body movements and changes in behavior that occur because of abnormal electrical activity in the brain), and Intellectual Disabilities. - Revision on 12-7-2023 Interventions: [Resident #13] may use 1/2 rails for mobility, positioning, and comfort. - Revision 7-17-2023. Record review of Resident #13's Order Summary Report with Active Orders as of 12-5-2024 revealed no physician orders for side rails. During an interview on 12-03-2024 at 09:44 AM Resident #13 reported that he was very upset that his bedrails were removed. Resident #13 reported that he used his bedrails for everything, to include getting in and out of bed, moving around in bed, and making sure he stayed safe. Resident #13 reported that he was told state told the facility they had to be removed and he did not appreciate that. Resident #13 wanted it corrected immediately and the bedrails returned. Resident #13 reported that he requested his bedrails be returned the day they were removed. Resident #13 reported that he has talked with multiple staff about getting bedrails back and on several different occasions and that he was going to a care plan meeting at 10:00 AM this day and was going to bring it up again. Resident #15 Record review of Resident #15's clinical record revealed a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include CHF (a chronic condition in which the heart dose not pump blood as well as it should), morbid obesity (a disorder involving excessive body fat that increase the risk of health problems), epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), polyneuropathy (malfunction of many peripheral nerves throughout the body), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), PVD (a circulatory condition in which narrowed blood vessels recue blood flow to the limbs), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), and osteoarthritis (a type of arthritis that occurs when flexible tissue at the ends of bones wears down). Record review of Resident #15's last MDS revealed a quarterly assessment completed on 11-5-2024 with a BIMS of 15 indicating she was cognitively intact, and she had a functionality of being dependent with chair/bed-to-chair transfers and partial/moderate assistance with rolling left and right. Record review of the care plan with admitted [DATE] for Resident #15 revealed the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Problem: [Resident #15] requires assistance from staff with performance of daily living and functional abilities related to CHF (congestive heart failure-a chronic condition in which the heart dose not pump blood as well as it should), AFIB (atrial fibrillation-an irregular, often rapid heart rate that commonly causes poor blood flow), HTN (hypertension-a condition in which the force of the blood against the artery walls is too high), OA (Osteoarthritis-a type of arthritis that occurs when flexible tissue at the ends of bones wears down), COPD chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), Epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), and weakness. - Revision on 7-30-2024 Interventions: [Resident #15] may use 1/2 rails for mobility, positioning, and comfort. - Revision 8-2-2024. Record review of Resident #15's Order Summary Report with Active Orders as of 12-5-2024 revealed the following physician's order: May use side rails for comfort and to aid in positioning and mobility . Order dated 08-29-2024. During an interview on 12-03-24 at 09:37 AM Resident #15 was in her room in her wheelchair. Resident #15 reported that her bedrails had been recently removed and she would like them back. Resident #15 reported that she had reported this to staff the day the bedrails were removed and a couple of times since then but she had not received any response other than to report that state told the facility they could not have bedrails. Resident #15 reported she uses the bedrails to get in and out of bed safely. Resident #47 Record review of Resident #47's clinical record revealed a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include osteoarthritis (a type of arthritis that occurs when flexible tissue at the ends of bones wears down), CAD (damage or disease in the hearts major blood vessels), chronic pain(persistent pain that can last years), macular degeneration (a degenerative condition affecting the central part of the retina), history of falls, and weakness. (a lack of muscle strength). Record review of Resident #47's last MDS revealed an annual assessment completed on 11-11-2024 with a BIMS of 13 indicating she was cognitively intact, and she had a functionality of requiring partial/moderate assistance with chair/bed-to-chair transfers. and rolling left and right. Record review of the care plan with admitted [DATE] for Resident #47 revealed there were no care plans related to the use of bedrails. Record review of Resident #47's Order Summary Report with Active Orders as of 12-5-2024 revealed no physician orders for side rails. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12-3-2024 at 09:04 AM Resident #47 was in her room in her wheelchair. Resident #47's bed was made with her bedrails under her bed. This surveyor attempted to move them and noted that they were securely locked in place. Resident #47 reported that she was currently [AGE] years old, had been in the facility for several years and that she has always used bedrails but the facility removed them and she wants them back. Resident #47 reported that the facility had locked her bedrails down. Resident #47 reported that she told the facility staff that she wanted her bedrails back, but they told her that state would not allow them, and she could not have her bedrails back. Resident #47 reported that she requested her bedrails be returned the day they were removed and several times since. Resident #70 Record review of Resident #70's clinical record revealed an [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses to include Alzheimer's (a progressive disease that destroys memory and other important mental functions), muscle weakness (a lack of muscle strength), pain, fracture for femur (thigh bone), history of falling, and peripheral vascular disease (blood circulation disorder) Record review of Resident #70's last MDS revealed a quarterly assessment completed on 11-6-2024 with a BIMS of 4 indicating he was severely cognitively impaired, and he had a functionality of being dependent on staff for chair/bed-to-chair transfers and rolling left and right. Record review of the care plan with admitted [DATE] for Resident #70 revealed the following: Problem: [Resident #70] uses side rail for positioning. - Revision on 7-05-2024 Record review of Resident #70's Order Summary Report with Active Orders as of 12-4-2024 revealed no physician orders for side rails. During an interview on 12-3-2024 at 09:59 AM FM H reported that the care and facility had been good except for one issue. The facility removed Resident #70's bedrails approximately 2 weeks ago and told FM H that state would not let them have bedrails for Resident #70 to use. FM H reported that Resident #70 was a tall/big man and used his bedrails all the time to reposition and transfer in and out of bed. FM H reported that since they have removed the bedrails and tied them down Resident #70 has been unable to access them. FM H reported that she requested Resident #70's bedrails be returned the day they were removed. This surveyor did note that Resident #70 did have his bedrails on his bed, they were under the bed and locked in place with zip ties. The bedrails could not be moved. Resident #75 Record review of Resident #75's clinical record revealed an [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include rheumatoid arthritis(autoimmune inflammation of the joints), osteoporosis (a medical condition in which the bones become brittle and fragile from loss of tissue, typically as a result of hormonal changes or deficiency of calcium of vitamin D), pain in right shoulder, muscle wasting(the loss of muscle mass and strength due to disease, injury, or lack of use), unsteadiness on feet, and history of fractures. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #75's last MDS revealed a quarterly assessment completed on 9-1-2024 with a BIMS of 15 indicating she was cognitively intact, and she had a functionality of requiring supervision or touching assistance with chair/bed-to-chair transfers and setup or clean-up assistance with rolling left and right. Record review of the care plan with admitted [DATE] for Resident #75 revealed the following: Problem: [Resident #75] uses side rail for position, mobility, and comfort. - Revision on 7-21-2024 Record review of Resident #75's Order Summary Report with Active Orders as of 12-5-2024 revealed no physician orders for side rails. During an interview on 12-3-2024 at 08:54 AM Resident #75 was noted in her room sitting in her recliner. She reported no issues with the facility other that they had removed her bedrails and she would like them back so she would be steadier with her transfers and she could move around in bed. Resident #75 reported that she requested the bedrails be returned the day the facility locked them down. During an anonymous interview with 5 residents on 12-4-2024 at 10:35 AM revealed all 5 residents reported that they were upset their bedrails were removed. One resident reported that the aides made her turn every two hours when in bed and that it hurts now because they had to push and pull her, and she had nothing that she could hold on to so she could assist them with turning or moving. Another resident stated he was mad about the bedrails and that they were still on the bed but underneath the bead and locked where he could not get them up. During an interview on 12-4-2024 at 01:40 PM the DON reported that the bedrails for residents had been used for mobility and positioning, that they (the DON and Managers) went through the facility on 9-22-2024 and zip tied all the bedrails down so resident would not be able to use them. The plan was to reassess each resident to see if they needed and could use the bedrails, obtain new consents and new orders for the bedrails, and add the bedrails to the resident's care plans. The DON reported that she herself and the managers would redo the evaluations and they did one on 12-3-2024 and planned to redo one today 12-4-2024. The DON reported that she has received multiple resident reports that they want the bedrails returned. The DON reported that she has 4-6 residents on each unit that have reported they want their bedrails back (this will be a total of 16-24 residents who have requested the return of their bedrails). The DON reported that they have notified all families by mail of the change in policy but did not say if they have discussed the policy with the residents. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12-05-2024 at 08:21 AM the Administrator reported that during last year's survey the facility was cited for a bedrail deficiency, that her nurse managers, DON, general management, and herself decided to rewrite the bedrail policy. The Administrator had the management nursing staff evaluate each resident to determine who had bedrails and found out that all but 9 residents had some type of bedrail, so they decided to remove all the bedrails and restart to determine which residents really needed them. The Administrator reported that they sent a letter to the families of the residents who could not respond and provided the letter to residents who were oriented on 11-19-2024 and removed all the bedrails on 11-22-2024. The Administrator reported that each resident would be reevaluated and if they qualified, they would get their bedrails back and if they did not qualify but wanted something for mobility then they would get a U-Bar which was a small rail that is less than 1/8th the length of the resident's bed. The Administrator reported that they planned to completely phase out the bedrails and replace them with the U-Bar's unless ordered by physical therapy. The Administrator reported that the intent was to evaluate and replace all the bed rails this week but state had taken the time of the management nursing staff and they have been unable to address the bedrail situation. The Administrator reported that as of 12-5-2024 the facility had evaluated 5-6 residents for bedrails. The Administrator reported that they were aware of 20 resident who either the family or resident had specifically requested the bedrails be put back in place and that with the current residents that have been evaluated they have approximately 15 of those Residents left. The Administrator reported that she feels the residents do have the right to participate in their care and make decisions about their care. The administrator reported that she feels 10 days, or more is not too much time to wait to make sure that they address this issue with the bedrails correctly. The Administrator stated, We have 4 nurse managers that could do this in one day if they needed to but currently, they have other things that are taking up their time. We had plans to do them this week, but state walked in. During an interview on 12-05-2024 at 01:07 PM the Administrator reported they had completed 8 more resident evaluations for the use of bedrails, and she expected they would complete the other 7 by the end of the day to have all 20 residents who requested the return of the bedrails evaluated. The Administrator stated, two weeks is a little too long to wait to get something done but we just have had too many distractions. Record review of the facility provided Resident Rights undated, provided as part of the facility's admission process to each resident revealed the following: Residents of Texas nursing facilities have all the rights .granted by the Constitution and laws of the stated and the United States. They have the right to be free of . and reprisal exercising these rights as a citizen of the United States. Freedom of Choice You have the right to: -make your own choices regarding personal affairs, care, benefits, and services. Record review of the policy provided by the Administrator on 12-5-2024 at 08:41 AM revealed the following: Texas Administrative Code (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident Rights Fee Choice (3) participate in planning care and treatment or changes in care and treatment, to the extent practicable.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534 Based on interview and record review the facility failed to ensure each resident was informed before, or at the time of admission, and periodically during the residents stay, of services available in the facility and of charges for those services, which included charges for services not covered under Medicare/Medicaid or by the facility's per diem rate for 3 of 3 residents (Resident #31, Resident #82, and Resident #240) reviewed for Medicare/Medicaid coverage. 1. The facility failed to ensure Resident #31, Resident #82, and Resident #240 were given a NOMNC (a notice that indicates when care is set to end from a home health agency, skilled nursing facility, comprehensive outpatient rehabilitation facility, or hospice) with information on how to appeal the decision when residents were discharged from skilled services prior to covered days being exhausted. 2. The facility failed to ensure Resident #31, Resident #82, and Resident #240 were given a SNF ABN (document that informs a Medicare beneficiary that Medicare will no longer pay for skilled services) when discharged from skilled services at the facility prior to covered days being exhausted. These failures could place residents at risk of not being aware of their right to appeal the decision to end Medicare coverage for skilled services and/or changes to provided services. Findings Included: Record review of Resident #31's admission record dated 12/04/24 revealed an [AGE] year-old female admitted to the facility on [DATE] and discharged from the facility on 11/20/24 to an assisted living facility. She had diagnoses that included, but were not limited to, unspecified sequalae of unspecified cerebrovascular disease (the resultant symptoms of stroke, transient ischemic attack, aneurysm, or vascular malformation), chronic obstructive pulmonary disease (inflammation of lung tissue due to non-infectious causes, which results in cough without mucus or phlegm, shortness of breath, and fatigue), heart failure (heart muscle fails to pump blood as it should), and dysphagia (difficulty in swallowing). Resident #31's primary payer was Private Pay, and her second payer was Medicare A coinsurance from insurance. She was admitted from an acute care hospital, and her admission type was listed as short term. Record review of Resident #31's Admission MDS completed on 10/24/24 revealed the following: Section A: Resident #31's most recent Medicare stay started on 10/15/24. Section C: Resident #31 had a BIMS of 11 which indicated moderately impaired cognition. Section I: Resident #31's primary medical condition was Stroke. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #31's care plan revealed an initiation date of 10/31/24. The care plan noted Resident #31's normal social routine had been disrupted by admission to the SNU and she required assistance from staff with ADLs due to CVA. Resident #31 was at risk for injuries related to impaired balance and was to receive of skilled occupational and physical therapy five times a week for 30 days. Attempted interview on 12/05/24 at 09:11 AM, a voicemail message was left for Resident #31. The call was not returned. Attempted interview on 12/05/24 at 09:13 AM, a voicemail message was left for Resident #31's family member. The call was not returned. Record review of Resident #31's SNF Beneficiary Review form revealed Resident #31's Medicare Part A start date of 10/15/24 and the last covered day of Medicare Part A service was 11/15/24. In answer to the question How was the Medicare Part A Service Termination/Discharge determined? the IP checked the box for Other and added a handwritten note which reflected, Resident met Part A stay then moved to [name of assisted living facility] on 11/25/24. There were no answers to the following questions on the form: 1. Was a SNF ABN, Form CMS-10055 provided to the resident? 2. Was a NOMNC, Form CMS 10123 provided to the resident? Record review of Resident #82's admission record dated 12/04/24 revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, other symptoms and signs involving the musculoskeletal system (affecting muscles, bones, joints and connective tissue), unspecified fall, atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and muscle weakness. He was admitted from an acute care hospital and his admission type was Short Term. Resident #82 had Medicare Part A and B coverage and his primary payer was listed as Private Pay. Record review of Resident #82's Admission MDS completed on 11/11/24 revealed the following: Section A: Resident #82's most recent Medicare stay started on 10/31/24. Section C: Resident #82 had a BIMS of 15 which indicated intact cognition. Section I: Resident #82's primary medical condition was Medically Complex Conditions. Record review of Resident #82's care plan revealed an initiation date of 11/18/24. The care plan noted Resident #82's normal social routine had been disrupted by admission to the SNU and he required assistance from staff with ADLs due to his diagnoses. Resident #82 was at risk for injuries related to impaired balance and weakness and was to receive skilled occupational and physical therapy five times a week for 30 days. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #82's SNF Beneficiary Review form revealed Resident #82's Medicare Part A start date of 10/31/24 and the last covered day of Medicare Part A service was 11/27/24. In answer to the question How was the Medicare Part A Service Termination/Discharge determined? the IP checked the box for Other and added a handwritten note which reflected, Respite on 11/27/24 Respite still in the facility. Resident no longer making progress in SNU. The plan was to transition him to our LTC. There were no answers to the following questions on the form: 1. Was a SNF ABN, Form CMS-10055 provided to the resident? . 2. Was a NOMNC, Form CMS 10123 provided to the resident? During an interview on 12/05/24 at 08:57 AM the IP stated Resident #82 came into the facility on respite and was hesitant to give the facility his financial information to get Medicaid Pending in progress. She did not have an answer when asked if he would have wanted to appeal the decision to end his skilled care. During an interview on 12/05/24 at 09:21 AM Resident #82's family member stated the facility did not inform her or Resident #82 of the right to appeal the decision to end his skilled care. She stated private pay since skilled care ended, This $274.00 a day is gonna break us. We will be in the poor house. Record review of Resident #240's admission record dated 12/04/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, nondisplaced fracture of medial condyle of left tibia (broken left lower leg), osteoarthritis of knee (degenerative joint disease), acute chronic diastolic heart failure (heart muscle fails to pump blood as it should), and muscle weakness. Resident #240 was admitted from an acute care hospital and her primary payer was Private Pay. Her second payer was Medicare A coinsurance from insurance. Her admission type was Short Term. Record review of Resident #240's discharge MDS [her Admission MDS was requested from facility but was not provided] completed on 11/14/24 revealed the following: Section A: The MDS was a SNF Part A Discharge Assessment. Resident #240's most recent Medicare-covered stay started on 10/17/24 and ended on 11/08/24. Section C: Resident #240 had a BIMS of 11 which indicated moderately impaired cognition. Record review of Resident #240's care plan revealed an initiation date of 11/04/24. The care plan noted Resident #240's normal social routine had been disrupted by admission to the SNU and she required assistance from staff with ADLs due to her diagnoses. Resident #240 was at risk for injuries related to impaired balance and weakness and was to receive skilled occupational therapy five times a week for 360 days and physical therapy five times a week for 30 days. Record review of Resident #240's SNF Beneficiary Review form revealed Resident #240's Medicare Part A start date of 10/17/24 and the last covered day of Medicare Part A service was 11/08/24. In answer to the question How was the Medicare Part A Service Termination/Discharge determined? the IP checked the box for Other and added a handwritten note which reflected, Resident transitioned to LTC room [room number of Resident #240] (private pay) met part A stay then transitioned to our LTC. There were no answers to the following questions on the form: 1. Was a SNF ABN, Form CMS-10055 provided to the resident? . 2. Was a NOMNC, Form CMS 10123 provided to the resident? (continued on next page)

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	745022	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ware Memorial Care Center	1510 S. Van Buren St. Amarillo, TX 79101

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/05/24 at 09:14 AM Resident #240's family member stated a facility staff member (he could not remember which one) told him he could appeal the decision to end Resident #240's skilled care but it would only extend care for 2-3 more days and there were a lot of hoops to jump through. He stated because of the 2-3-day extension and because he was receiving cancer treatments and his wife was in the hospital for a hip replacement he decided not to appeal. He stated, There is no doubt she (Resident #240) should have had longer (skilled care). Because she's 97 and they don't respond as fast (to treatment). We were just at a place were filling out forms was not an option, especially for just a few more days of services. During an interview on 12/05/24 at 08:57 AM the IP stated she was responsible for issuing NOMNCs and SNF ABN notices to residents. She stated she had not had to do any SNF ABN notices in the facility. She stated the facility became licensed for SNF in September of 2023. The IP stated she had not received any training on NOMNCs or SNF ABNs, but she worked closely with the Social Worker who was in charge of them at her last facility, so she was familiar with the process. When asked why Resident #31, Resident #82, and Resident #240 did not receive either notice she stated they did not need the notices because they transitioned to a lower level of care due to not needing skilled care any longer. The IP stated the three residents would not have needed to appeal the decisions to lower their care as it was a team decision made during team meetings so they would not have wanted to appeal. The IP stated none of the three residents exhausted their 100 days of skilled care but they could not receive skilled care for 100 days if they did not need it. During an interview on 12/05/24 at 08:57 AM the DON stated she was only partially familiar with NOMNCS and SNF ABNs. She stated, We get them for issues with insurance. If (the resident is) not progressing with goals, we get the information to discharge them from services. I know there is an appeal process. We give them (the residents) a heads up (that services are ending). The DON stated residents were told that they could appeal and if their benefits ran out before the appeal was approved, they would be responsible for the cost of care. She stated a possible negative outcome for residents not receiving the NOMNC and SNF ABN was they could miss out on more services. During an interview on 12/05/24 at 08:59 AM the ADM stated she did not know anything about NOMNCs or SNF ABNs. She stated the IP was responsible for both. During an interview on 12/05/24 at 10:36 AM the ADM stated the facility did not have policies addressing NOMNCs or SNF ABNs. She said, I looked high and low, and didn't find any.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813 Based on interview and record review, the facility failed to ensure an assessment accurately reflected a resident's status for 1 of 19 residents (Resident #1) reviewed for accuracy of MDS assessments. -The facility failed to accurately assess Resident #1 who was listed for having a urinary catheter on her 9-3-2024 quarterly MDS. This failure to accurately assess a resident could place residents at risk for inaccurate and incomplete MDS assessment which could result in residents not receiving correct care and services. Finding include: Record review of Resident #1's face sheet printed 12-5-2024 revealed a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include cerebrovascular disease (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), Lupus (an illness that occurs when the immune system attacks health tissue and organs), diabetes (a chronic condition that affects the way the body processes blood sugar (glucose), and dementia (a group of thinking and social symptoms that interferes with daily functioning). Record review of Resident #1's quarterly MDS assessment started 9-3-2024 and completed 9-16-2024 revealed she had a BIMS of 7 indicating she was severely cognitively impaired, and she had a functionality of being dependent on staff for most of her adl's and activities. Record review of Section H, Bladder and Bowel, H0100 Appliances-Resident #1 was marked as having an Indwelling Catheter. Record review of Resident #1's Order Summary Report with active orders from 11-10-2022 to 12-5-2024 revealed no orders for an indwelling catheter or for indwelling catheter care. Record review of Resident #1's care plan with admitted [DATE] with last revision on 9-16-2024 revealed no care plans for an indwelling catheter or indwelling catheter care. During an observation on 12-3-2024 at 08:56 AM revealed Resident #1 was in her bed with a pillow under her right arm for positioning. Resident #1 was unable to respond to questions appropriately. Resident #1 was noted to not not have an indwelling catheter present. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12-4-2024 at 01:15 PM MDS Coordinator A verified that Resident #1 did not have and has not had an indwelling catheter. MDS Coordinator A reviewed the 9-3-2023 Quarterly MDS for Resident #1 and reported that it was marked as Resident #1 having an indwelling catheter and that the MDS was marked incorrectly. MDS Coordinator A stated, I think someone marked it by accident. MDS Coordinator A then checked Resident #1's chart, orders, and care plans, MDS Coordinator A found no information that Resident #1 had a catheter. MDS Coordinator A reported that if a MDS was marked incorrectly the facility could lose money and the residents could be affected in that that way (they may not receive some services or supplies because the facility could not afford it) and it could be considered fraud if a staff member was marking the MDS with information on purpose. MDS Coordinator A reported that the facility used the RAI manual to complete all MDS's. During an interview on 12-4-2024 at 01:49 PM the DON reported that an MDS should accurately reflect a resident's condition and that if the MDS did not reflect the residents condition it was a problem and could affect reimbursement, billing, and could be considered fraud. Record review of the facility provided policy titled MDS Assessment Policy dated 8-29-2017, revealed the following: Policy: The assessment will accurately reflect the resident's current status at the time of the assessment. Record review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1. 18.11, dated October 2023 revealed the following: SECTION H: BLADDER AND BOWEL H0100: Appliances Steps for Assessment 1. Examine the resident to note the presence of any urinary or bowel appliances. 2. Review the medical record, including bladder and bowel records, for documentation of current or past use of urinary or bowel appliances. Coding Instructions Check next to each appliance that was used at any time in the past 7 days. Select none of the above if none of the appliances (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A-D were used in the past 7 days. o H0100A, indwelling catheter (including suprapubic catheter and nephrostomy tube)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813 Based on observation, interview, and record review, the facility failed to ensure that residents who need respiratory care were provided such care consistent with professional standards of practice for 2 (Resident #6 and Resident #79) of 5 residents reviewed for respiratory care. The facility failed to change nebulizer tubing for Resident #6 for 4 months. The facility failed to change nebulizer tubing for Resident #79 for 6 months. This failure could affect residents on respiratory therapy by placing them at risk for respiratory compromise and associated complications such as shortness of breath, confusion, respiratory failure, and exacerbation of their condition. Findings include: Resident #6 Record review of Resident #6's clinical record revealed a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), chronic bronchitis(productive cough for more than 3 months occurring within a span of 2 years), chronic kidney disease (longstanding disease of the kidneys leading to kidney failure), epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), macular degeneration(a degenerative condition affecting the central part of the retina), and dependent on supplemental oxygen. Record review of Resident #6's clinical record revealed her last MDS was a quarterly completed 10-10-2024 listing her with a BIMS of 15 indicating she was cognitively intact, and she had a functionality of requiring partial/moderate assistance with most of her activities of daily living. Record review of Resident #6's Order Summary Report with Active Orders as of 12-5-2024 revealed the following order: -Albuterol Sulfate Inhalation Nebulization Solution -1 vial inhale every 6 hours as needed for SOB four times daily as needed. - Start date 7-3-2024 -no orders were noted for respiratory equipment care to include the changing of tubing to masks. Record review of Resident #6's clinical record revealed a care plan with the admitted [DATE], last review date of 10-23-2024 revealed the following: Focus: Resident has impaired breathing and impaired oxygen absorption related to her medical diagnosis of COPD/Asthma. - Date initiated 1-3-2024. Revision 4-22-2024 Procedure: 7-3-2024 - Albuterol Sulfate Inhalation Nebulization Solution . 1 vial inhale orally every 6 hours as needed of for SOB 4 times daily as needed. - Initiation Date 7-24-2024. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No procedures were listed with care of any respiratory equipment to include changing of the nebulizer tubing or masks. During an observation on 12-03-2024 at 08:37 AM revealed Resident #6 was not in her room. There was an O2 concentrator next to the bed with water/hydration bottle dated 11-1-2024, no date on the O2 tubing or cannula. A nebulizer was on the bed with tubing dated 8-1-2024 and no date on nebulizer mask. The tubing appeared cloudy and the mask appeared to have small particles on the inside of the mask. There was no date on the nebulizer mask. During an observation and interview on 12-03-2024 at 09:16 AM Resident #6 was in her room in her wheelchair wearing her O2 at 2L/min via her nasal cannula. Resident #6's nebulizer was wrapped in a bag on her bedside dresser. Resident #6 reported that the staff have provided all her respiratory care to include her tubing, cannula, and mask changes and that she had no particular concerns. Resident #79 Record review of Resident #79's clinical record revealed a [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses to include obstructive sleep apnea (a sleep disorder that involves cessation or significant decrease in airflow in the presence of breathing effort), allergic rhinitis (a common condition that occurs when the immune system overreacts to allergens), dementia (a group of thinking and social symptoms that interferes with daily functioning), traumatic brain injury(an injury to the brain cause by an external force, such as a blow to the head or an object piercing the skull), anxiety (a mental health disorder characterized by feeling of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), dependence on other enabling machines and devices (such as a nebulizer and respiratory equipment). Record review of Resident #79's clinical record revealed his last MDS was an annual completed 11-9-2024 listing him with a BIMS of 10 indicating he was moderately cognitively impaired, and he had a functionality of being dependent on staff for assistance with most of his activities of daily living. Record review of Resident #79's Order Summary Report with Active Orders as of 12-5-2024 revealed the following order: -Albuterol Sulfate Inhalation Nebulization Solution -1 vial inhale orally via nebulizer every 8 hours as needed for cough. - Start date 3-16-2024 -no orders were noted for respiratory equipment care to include the changing of tubing to masks. Record review of Resident #79's clinical record revealed a care plan with the admitted [DATE], last review date of 5-22-2024 revealed the following: Focus: Resident has impaired breathing and impaired oxygen absorption. - Revision on 5-22-2024. Procedure: -No procedures were listed with care of any respiratory equipment to include changing of the nebulizer tubing or masks. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12-03-24 at 09:25 AM Resident #79 was in his room sitting in his chair. When questioned he did not respond. Noted was a nebulizer on Resident #79's bedside dresser. The tubing on the nebulizer machine was dated 6-1-2024. The nebulizer tubing appeared cloudy with some discoloration and the mask was noted to have some small particles on the inner surface. There was no date on the nebulizer mask. During an observation and interview on 12-0424 at 11:34 AM this surveyor observed LVN B checked Resident #79's nebulizer tubing and found that the tubing had been removed with no replacement provided and then checked Resident #6's nebulizer tubing and found it dated 12-3-2024. When presented with the photo of Resident #6's tubing with it dated 8-1-2024 LVN B reported that the tubing was supposed to be changed each month according to the facility policy and that with Resident #6's tubing being left for 4 months and Resident #79's tubing being left for 6 months was too long and that not changing the tubing could place a resident at risk for infection especially respiratory infection and that would affect the residents health. During an interview on 12-04-2024 at 01:47 PM the DON reported that the policy for oxygen/nebulizer/respiratory equipment care was that they were changed monthly and assessed nightly. The secondary equipment such as tubing, cannula, and mask were changed monthly and checked nightly for defects or damage. The DON reported that if a nebulizer tubing that was left for 4 month or even 6 months was a problem, that they should be replaced monthly. The DON reported that if they were not replaced then the resident was placed at higher risk for infection and exposure to bacteria. During an interview on 12-5-2024 at 01:44 PM the Administrator reported that the facility did not have a policy that specifically listed when respiratory equipment care would be provided, just that it would be provided. Record review of the facility provided policy titled Respiratory Equipment Maintenance dated 12-27-2016, revealed the following: Policy: Respiratory maintenance will be performed in a standardized manner. Equipment will be changed out consistently to ensure clean, properly maintained equipment.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 39813 Based on observation, interview, and record review; the facility failed to provide pharmaceutical services that included the accurate acquiring and dispensing of all drugs and biologicals to meet the needs of each resident for 1 (Resident #75) of 19 residents reviewed for medication therapy and 2 (the Rehabilitation and Long-Term Care medication room and the 1-North medication room) of 8 medication storage areas reviewed for medication storage. -LVN B left the morning medications with Resident #75 unattended and did not verify if Resident #75 took the AM medications. -the Rehabilitation and Long-Term Care medication room had an expired OTC medication. -the 1-North medication room had an expired OTC medication. The facility's failure to ensure medications were dispensed in accordance with currently accepted professional principles which could result in a resident receiving or not receiving the correct medication therapy that would be ineffective for their treatment resulting in exacerbation of the resident's condition and disease processes. Findings include: Record review of Resident #75's clinical record revealed an [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include rheumatoid arthritis (autoimmune inflammation of the joints), osteoporosis (a medical condition in which the bones become brittle and fragile from loss of tissue, typically as a result of hormonal changes or deficiency of calcium of vitamin D), pain in right shoulder, muscle wasting (the loss of muscle mass and strength due to disease, injury, or lack of use), unsteadiness on feet, depressive episodes (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and traumatic hemorrhage of the cerebrum (bleeding in the brain tissue that occurs after a head injury). Record review of Resident #75's last MDS revealed a quarterly assessment completed on [DATE] with a BIMS of 15 indicating she was cognitively intact, and she had a functionality of requiring supervision or touching assistance with most of her activities of daily living. Record review of the care plan with admitted [DATE] for Resident #75 revealed the following: Problem: [Resident #75] is at risk of aspiration, swallowing, and pain related to the medical diagnoses of GERD. Revision on: [DATE] -There was no care plan for self-administration of medications. Record review of Resident #75's Medication Administration Report revealed 12 p.o. medications were administered at 08:00 AM the morning of [DATE] to Resident #75 by LVN B. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on [DATE] at 08:54 AM revealed Resident #75 was noted in her room sitting in her recliner with her bedside table in front of her. Resident #75 was watching her TV and had finished her breakfast. On her bedside table was a medication cup with her morning pills. Noted ,d+[DATE] pills were present. Resident #75 reported that she was slow to swallow her pills because she often gets choked so they just leave them for me. During an interview on [DATE] at 11:31 AM LVN B reported that Resident #75 would often eat her meals in the dining room and sometimes eat them in her room. Either way, Resident #75 would often take a bite then take one of her pills. Resident #75 would usually take between ,d+[DATE] minutes to take her medications and due to that and the fact that Resident #75 was pretty much with it LVN B felt that Resident #75 was safe to take her medications independently. LVN B stated, I don't feel uncomfortable leaving her pills with her. LVN B reported that they have only one resident on Resident #75's hallway that wandered and that Resident #75 leaves her door shut and the resident that wanders would not enter a room when the door was shut. LVN B reported that she did not feel there would be any negative outcomes from letting Resident #75 take her medications independently and unsupervised. During an interview on [DATE] at 01:51 PM the DON reported that a nurse was expected take medications to a resident, make sure the resident took those medications, then document what medications were taken and when. The DON reported that a nurse leaving medications in a resident's room unattended was an issue. The DON reported the nurse would not know if that resident had taken those medications and if that resident was receiving the treatment the Resident was supposed to get. The DON reported that if that was to occur then the residents care could be affected in several ways especially if the resident intended for the medication did not take the medication or another resident were to get ahold of it. During an observation on [DATE] at 08:19 AM of the Rehabilitation and Long-Term Care medication room extra stock storage area of OTC medications available for use with LVN C revealed an unopened bottle of CertaVite that expired ,d+[DATE]. During an interview on [DATE] at 08:31 AM LVN C reported that an expired medication was an issue due to a staff member could administer the expired medication to a resident and the medication would not be as affective affecting the residents care and health. During an observation on [DATE] at 08:47 AM of the 1-North medication room extra stock storage area of OTC medications available for use with LVN D, noted was an unopened bottle of Meclizine that expired , d+[DATE]. During an interview on [DATE] at 08:49 AM LVN D reported that using an expired medication can affect the way a medication acts and the way a resident reacts to that medication. LVN D reported that giving an expired medication would negatively affect a resident because they would not be receiving ordered treatment. During an interview on [DATE] at 01:51 PM the DON reported that nurses should check all medications for expirations and if the medication is expired then it should be disposed of properly. The DON reported that it was the floor nurses' job to check medications for expiration. The DON reported that giving an expired medication to a resident can result in it not being effective and the resident not receiving the needed care and treatment. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of the facility provided policy titled Drug Administration Policy dated [DATE], revealed the following: Policy: Except for self-administration, drugs and biologicals are administer in accordance with physicians' orders only by the following: a. Physicians b. Licensed nursing personnel c. Medication aides; or d. Student nurse, student medication aides, or graduate nurses who are directly supervised by a licensed nurse . [DATE] at 2:49 PM requested policy for mediation storage from Administrator with no response. [DATE] at 08:19 AM reviewed provided policies and noted no policy for medication storage, requested from DON. [DATE] at 1:10 PM requested policy for medication storage from Administrator with no response. Record review on [DATE] at 09:28 AM of facility policy manual noted at 1-North Unit nurses station revealed no policy for medication/narcotic storage.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39813 Based on observation, interview, and record review; the facility failed to store a controlled drug subject to abuse properly for 1 (the Rehabilitation and Long-Term Care medication room) of 8 medication storage areas reviewed for medication storage. The Rehabilitation and Long-Term Care medication room had a Schedule III narcotic stored improperly in the refrigerator. The facility's failure to ensure medications were stored properly could result in medication diversion leading to a resident not receiving ordered treatment affecting the resident's treatment and care leading to deterioration in their health. Findings included: During an observation on 12-4-2024 at 08:19 AM of the Rehabilitation and Long-Term Care medication room storage refrigerator revealed a container with Buprenorphine (a schedule III narcotic) 0.25mg (3 tablets present in the package) that were on the refrigerator shelf. The narcotic was not stored in the locked box provided on the refrigerator door. During an interview on 12-4-2024 at 08:32 AM LVN C reported that storing a narcotic in the refrigerator and not in a locked box could be a big issue. LVN C stated that any nurse could access the narcotic and the facility would not know since there was no log for the narcotic when it was in the refrigerator and not being used. LVN C reported that it would affect the residents care negatively because the medication would not be available to provide for the resident's treatment. During an interview on 12-4-2024 at 01:51 PM the DON reported that a refrigerated narcotic was supposed to be stored in a refrigerator in a locked box to comply with the double lock system. The DON reported that they have had a problem with not having a key to the lock box in the refrigerator in the medication room and she feels that someone put the narcotic in the refrigerator and probably forgot about it. The DON reported that they have called maintenance and it is supposed to be fixed today. The DON reported that leaving a narcotic medication stored incorrectly can result in that medication being stolen. 12-4-2024 at 2:49 PM requested policy for medication storage from Administrator with no response. 12-5-2024 at 08:19 AM reviewed provided policies and noted no policy for medication storage, requested from DON. 12-5-2024 at 1:10 PM requested policy for medication storage from Administrator with no response. Record review on 12-5-2024 at 09:28 AM of facility policy manual noted at 1-North Unit nurses station revealed no policy for medication/narcotic storage.

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	745022	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ware Memorial Care Center	1510 S. Van Buren St. Amarillo, TX 79101

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31882 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with the professional standards for food service safety for 7 out of 8 resident snack refrigerators located in the residents dining rooms, reviewed for kitchen sanitation. 1. The facility failed to ensure food items were properly stored, labeled, and dated. 2. The facility failed to ensure refrigerators were free of expired foods, non-food items and staff items. 3. The facility failed to ensure cleanliness was maintained in the refrigerators. These failures could place residents who ate food served by the kitchen, and stored food in the resident refrigerators were at risk of food-borne illness. Findings include: North Side First Floor In an observation and interview on [DATE] at 8:25 am of the initial tour of the lower-level resident dining room on the North side called the North First Floor Dining there were 2 refrigerators in the dining room. The refrigerators were stainless steel and had freezers on the bottom portion of the refrigerator. There were no postings on the refrigerators and no cleaning sheets. Residents in the dining room eating breakfast and staff in the dining room assisting residents confirmed the refrigerators were for resident foods. In an observation on [DATE] at 8:36 am, of the resident refrigerators located on the North side Lower-Level Dining called the North First Floor Dining room the following was observed: In the freezer: 1. A Michelina frozen dinner, no residents name, no label or date. 2. A Thai Curry Chicken frozen dinner, no resident name, no label or date. 3. Frozen spicy beef dinner, no resident name, open to air, no label or date with an expiration date of [DATE]. 4. Assorted ice cream bars loose in the freezer, no label or date, no resident name, not in original box. 5. A Ziplock baggie with one breaded meat patty, no label or date, no resident name, not in original package. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. Food spills and food crumbs were observed in the bottom of the freezer bin. South Side Second Floor In an observation and interview on [DATE] at 8:55 am of the initial tour of the upper -level resident dining room on the South side titled South Second Floor Dining there were 2 refrigerators in the dining room. The refrigerators were stainless steel and had freezers on the bottom portion of the refrigerator. There were no postings on the refrigerators and no cleaning sheets. Residents and staff in the dining room area confirmed the refrigerators were for resident foods. In an observation on [DATE] at 9:55 am of the resident refrigerators located on the South Second Floor Dining room the following was observed: In the refrigerator: 1. A sandwich, partially wrapped in torn foil with holes in the foil, no label or date, no resident name. 2. A slice of pumpkin pie no label or date, no resident name, not in original container. 3. A plastic grocery bag containing a bag of green fruit and a banana and empty plastic storage bowls, no resident name, no label or date. 4. A yeti soft sided lunch cooler, no label or date, no resident name. 5. A glass of thickened liquid, no resident name, no label or date 6. A plastic storage container that appeared to hold a noodle substance, no label or date, no resident name, a foul smell coming from the container. 7. A Dairy Queen cup of frozen blizzard type ice cream laying on its side in the bottom of the freezer, , no resident name, no lid or covering for the top of the blizzard, no date. South First Floor In an observation on [DATE] at 11:30 am, of the resident refrigerators located on the South First Floor Dining room the following was observed: 1. 1 red plastic container with fruit salad, no label or date, no resident name 2. A piece of cheesecake, no resident name, dated [DATE]. 3. There were crumbs on the shelves and food spills in the refrigerator. 4. An individual fruit salad in a cup from the kitchen, no label or date, no resident name. 5. In the freezer there was a package with one corn on the cobb, open to air, no label or date. There were crumbs and food spills in the bottom of the freezer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	South Second Floor In an Observation and Interview on [DATE] at 9:15 am, of the South Second Floor refrigerator, DA J stated the resident refrigerators were for resident use only and staff were supposed to use the employee refrigerators in the breakroom. She stated she thought staff had used the resident refrigerators for their personal foods. She stated she did not know who was responsible for maintaining the refrigerators but thought it was housekeeping or nursing services. DA J stated of the half-wrapped sandwich wrapped in foil, that it should have a label, date and be covered completely. She stated she would throw it out. DAJ also took the pumpkin pie with no label or date and a bottle of Gatorade out of the refrigerator and threw them away. In an observation on [DATE] at 9:25 am of the South Second Floor refrigerator there was a cup of thickened liquid from the kitchen, no label or date, no resident name. The Dairy Queen Blizzard type ice cream was in the bottom of the freezer, on its side, no covering, no label or date, no resident name. North First Floor In an observation on [DATE] at 11:30 am of the North First Floor resident refrigerator the following was observed: 1. A package of opened partially used blood worms in the freezer with an expiration date of ,d+[DATE]. The package stated Not for Human Consumption. 2. A breaded meat patty in a Ziplock bag, no resident name, no label or date. 3. The refrigerator and freezer had food spills and crumbs on the shelves. South Second Floor In an observation on [DATE] at 2:10 pm, of the resident refrigerators located on the South Second Floor Dining room the refrigerator contained a glass of thickened liquid, no label or date, no resident name, and the Dairy Queen cup of ice cream, open to air, no label or date, no resident name lying on its side in the bottom of the freezer. North Second Floor In an observation on [DATE] at 3:07 pm of the resident refrigerators located on the North Second Floor Dining room the following was observed: In the refrigerator: 1. A package of turkey breast, no label or date, no resident name. 2. A bowl of fruit from a deli grocery store, no label or date, no resident name. 3. A plastic grocery bag containing a piece of pie dated ,d+[DATE], no resident name. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. A frozen pizza, no resident name, no label or date. 5. A plastic storage container that appeared to hold a noodle substance, no label or date, no resident name, a foul smell coming from the container. In an observation on [DATE] at 2:00 pm, of the facility break room for employees revealed a black refrigerator in the locked breakroom that was labeled for staff use. In an interview on [DATE] at 3:15 pm, the ADM stated she believed the staff were using the resident refrigerators on the units. She stated the nursing staff were not supposed to use the resident refrigerators. She stated everything must be labeled, dated, and have the residents name on the food item. She stated if the food item did not have a name or date on it, it should be thrown out. The ADM stated the kitchen is responsible for cleaning the refrigerators. She stated the consequences of not labeling and dating foods would be foodborne illness. In an interview on [DATE] at 8:30 am the AD stated she had only one refrigerator used for activities, and it was locked all the time. She stated the residents know the refrigerators in the dining areas were for their use. She stated she thought housekeeping was in charge of cleaning the refrigerators but was not sure who was responsible to clean them. She confirmed all the other refrigerators on the ding area units were the resident refrigerators and were not supposed to be used by staff. In an interview on [DATE] at 8:35 am LVN I stated the refrigerators on the units were the resident refrigerators and were not for staff use. She stated there was a refrigerator in the employee breakroom for employees to use. She stated she was not sure who was responsible for cleaning the refrigerators but stated the cooks stock the refrigerators with snacks and juices for the residents' snacks and residents put food in the refrigerators for eating later. She stated when a resident puts food in the refrigerator the nursing staff were supposed assist the resident to label and date the food. She stated all foods should have the residents name and the date the food was put in the refrigerator. She stated a consequence of unlabeled, undated foods and expired foods would be a food borne illness. She stated she was not aware of the current condition of the refrigerator where food was uncovered or unlabeled and undated. In an interview and observation on [DATE] at 9:20 am Dietary Manager F stated the housekeepers clean the resident refrigerators on the units. He stated he was aware nursing staff frequently puts their foods in the resident refrigerators but were not supposed to. When told there were expired foods, foods were not labeled and dated, there were dirt, food spills and food crumbs he stated he was not aware of that. He stated the consequences of not keeping food refrigerators in order were food borne illness. He stated he was trained by the dietician in all areas of the kitchen, and he trained his staff in all aspects of the kitchen duties. He stated he had no cleaning sheets for the resident refrigerators. He stated he had no policies for the resident refrigerators. In an interview and observation on [DATE] at 9:40 am Housekeeper E stated the housekeepers do not clean the resident refrigerators on the unit. She stated she has never been told to clean the resident refrigerators. She stated the housekeepers do clean the staff refrigerator and pointed to the black refrigerator in the breakroom that the staff use. She stated she has never been told by her supervisor to clean the resident refrigerators. (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 [DATE] at 9:40 am Housekeeper E stated the housekeepers do not clean the resident refrigerators on the unit. She stated the resident refrigerators were for resident foods only. She stated she did not know who was supposed to clean the resident refrigerators. She confirmed the black refrigerator in the break room was for employees. In an interview and observation on [DATE] at 9:48 am Housekeeping Supervisor F stated the housekeepers do not clean the resident refrigerators on the units. She stated the housekeepers have never been told to clean the resident's refrigerators. She stated no one had ever told her to clean the refrigerator but thought the kitchen was supposed to clean the refrigerators. She stated there was a problem with not labeling or dating foods and not putting resident's names on the food. She stated there was one activity refrigerator which is always locked, and she assumed the activity personnel clean that one. She stated she had no policies for cleaning. She stated residents could get food borne illnesses from expired and unlabeled undated foods. She stated the one refrigerator that is locked is the AD refrigerator for resident activities. She confirmed none of the refrigerators were labeled as to being the resident refrigerators, but everyone knew the refrigerators were for residents to use. In an interview on [DATE] at 8;30 am, the DM was asked for policies regarding such topics as resident refrigerators, discarding foods from the resident refrigerators, refrigerators on the units, employee food, labeling and dating, in and out procedures for storing foods, cleaning resident refrigerators in the dining room, policies for staff and residents for resident refrigerators. The DM stated he would look for these policies. In an interview on [DATE] at 9:20 am, the DM stated he could not locate any policies for the resident refrigerators. In an interview on [DATE] at 10:36 am, the ADM stated she did not have any policies for the resident refrigerators. In an interview on [DATE] at 2:09 pm, CNA G stated the CNAs are supposed to use the black refrigerator in the employee break room for their food storage. She stated she had been told not to use the refrigerators on the units as they are for the resident's food. She stated she had known of staff who had used the resident refrigerators for their personal food. She stated she had never been told the CNAs were responsible for cleaning the resident refrigerators. She stated she thought the kitchen staff were responsible to clean the resident refrigerators. She stated she had been told to label and date foods they put in the resident refrigerators. She stated both refrigerators on the east and west were resident refrigerators. Record review of the facility policy titled, Special Meal Arrangements and Guest Tray Policies, dated [DATE], revealed the following documentation, . Food may be brought to the facility by family and visitors. The facility is responsible for storing food brought in by family or visitors in a way that is separate and distinguishable from facility food. The facility is responsible for helping family and visitors understand safe food handling practices. Facility staff must use safe food handling practices. Record review of the facility policy titled Eating /Drinking in Food Service Areas , dated [DATE], revealed the following documentation, . The Food Service manager will encourage the use of employee break rooms for staff use. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the facility policy titled Cleaning and Sanitation of Food Service Areas and Equipment dated [DATE], revealed the following documentation, . The Food Service Department will clean and sanitize the food service area and any equipment used daily and weekly by following the daily and weekly cleaning schedule provided by the Food Service Manager. The facility will follow proper cleaning procedures on all equipment used. Record review of the facility policy titled Food Storage, Food Safety in Display and Service , dated [DATE], revealed the following documentation, . While being stored, served . food shall be protected from potential contamination, including dust, insects, unclean equipment and utensils, unnecessary handling, coughs, and sneezes, Food will be stored in a clean covered container when not in use or preparation.