STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. Building B. Wing	11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Villa	1100 East Montclair Springfield, MO 65807

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on observation, interview, and record review, the facility failed to provide selected food and beverage choices for six residents (Resident #51, #92, #71, #84, #83, and #89) out of a total of 20 sampled residents and 10 supplemental residents when residents' food preferences and selections for meals documented on their tray cards were not followed. The facility census was 94. 1. During an interview on 11/19/23, at 9:42 A.M., the Dietary Manager (DM) said residents were provided meal choices daily and utilized an Anytime menu. When breakfast trays were distributed, residents were sent paper menus with the meal selections for lunch and dinner that day and for breakfast the following day. Residents marked on the paper menus which foods and beverages they wanted, and the menus were returned to the kitchen via the residents' returned breakfast trays. When the menus were received in the kitchen after breakfast, she wrote the residents' selections on their tray cards for lunch, dinner, and breakfast the next day. 2. Review of Resident Council Minutes, dated June 2023 to November 2023, showed concerns with residents' food/beverage selections: -Resident Council Minutes, dated 06/02/23, under food concerns showed, Staff not paying attention to menus, getting things on tray not ordered, anytime menu always the same. -Resident Council Minutes, dated 08/04/23, under food concerns showed, need more vegetable choices on anytime menu; -Resident Council Minutes, dated 11/03/23, under food concerns showed, . orders not followed. 3. Review of the Resident #92's Face Sheet, undated, in the electronic medical record (EMR) under the Resident tab showed the resident was admitted to the facility on [DATE]. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), with an assessment reference date (ARD) of 10/24/23, in the EMR under the RAI (Resident Assessment Instrument) tab, showed the resident's cognition was intact. During an interview on 11/19/23, at 11:49 P.M., the resident said he/she did not like oatmeal, and this was reflected on his/her tray card. He/She had been served oatmeal that morning. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observations on 11/21/23, at 7:54 A.M. showed the resident showed the surveyor his/her breakfast tray which was observed to include apple juice. The resident said he/she did not like apple juice and it was supposed to be cranberry juice instead. The resident had not received cranberry juice. Review of the resident's tray card for breakfast, dated 11/21/23, showed cranberry juice had been handwritten onto the card. 4. Review of Resident #71's Face Sheet, undated, in the EMR under the Resident tab, showed the resident was admitted to the facility on [DATE]. Review of the resident's quarterly MDS, with an ARD of 10/4/23, in the EMR under the RAI tab, showed the resident's cognition was intact. During an interview on 11/19/23, at 12:22 P.M., in the dining room during lunch, the resident said he/she had ordered a ham sandwich for lunch that day. He/She showed the surveyor the meal he/she had been served which included a thick piece of pork and a dry hamburger bun. The resident said he/she was served the pork with hamburger bun instead of a ham sandwich. He/she said he/she could not eat a dry piece of pork on a plain bun. The ham sandwich was documented on the resident's tray card. 5. Review of Resident #84's Face Sheet, undated, in the EMR under the Resident tab, showed the resident was admitted to the facility on [DATE]. Review of the resident's quarterly MDS, with an ARD of 11/13/23, in the EMR under the RAI tab, showed the resident had moderately impaired in cognition. Observation during lunch meal service on 11/20/23, at 12:25 P.M., showed the resident's tray card read, No pork. Staff served the resident the main entree which was a bowl of ham (pork) and beans. 6. Review of Resident #83's Face Sheet, undated, in the EMR under the Resident tab, showed the resident was admitted to the facility on [DATE]. Review of the resident's quarterly MDS, with an ARD of 08/16/23, in the EMR under the RAI tab, showed the resident had severely impaired in cognition. Observation during lunch meal service on 11/20/23, at 12:26 PM, showed the resident's tray card read, No pork. Staff served the resident the main entree which was a bowl of ham and beans. 7. Review of Resident #89's Face Sheet, undated, in the EMR under the Resident tab, showed the resident was admitted to the facility on [DATE]. Review of the resident's quarterly MDS, with an ARD of 11/02/23, in the EMR under the RAI tab, showed the resident had severely impaired in cognition. Observation during lunch meal service on 11/20/23, at 12:26 PM, showed the resident's tray card read, finger foods. Staff served the resident the regular lunch consisting of a bowl of ham and beans, boiled potatoes, cooked cabbage, a piece of cornbread, and canned mandarin oranges in syrup in a dessert cup. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/21/23, at 8:27 A.M., the DM said the resident should have been served sandwiches for lunch and other foods that could be picked up and eaten with her hands. The regular diet of ham and beans, cabbage, boiled potatoes, and mandarin oranges should not have been served to the resident. 8. Review of Resident #51's quarterly MDS in the EMR under the MDS tab, showed the resident's cognition was intact. During an interview on 11/19/23, at 5:28 P.M., the resident said that the kitchen staff gives him a meal menu card each day so he can select his choice of foods offered on the menu. He/she said, I may as well not select anything because the staff never get my choices right. Observation of the resident's breakfast meal on 11/21/23, at 9:27 A.M showed it included oatmeal. Review of the resident's menu card indicated to not serve him/her oatmeal and he/she preferred cold cereal with milk. 9. During an interview on 11/21/23, at 8:27 A.M., the DM said ham was pork and residents such as Resident #83 and Resident #84 should not be served ham. 10. During an interview on 11/21/23, at 3:18 P.M., the Registered Dietitian (RD) said dietary staff should serve residents the selections they made on their menus. 11. During interviews on 11/21/23 at 4:51 P.M. and at 6:17 P.M., the Administrator stated he was aware of some of the residents' concerns about the food/dietary services and the facility should offer food/beverage choices to residents that they have selected. The facility did not have a policy addressing residents' choices. 36917

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11599 Based on observations and interviews, the facility failed to provide a homelike environment to all residents when one resident (Resident #56) had a dresser with a broken drawer; when two residents (Residents #51 and #88) had broken blind slats; and when staff failed to maintain the Memory Care Unit in good repair. The sample size was 20 residents with a facility census of 94. 1. Observation and interview on 11/19/23, at 4:25 P.M., showed Resident #56's dresser drawer had a broken front panel on the right side of the dresser that prevented the resident from opening the drawer. The resident said he/she had requested several times that the drawer be repaired, but it was still broken. The drawer contained personal items and the resident was not able to open the drawer to access them. During an interview on 11/21/23, at 2:55 P.M. the Maintenance Director said that she was aware the resident's dresser needed repair. 2. Observation and interview on 11/19/23, at 5:28 P.M., showed Resident #51's room had five broken window blind slats that prevented closing the blinds for privacy. The resident said he/she had requested several times that the window blinds be repaired, but was told by the facility Maintenance Director that they do not have the budget to fix the blinds. During an interview on 11/21/23, at 2:55 P.M., the Maintenance Director said she was aware that window blinds in seven different rooms were broken and in need of repair, including the resident's window blind. 3. Observation on 11/19/23, at 9:48 A.M., showed the window blinds in Resident #88's room were noted to have broken and missing slats. Observation on 11/20/23, at 11:38 A.M., showed the resident was in his/her room, seated on his/her bed, fidgeting with the linens. The window blinds were closed. There was an approximately six-inch gap with an additional four broken slats that were broken preventing privacy. During an interview on 11/21/23, at 1:00 P.M., the Maintenance Director confirmed the blinds were broken and needed replaced. During an interview on 11/20/23, at 4:12 PM, the resident's family member said he/she would be glad if the blinds were fixed, they've always been broken. 4. Observations on 11/19/23, at 9:53 A.M., of the Secured Dementia Care Unit showed the following: -Window blinds in the dining room had numerous slats that were broken, broken in half, and missing; -We window blinds, on an exterior door by room [ROOM NUMBER], had broken slats; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The baseboard outside the tub/shower room, across from the nurses' station, was missing exposing wall damage; -Three overhead lights were burnt out on the hallway starting with room [ROOM NUMBER]. During an interview on 11/21/23, at 1:00 PM, the Maintenance Director confirmed the blinds were broken, the baseboard was missing, and the light bulbs were burnt out and stated. 5. Review and interview showed the facility's routine maintenance logs, including weekly, monthly, and yearly system checks, showed no routine check of the window blinds. The Maintenance Director said, on 11/21/23, at 1:00 PM, that she checked with the nursing staff every morning and relied on them to inform her of concerns. 6. During an interview on 11/21/23, at 1:10 P.M., Licensed Practical Nurse (LPN) #4 said the unit had a maintenance logbook to enter concerns or staff would just tell the maintenance director.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on interview and record review, the facility failed to ensure one resident (Resident #92), out of five sampled residents, resuscitation status as in accordance with the resident's and resident's wishes. The facility census was 94. Review of theCardiopulmonary Resuscitation (CPR - lifesaving technique that's useful in many emergencies in which someone's breathing or heartbeat has stopped), undated, document provided by the facility showed the following: -Purpose to establish circulation on a resident with absence of respirations and pulse; -Do not initiate CPR if a valid DNR (resident did not wish to receive CPR) order is in place. Review of the Advance Directive document, undated, provided by the facility showed the following: -The facility will respect advance directives in accordance with state law; -The facility has defined advanced directives as preferences regarding treatment options and include, but are not limited to DNR. 1. Review of Resident #92's Face Sheet, undated, in the electronic medical record (EMR) under the Resident tab showed the following: -admitted [DATE]; -Resident was Full Code (wished to receive CPR); -The resident had a diagnosis of unspecified B-cell lymphoma (cancer). Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment completed by facility staff) with an assessment reference date (ARD) of [DATE], in the EMR under the RAI (Resident Assessment Instrument) tab, showed the resident's cognition was intact. Review of resident's physician's Active Orders, dated [DATE], in the EMR under the Resident tab showed a current order for resident to be full code. Review of the resident's Health Care Directive, Durable Power of Attorney for Health Care (DPOA - document by which a person appoints a person to act as his/her agent), dated [DATE], in the EMR under the Documents tab and signed by the resident showed the following: -The resident did not desire to have his/her unduly prolonged by the initiation or continuance of life-sustaining medical procedure or treatment in any of the following circumstances: (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If the resident had a condition, disease, or other medical problem which is incurable or irreversible and which, without life-sustaining treatment, will or is reasonably expected to result in death within a relatively short period of time; -If the resident's body can no longer sustain respiration, circulation and/or nutrition without artificial aide; - Two family members were designated as joint DPOA for health care. Review of the resident's Outside The Hospital Do-Not-Resuscitate (OHDNR) Order, dated [DATE], showed the following: -The resident's family member, who was joint DPOA, signed the document directing staff not to resuscitate the resident in the event he/she suffered cardiac or respiratory arrest; -The physician had not signed the form. During an interview on [DATE], at 3:06 P.M., the Social Service Director (SSD) said the facility was waiting on the resident's physician to sign the OHDNR order. The SSD stated if the resident went into cardiac or respiratory arrest now, the facility would conduct CPR since the OHDNR form had not been signed by the physician and it was not valid. During an interview on [DATE], at 3:44 P.M., the SSD stated there was a folder for documents the physician was to sign and the OHDNR was in the folder. The SSD had also given the resident;s OHDNR form to the physician twice since it was signed by the family on [DATE]; however, it had not been signed by the physician. During an interview on [DATE], at 12:37 P.M., the Assistant Director of Nursing (ADON) said the resident's status was full code. The ADON stated the resident's physician came to the facility every two weeks, and it did not typically take this long for the OHDNR to be signed by the physician. During an interview on [DATE], at 5:13 P.M., the Administrator said the physician had been in the facility after the resident's OHDNR form was filled out and he was not sure why it had not been signed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11599 Based on observation, interview, and record review, the facility failed to ensure an environment free of accident hazards for all residents when the staff failed to lock two tub/shower rooms in the dementia care unit where one resident (Resident #75), of 13 sampled residents, wandered continuously and routinely pushed on doors throughout the dementia care unit. The facility census was 94. 1. Review of Resident #75's Census Record, located under the Resident Census tab of the electronic medical record (EMR), showed the following: -admitted [DATE]; -Diagnoses included Alzheimer's disease early onset. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), with an assessment reference date (ARD) of 11/02/23 and located under the MDS tab of the EMR, showed the resident was severely cognitively impaired and a wanderer. Review of the resident's Care Plan, dated 11/02/23, showed the following: -Tendency for wandering (moves with no rational purpose, seemingly oblivious to needs or safety); -The goal was noted as I will not injure/harm myself secondary to wandering through next review; -Interventions included redirect me from other resident's rooms and unsafe situations. Review of the resident's Wandering or Elopement Risk Assessment, dated 11/02/23, showed the resident was identified as a high risk due to history of wandering, confusion, paces, disorientation, cognitively impaired, restlessness, depression, and medications. Observation of the resident on the secured dementia care unit showed the following: -On 11/19/23, at 9:58 A.M., the resident was observed wandering about the unit, up and down the two halls, pushing on the locked doors; -On 11/19/23, at 10:18 A.M., the tub/shower room door was not locked. The door had a key punch locking mechanism on the outside of the door. Inside the tub/shower room was a shaving razor on top of a can of shaving cream, body wash, curling iron, hair dryer, and an unlocked cabinet with a second shaving razor inside on the shelf; -On 11/19/23, at 10:20 A.M., the resident was observed wandering about the unit, frequently pushing on the exit doors; -On 11/19/23, at 10:34 A.M., the resident was observed following staff in and out of rooms and up and down the halls; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 11/19/23, at 10:47 A.M., the resident was observed to move very quickly toward the exit in an attempt to follow a staff member off the unit. The resident immediately turned and entered the tub/shower room which was unlocked. At the time of the observation, the Nurse Aide (NA) 1 and the Licensed Practical Nurse (LPN) 1 were not visible on the unit; -On 11/19/23, at 12:09 PM, housekeeping was observed cleaning the tub/shower room. Upon exiting the room, the door was not completely closed which did not lock, therefore the door was easily pushed open; -On 11/19/23, at 12:29 PM, the two tub/shower room remained unlocked. Both rooms had unlocked shaving razors, body wash, and equipment stored in the rooms; -On 11/20/23, at 11:33 AM, the resident was observed wandering throughout the secured unit, pushing on exit doors. The tub/shower rooms were observed to be unlocked; -On 11/20/23, at 11:45 AM, the resident was observed wandering about the unit, up to the nurses' station, and was noted to be holding her left side. LPN 4 took the resident by the hand into the tub/shower room to assess the resident. Upon leaving the tub/shower room, LPN 4 did not ensure the door was closed completely and locked; -On 11/20/23, at 12:47 P.M., the tub/shower rooms remained unlocked. The rooms contained shaving razors, shaving cream, shampoo, conditioner, body wash, hair dryers, curling irons, and stored equipment. During an interview on 11/20/23, at 1:35 P.M., LPN 4 said the resident is always looking to get out the doors. During an interview on 11/21/23, at 1:20 P.M., with LPN 4 and CNA 1, LPN 4 said he/she tried to make sure the tub/shower rooms are locked. During an interview on 11/21/23, at 4:50 P.M., with the Director of Nurses (DON), Assistant Director of Nurses (ADON), and the MDS Coordinator (MDSC), the staff members confirmed that all staff needed to lock the tub/shower rooms to prevent potential accidents. During an interview on 11/21/23, at 11:30 A.M., the Administrator said they did not have a policy on locking the tub/shower room.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on observation, interview, and record review, the facility failed to ensure there was sufficient staffing of the dietary department to ensure timely meal service for all residents when meals were served late to all units due to staffing shortages in the dietary department. The facility census was 94. Review of the document titled Mealtimes, provided by the facility, showed the following: -Breakfast 7:00 A.M. to 8:15 A.M.; -Lunch 11:30 A.M. to 1:00 P.M.; -Dinner 5:00 P.M. to 6:15 P.M. 1. During an interview on 11/21/23, at 8:27 AM, the Dietary Manager (DM) said the serving order of the meal carts was the Secure Unit, the Dining Room, Love 1 (100 hall), Hope (200 - 300 halls), and Love 2 (100 hall). 2. Review of Resident Council Minutes, dated 11/03/23, showed residents voice a concern with ,mealtimes getting later. 3. Review of Resident #34's Face Sheet, undated, in the electronic medical record (EMR) under the Resident tab showed the resident was admitted to the facility on [DATE]. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff) with an assessment reference date (ARD) of 10/16/23 in the EMR under the RAI tab, showed the resident's was cognition was intact. During an interview on 11/19/23, at 5:13 PM, the resident said the food was always late. 4. Review President #51's Face Sheet, undated, in the EMR under the Resident Tab showed the resident was admitted to the facility on [DATE]. Review of the resident's quarterly MDS with an ARD of 08/27/23 in the EMR under the RAI tab, showed the resident was cognitively intact. During an interview on 11/19/23. at 5:28 P.M., the resident said the food was always late. 5. Review of Resident #22's Face Sheet, undated, in the EMR under the Resident Tab showed the resident was admitted to the facility on [DATE]. Review of the resident's quarterly MDS with an ARD of 11/20/23 in the EMR under the RAI tab, showed the resident was moderately impaired in cognition. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/19/23, at 12:50 P.M., the resident said he/she was, so hungry. The resident was in his/her room waiting for lunch to be served and said lunch was late. The resident said he/she should be served lunch by 12:00 P.M. and no later than 12:30 P.M. 6. Observations showed the following: -On 11/19/23, the trays for the secure unit arrived at 12:15 P.M. (45 minutes after the posted mealtime). The secure unit was the unit whose meal trays were served first. The trays for Love 1 (first cart to 100 hall) arrived at the unit at 12:40 PM. (an hour and 10 minutes after the posted mealtime). There were two more carts and approximately 60 residents still to be served (Hope and Love 2) after 12:40 PM. -On 11/20/23, observations of tray line meal service showed the first tray was served at 12:20 P.M. (50 minutes after the posted mealtime of 11:30 A.M.) The trays for the secure unit arrived at 12:32 P.M. (over an hour after the posted mealtime). The last resident served on Love 1 received their tray at 1:29 P.M. (30 minutes after the end of the meal service time. The Hope cart and Love 2 cart, serving approximately 60 residents, had not yet been delivered as of 1:29 P.M. 7. During an interview on 11/20/23, at 12:32 P.M., Licensed Practical Nurse (LPN) 4 said the meals could come anytime between 11:30 A.M. and 12:30 P.M. The secure unit was the first unit to be served. 8. During an interview on 11/21/23, at 8:27 A.M., the Dietary Manager (DM) said on 11/19/23, she was short two staff during the day, a prep cook and a drink aide. She was not able to find a replacement for either position. She covered the shifts on 11/19/23. They were short two staff on 11/20/23 as well during the day and she could not find a replacement for either position. She tried to cover these two shifts on 11/20/23 in addition to fulfilling her DM responsibilities. The DM said the meals were late on 11/19/23 and 11/20/23 due to staffing shortages in the dietary department. 9. During an interview on 11/21/23, at 4:51 PM, the Administrator stated he was aware of staffing concerns in the dietary department. He stated the facility had been reviewing applicants and had ongoing recruitment efforts in place.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Villa	1100 East Montclair Springfield, MO 65807

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on observation, interview, and record review, the facility failed to prepare and serve palatable food to seven residents (Residents #92, #71, #34, #51, #12, #28, and #200) out of a total of 20 sampled residents and 10 supplemental residents, when the food was not hot, not flavorful, overcooked, and served without seasoning and/or without condiments when residents received their meal trays. The facility census was 94. Review of the facility's policy titled Food Temperatures, dated May 2015, showed hot foods should be at least 120 degrees F (Fahrenheit) when served to the resident. Review of the facility's policy titled Food Preparation and Distribution, dated May 2015, showed the Dining Services Department will prepare foods by methods that are safe and sanitary while conserving nutritive value as well as enhancing flavor. Food is prepared by methods that conserve nutritive value, flavor, and appearance. 1. Review of Resident Council Minutes, dated July 2023 to November 2023, showed the following: -Resident Council Minutes, dated 07/07/23, under food concerns noted boneless skinless chicken was awful and room trays were being served cold; -Resident Council Minutes, dated 08/04/23, under food concerns noted grilled ham and cheese underdone; -Resident Council Minutes, dated 11/03/23, under food concerns noted condiments not on carts. 2. Review of Resident #92's Face Sheet, undated, in the electronic medical record (EMR) under the Resident tab, showed the resident was admitted to the facility on [DATE]. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment complete by facility staff), with an assessment reference date (ARD) of 10/24/23 in the EMR under the RAI (Resident Assessment Instrument) tab, showed the resident cognitively intact. During an interview on 11/19/23, at 11:49 P.M., the resident said the food was not hot when he/she received meals served in his/her room. 3. Review of the Resident #71's Face Sheet, undated, in the EMR under the Resident tab, showed the resident was admitted to the facility on [DATE]. Review of the resident's quarterly MDS, with an ARD of 10/04/23, in the EMR under the RAI tab, showed the resident's cognition was intact. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/19/23, at 12:22 P.M., in the dining room during lunch, the resident showed the surveyor the meal he/she had been served which included a thick piece of dry pork and a plain hamburger bun. The resident said he/she had ordered a sandwich. The resident said she could not eat the pork on a hamburger bun without mayonnaise. The sandwiches are served without mayonnaise, mustard, lettuce, tomato, etc. and it was unappetizing. During an interview on 11/21/2,3 at 8:27 A.M., the Dietary Manager (DM) said the meat sandwiches consisted of bread and meat only. If a resident wanted mayonnaise, mustard, lettuce, tomato, or cheese on their sandwich, this had to be requested because it did not come on or with the sandwich. 4. Review of Resident #34's Face Sheet, undated, in the EMR under the Resident tab, showed the resident was admitted to the facility on [DATE]. Review of the resident's quarterly MDS, with an ARD of 10/16/23, in the EMR under the RAI tab, showed the resident was cognitively intact. During an interview on 11/19/23, at 5:13 P.M., the resident said The food is terrible. It is always cold. 5. Review Resident #51's Face Sheet, undated, in the EMR under the Resident tab, showed the resident was admitted to the facility on [DATE]. Review of the resident's quarterly MDS, with an ARD of 08/27/23, in the EMR under the RAI tab showed the resident's cognition was intact. During an interview on 11/19/23, at 5:28 P.M., the resident said the food was not good. 6. Review of Resident #12's Face Sheet, undated, in the EMR under the Resident tab, showed the resident was admitted to the facility on [DATE]. Review of the resident's quarterly MDS, with an ARD of 11/06/23, in the EMR under the RAI tab, showed the resident's cognition was intact. During an interview on 11/19/23, at 12:22 P.M., in the dining room during lunch, the resident said, The food is not good and further said it was very starchy. 7. Review of Resident #200's Face Sheet, undated, in the EMR under the Resident tab, showed the resident was admitted to the facility on [DATE]. Review of the resident's admission MDS, with an ARD of 11/15/23, in the EMR under the RAI tab showed the resident's cognition was intact. During an interview on 11/19/23, at 12:28 P.M., in the dining room during lunch, the resident said the food was bland and the oven baked chicken he/she was recently served was too tough to eat. 8. Review of Resident #28"s Face Sheet, undated, in the EMR under the Resident tab, showed the resident was admitted to the facility on [DATE]. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the the resident's quarterly MDS, with an ARD of 09/03/23, in the EMR under the RAI tab, showed the resident's cognition was intact. During an interview on 11/19/23, at 11:26 A.M., the resident said the food did not taste good and the meat was like shoe leather. His/her meals were not hot when he/she received his/her trays. 9. Observations on 11/20/23, of the lunch meal, showed served to the 100-hall showed the following: -The cart contained approximately 25 trays on the food; -The distribution of all the meals from the food cart were observed; -One resident was offered margarine to go with the corn bread; -None of the residents were observed to be offered the salt and pepper packets that were available on top of the cart; -The trays did not include margarine,salt, or pepper; -The main meal consisted of ham and beans, cooked cabbage, corn bread, fried potatoes, and canned mandarin oranges. During an interview on 11/20/23, during the lunch meal service on 100-hall, the DM verified the nursing staff had not provided salt, pepper, or margarine that was available on the food cart when residents were served their meals. 10. Observation and interview on 11/20/23, at 1:29 P.M., of a test tray showed the following: -The mashed potatoes with gravy were gray tint, bland, and pasty in texture. The DM verified the potatoes were bland and stated the cooks should add salt according to the recipes. -The puree cabbage was 114 degrees F and had pieces of cabbage that required chewing. It was not a smooth consistency. It was lukewarm to the palate and bland. The DM stated the cabbage texture was not correct. It should have been smooth in texture and without pieces requiring chewing. The DM verified it was bland and lukewarm; -The regular cabbage was 92 degrees F and was cool to the palate which was verified by the DM; -The fried potatoes were 112 degrees F and were lukewarm and bland. The DM verified the potatoes were not hot enough and lacked seasoning; -The mandarin oranges were 50 degrees F. The DM stated they should be colder. 11. During an interview on 11/21/23, at 3:18 P.M., the Registered Dietitian (RD) said dietary staff should follow the recipes/menu when preparing food. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12. During an interview on 11/21/23, at 4:51 P.M., the Administrator said he was aware of some of the residents' concerns about the food/dietary services. The Administrator stated residents should be offered condiments.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on observation, interview, and record review, the facility failed to ensure proper food service practices were implemented in the kitchen to prevent the potential spread of food borne illness to all residents receiving meals in the facility when four residents (Residents #92, #200, #7, and #33) were served over easy non-pasteurized eggs creating risk for salmonella (bacteria) food borne illness; when bulk foods and refrigerated shakes were not labeled; when the dishwasher's wash temperature was below the minimum required temperature; when food from significantly dented cans was served, and when a dietary staff member failed to wear a hair covering in the kitchen. The facility census was 94. Review of the facility's policy titled Safe Food Handling, dated May 2015, showed the following: -Dietary employees will follow safe food handling guidelines to prevent the spread of foodborne illness; -Potentially hazardous foods should be thawed in the refrigerator; -Food items are to be labeled and dated when removed from the freezer to be thawed; -All food, including bulk items, should be tightly sealed with an identifying label and date. Review of the facility's policy titled Dish Machine Temperature, dated May 2015, showed the following: -To ensure that the wash and rinse temperatures are properly monitored and controlled, a log must be completed by those who are directly involved in the dishwashing process; -Entries must be made for each meal; -Actual wash and rinse temperatures must be observed and logged at the beginning of the dishwashing period by the dish machine operator; -Report temperatures that are below the required levels to the DSM (Dietary Service Manager) immediately; -Chemically sanitized machines should be checked daily with test strip. Review of the facility's policy titled Dietary Personnel Guidelines, dated May 2015, showed hairnets or bouffant disposable caps should be worn at all times and should cover the entire head of hair. Review of the facility's policy titled Food Purchases, dated May 2015, showed leaking or severely dented cans should be disposed of promptly. 1. Observations on 11/19/23, from 9:26 A.M. to 10:09 A.M., showed the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Dietary Aide (DA) 1 was washing dishes using the commercial dishwasher. The manufacturer's name plate affixed to the exterior of the machine showed the minimum wash and rinse temperatures were both 120 degrees Fahrenheit (F) and the minimum level of chlorine chemical sanitizer, was 50 parts per million (PPM). Two cycles of dishwashing were observed. Observation of the first cycle showed the wash temperature was 100 degrees F and the wash temperature of the second cycle was 110 degrees F. The temperatures were verified by DA 1, who showed the surveyor the dish machine temperature log and the wash temperature were consistently 110 degrees F. -Two large bins of bulk food, which had been removed from the original packaging, were observed in the kitchen without labels on the bins specifying what the contents was. Each contained a white food. The contents of the first bin looked like flour or cornstarch and the contents of the second bin looked like white sugar or salt. -At 9:42 AM, the Dietary Manager (DM) arrived in the kitchen and was not wearing a hairnet/hair covering during the inspection that occurred throughout the kitchen; -During an observation in the walk-in refrigerator, there were four boxes of individual serving cartons of health shakes in different flavors. There was no label on the boxes, on the shakes, or anywhere else identifying when they were pulled out of the freezer and placed into the walk-in refrigerator. The DM said their practice was to remove boxes of the shakes from the freezer and place them on the counter in the kitchen, at room temperature, for a few hours to thaw and then to transfer them into the walk-in refrigerator; -Observation in the dry store room showed a can of black eye peas that was significantly dented along the top seam. This can was in the can rack and had not been set aside to be returned to the vendor. There was no area in the dry storeroom that was labeled for dented cans that were not to be used. Observations on 11/20/23, 11:23 A.M. through 12:03 P.M., of the kitchen showed the following: -Two bins of bulk white foods lacked labels specifying the contents. The DM said one bin contained flour and the other one contained white sugar. The DM verified the labels for the bulk foods were no longer present and the foods could have more than one identity; -DA 1 had four cans of mandarin oranges on the counter and had opened two of them. DA 1 was dishing up oranges from the opened, dented cans into individual dessert cups for lunch. The two cans that had been opened had large, significant dents along the top and/or bottom seams and in the middle. DA 1 said he/she was allowed to use dented cans if the cans were not punctured. The DM, who was present, stated normally she placed dented cans on the top shelf in the dry storeroom to be returned to the vendor; however, she was aware of how the cans became dented. The DM stated the cans of mandarin oranges were dropped when the order came in and were okay to be used; -The DM and surveyor entered the dry storeroom. The dented can of black eye peas continued to be on the can rack. The DM stated the dent was significant and removed the can and placed it on another shelf. The area where she placed the dented can was not labeled for dented cans or foods to be returned; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-During an observation in the walk-in refrigerator, the four boxes of health shakes remained in their respective boxes on the shelves without labels. The DM and surveyor looked at the label of one of the individual cartons which read, Discard after 14 days. The DM stated the dietary staff had not been labeling shakes when they were pulled from the freezer and placed into the walk-in refrigerator and had not known the shelf life once placed in the refrigerator was 14 days; -A cycle of dishwashing was observed, and the temperature of the wash cycle was 110 degrees F. Review the temperature log, dated November 2023, showed all the wash temperatures were 110 degrees F and DA 1 stated that was the normal wash temperature. During an interview on 11/21/23, at 8:27 A.M., the DM verified the dish machine temperature log showed wash temperatures of 110 degrees F were recorded consistently for the month of November 2023. The DM stated she was not aware the wash cycle was running at 110 degrees F. The DM verified the wash temperature should be at least 120 degrees F. The DM stated staff were supposed to, but had not, let her know if the machine temperatures were not within specifications. The DM stated the vendor had not been called to look at the dish machine. During the interview on 11/21/23, at 8:27 PM, the DM stated she had just come into the kitchen to meet with the surveyor and did not get her hairnet donned. The DM verified she completed the kitchen inspection without wearing a hair net/covering; however, should have been wearing one. The DM stated staff should apply hair nets before they enter the kitchen. 2. Review of the facility's policy titled Safe Food Handling, dated May 2015, showed the following: -Egg guidelines prohibit uncooked eggs in uncooked products. Use only pasteurized egg products. Review of the FDA (Food and Drug Administration) Food Code dated 2023 showed the following: -Eggs that have not been specifically treated to destroy all viable Salmonellae shall be labeled to include safe handling instructions; -In a food establishment that serves a highly susceptible population pasteurized eggs or egg products shall be substituted for raw eggs in the preparation of soft-cooked eggs that are made from raw eggs. Observation on 11/19/23, at 9:49 A.M., with the DM, showed there were two boxes of whole shell eggs in the walk-in refrigerator. One box was labeled, Pasteurized. The box was sealed and none of the eggs had been used. The second box did not have a label indicating the eggs were pasteurized and had a label that read, Safe Handling Instructions: To prevent illness from bacteria: Keep eggs refrigerated, cook eggs until yolks are firm, and cook foods containing eggs thoroughly. The box of unpasteurized eggs was open and approximately two thirds of the eggs had been used. The DM verified the second box did not have a label indicating the eggs were pasteurized and acknowledged the Safe Handling Instructions printed on the exterior of the box. The DM stated the food vendor must have substituted regular whole shell eggs for pasteurized eggs because she had ordered pasteurized eggs. The DM stated all whole eggs should be pasteurized. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observations on 11/21/23, at 7:06 A.M., of the kitchen showed [NAME] 1 said he/she had already prepared the over easy eggs for breakfast and they were currently in the steam table. [NAME] 1 was preparing fried eggs on the grill and stated these would be the over hard eggs. There was a box of non-pasteurized whole eggs sitting on the counter and [NAME] 1 stated she used this box of eggs to prepare the over easy and over hard eggs. [NAME] 1 stated there were about five residents who ordered over easy eggs every day. [NAME] 1 verified there was no label on the box of eggs indicating the eggs were pasteurized and that there was a Safe Handling Instruction warning label on the exterior of the box of whole shell eggs. Observations on 11/21/23, at 7:08 A.M., of the walk-in refrigerator, showed one box of whole shell eggs: the unopened box of whole shell pasteurized eggs. 3. Review of Resident #200's Face Sheet, undated, in the electronic medical record (EMR) under the Resident tab showed the resident was admitted to the facility on [DATE]. Review of the the resident's admission Minimum Data Set (MDS - a federally mandated assessment completed by facility staff) with an assessment reference date (ARD) of 11/15/23 in the EMR under the RAI tab, showed the resident's cognition was intact. Observation and interview on 11/21/23, at 7:51 A.M., showed the resident was eating breakfast in the dining room. He/she said he/she had been served three over easy eggs for breakfast per his/her request. The yellow runny yolk from the over easy eggs was observed on the resident's plate. The resident's tray card indicated his request for over easy eggs. 4. Review of Resident #92's Face Sheet, undated, in the EMR under the Resident tab,s showed the resident was admitted to the facility on [DATE]. Review of the resident's admission MDS, with an ARD of 10/24/23, in the EMR under the RAI tab, showed the resident's cognition was intact. During an interview on 11/19/23, at 11:49 A.M., the resident said I get over easy fried eggs every day. During an observation on 11/21/23, at 7:54 AM, the resident had just been served breakfast in his/her room. The resident had two fried eggs on his/her plate. The resident poked the yolk of one of her eggs and the yolk of the egg was runny; the liquid yolk spread onto the plate. The resident stated, It is soft. The resident's tray card documented her request for over easy eggs for breakfast. 5. Review of Resident #7's Face Sheet, undated, in the EMR under the Resident tab, showed the resident was admitted to the facility on [DATE]. Review of the resident's quarterly MDS, with an ARD of 11/12/23, in the EMR under the RAI tab, showed the resident's cognition was intact. During an observation on 11/21/23, at 7:52 A.M., the resident had been served two over easy eggs for breakfast. One egg had a runny yolk and the resident verified over easy eggs were preferred. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. Review of Resident #33's Face Sheet, undated, in the EMR under the Resident tab, showed the resident was admitted to the facility on [DATE]. Review of the resident's quarterly MDS, with an ARD of 08/17/23, in the EMR under the RAI tab, showed the resident was moderately impaired in cognition. During an observation on 11/21/23, at 8:07 A.M., the resident said he/she received his/her breakfast tray with sunny side up eggs which he/she liked. The resident popped the egg yolk, and it ran onto the white of the egg. The resident proceeded to eat the egg. 7. During an interview on 11/21/23, at 8:11 A.M., [NAME] 1 and [NAME] 2 said they did not know of any requirements for use of non-pasteurized eggs. [NAME] 1 and [NAME] 2 said they prepared over easy eggs for residents who wanted them, and they had not been informed about needing to use pasteurized eggs when preparing over easy eggs. [NAME] 1 and [NAME] 2 said they would have to check with the DM to find out if there were restrictions on use of non-pasteurized eggs. 8. During an interview on 11/21/23, at 8:20 A.M., the DM said the dietary staff prepared and served over easy eggs daily. Normally they only purchased pasteurized eggs; however, the vendor had substituted in a box of unpasteurized eggs. The DM stated she was not aware that non-pasteurized eggs should not be used when serving eggs with runny yolks. She knew eggs contained salmonella and verified that was the reason pasteurized eggs were purchased. 9. During an interview on 11/21/23, at 3:18 P.M., the Registered Dietitian (RD) said that 120 F was the minimum wash temperature for a low temperature dish washer. If cans were significantly dented, the cans should be separated from the general can supply and should be returned to vendor. Pasteurized whole eggs should be used to make over easy eggs. She stated soft, cooked eggs did not get hot enough to kill salmonella, which could cause food borne illness. A a frozen item that was potentially hazardous should be thawed in the refrigerator or under cool running water. Shakes should be dated when they were removed from the freezer and placed into the walk-in refrigerator. Staff in the kitchen should be wearing hairnets/hair covering. Bulk foods removed from their original packaging should be in containers with labels identifying the bulk food. 10. During an interview on 11/21/23, at 4:51 P.M., the Administrator said he was not aware dietary staff had served undercooked unpasteurized eggs to residents and was not aware the dish machine wash temperature was too low.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 11599 Based on observation, interview, and record review, the facility failed to provide a sanitary environment for all residents, staff and public when staff failed to ensure one of two exterior doors, on the secured dementia care unit, had proper weather stripping to prevent cold air, rodents, or bugs from entering the facility. The facility census was 94. 1. Observations on 11/19/23, at 9:53 A.M., of the secured dementia care unit, showed two exterior doors leading from the lounge out to a courtyard were noted to be missing weather stripping allowing a gap approximately 3/4th inches between the doors and approximately 7/16th inches underneath the doors. Four live crickets were observed on the floor in the lounge and two live crickets were observed in the dining room attached to the lounge. During an observation on 11/19/23, at 11:38 A.M., two crickets were observed in the tub/shower room across from the nurses' station and one cricket was observed in the second tub/shower room. During an interview on 11/20/23, at 3:33 P.M., the Maintenance Director confirmed the gap in the doors and stated. During an interview on 11/20/23, at 3:58 P.M., with the Licensed Practical Nurse (LPN) 4 and the Certified Nurse Assistant (CNA) 1, each staff member confirmed the gap in the door and the potential for rodents and cold air to enter through the gap.