STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676255	A. Building B. Wing	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Worth Transitional Care Center	850 12th Avenue Fort Worth, TX 76104

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 44140 Based on observation, interview, and record review, the facility failed to ensure residents have a safe, clean, comfortable and homelike environment for 2 of 5 residents (Resident #37 and #49) reviewed for physical environment as evidenced by: The facility failed to ensure Resident #37 and #49's g-tube poles and floor were clean. These failures could place the three residents observed on g-tube feeding, at risk for the spread of infection and disease, a diminished quality of life and a diminished clean, homelike environment. Findings included: 1. Review of Resident #37's face sheet, dated 12/14/23, revealed the resident was a [AGE] year-old-female who admitted to the facility on [DATE] and readmitted on [DATE]. The resident's diagnoses included encounter for attention to gastrostomy (a surgical opening through the skin of the abdomen to the stomach), epilepsy (seizure disorder) and dysphagia (difficulty swallowing). Review of Resident #37's quarterly MDS assessment, dated 09/22/23, revealed her BIMS score was 0, indicative of severe cognitive impairment. Resident #37 nutritional approach was feeding tube. Observation on 12/12/23 at 11:04 AM revealed Resident #37 lying in bed sleeping. A feeding pump was next to Resident #37's bed but was not infusing. A bottle of enteral feeding was hanging from the pole with dried formula spills on the floor and pole. 2. Review of Resident #49's face sheet, 12/14/23revealed the resident was [AGE] year-old male admitted to the facility on [DATE] and readmitted [DATE]. The resident's diagnoses included attention to gastrostomy and dysphagia. Review of Resident #49's quarterly MDS assessment, dated 11/10/23, revealed her BIMS score was 00, indicative of severe cognitive impairment. Resident #49 nutritional approach was feeding tube. Observation on 12/12/23 at 11:31 AM revealed Resident #49 lying in bed sleeping. A feeding pump was next to Resident #49's bed, and it was infusing. A bottle of enteral feeding was hanging from the pole with dried formula feeding spills on the floor and pole. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/14/23 at 10:39 AM with Housekeeper C revealed she was the housekeeper assigned for the third floor short hall. She stated on her hall she had one resident with a feeding pole. She stated she had noticed Resident #37's floor and g-tube pole to be dirty. She stated she had cleaned it several times; however, the dried formula was hard to remove. She stated she had cleaned Resident #37's room and was scrubbing the floor and pole but the formula would not remove. She stated dried formula piled up. Housekeeper C stated at times the formula bottles leaks and when that happens, she would notify the nurse on the hall. She stated she was not sure if the facility had extra poles to hang the formula. Interview on 12/14/23 at 10:50 AM with CNA B revealed she was the CNA assigned to Resident #37. She stated g-tube poles are cleaned by housekeeping or the nurse on duty. She stated she had not noticed the g-tube poles being dirty. Observed CNA B enter Resident #37's, Resident #49's room and stated the g-tube poles and the floor around the g-tube poles were dirty and filthy. She stated she had not noticed the poles or the floors had dried formula when she assists the residents. She stated the potential risk of g-tube poles being dirty could be infection control. Interview on 12/14/23 at 11:01 AM with ADON D revealed g-tube poles are cleaned by housekeeping and the night shift staff. ADON D stated they should be sanitizing the poles. She stated she was unaware the poles and floors had dried formula. When asked about the potential risk, she stated there was no risk to the resident, but it was not good to look at. Interview on 12/14/23 at 2:42 PM with the DON revealed Central Supply staff were responsible for cleaning the g-tube poles. She stated they should be wiping them down. She stated the potential risk would be germs in the room and could cause resident to get sick. Interview on 12/14/23 at 3:47 PM with Central Supply revealed she was advised today (12/14/23) by staff that it was her responsibility to be cleaning the g-tube poles. She stated she was unaware when cleaning g-tube poles became part of her job. She stated prior to today (12/14/23) she was not aware that it was her responsibility. A policy for enteral feeding equipment was requested to the DON on 12/14/23 at 3:00 PM; however, it was not provided prior to exit.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on interview and record review, the facility failed to develop a baseline care plan within 48 hours of admission for 3 of 7 residents (Residents #12, #31, and #132) reviewed for baseline care plans. The facility failed to ensure Residents #12, #31, and #132 had a baseline care plan, or conversely a comprehensive care plan, within 48 hours of admission. These failures could place the residents at risk of having their needs and preferences met. Findings included: Review of Resident # 12's undated Admission Record revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included sick sinus syndrome (irregular heart beats and arrhythmia) requiring pacemaker placement, respiratory failure, and kidney failure. Review of Resident #12's admission MDS, dated [DATE], revealed a BIMS score of 5, indicating severe cognitive impairment. His Functional Status indicated he required assistance with all of his ADLs. Review of Resident #12's baseline care plan revealed it was not completed until 12/02/23. Review of Resident #31's undated Admission Record revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included bone infection to left foot and ankle resulting in toe amputation, and diabetes. Review of Resident #31's admission MDS, dated [DATE], revealed a BIMS score of 13, indicating he was cognitively intact. His Functional Status indicated he required minimal assistance with his ADLs. Review of Resident #31's baseline care plan revealed it was completed on 12/02/23. Review of Resident #132's undated Admission Record revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included traumatic brain injury resulting in loss of consciousness, inability to swallow requiring gastric tube placement, seizures, respiratory failure requiring trach placement, and diabetes. Review of Resident #132's admission MDS revealed it had not been completed at time of survey. Review of Resident #132's baseline care plan and her comprehensive care plan had not been completed. Resident's care plan only included one problem Social Isolation that was initiated on 12/11/23. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/14/23 at 2:00 PM MDS Coordinator I stated the baseline care plan needed to be completed within 48 hours to establish the resident's needs and desires. The baseline care plan was the responsibility of the admitting nurse. The MDS coordinators would then complete the admission MDS and create the comprehensive care plan based on needs identified in the MDS within 7 days of admission. Review of the facility's policy Baseline Care Plan, dated 10/22/22, reflected: The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. 1. The baseline care plan will: a. Be developed within 48 hours of a resident's admission

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on observation, interview, and record review, the facility failed to ensure a resident who was fed by enteral means received appropriate treatment and services to prevent complications for two (Resident #65 and #64) of four reviewed for feeding tubes. 1. The facility failed to follow physician's orders of providing Resident #65 with his 20 hours of feeding intake. 2. LVN F failed to provide Resident #64 her 10:00 AM bolus feeding as ordered by the physician. This failure could place residents at risk for a decline in health or adverse effects due to inappropriate management of G-tube care. Finding included: 1. Review of Resident #65's MDS dated [DATE] revealed he was a [AGE] year-old male admitted to the facility on [DATE]. The resident's diagnoses included anemia, quadriplegia, COPD, moderate protein calorie malnutrition, and encounter for attention gastrostomy (g-tube) a tube inserted through the belly that brings nutrition directly to the stomach. Resident #65 had a BIM of 3 (cognition severely impaired) and was sometimes understood. The MDS further reflected the resident had a feeding tube. Review of Resident #65's care plan initiated 07/20/23 revealed he required a feeding tube related to dysphagia, swallowing problem. The care plan further reflected the resident had a nutritional problem or potential nutritional problem related to ordered NPO with enteral feedings via Gtube. Goals included the resident will maintain adequate nutritional status as evidenced by maintaining weight and no signs/symptoms of malnutrition daily through the next review date. Review of Resident #65's December 2023 Order Summary Report reflected the following: Enteral Feed Order every shift (Jevity 1.5) at (50ML per hour) via G-tube stationary pump. Down time: (0800-1200) [8AM-12PM] Observation on 12/12/23 of Resident #65 at 10:07 AM revealed the resident was in bed with his eyes closed and his feeding pump was turned off. Further observation at 12:49 PM revealed the resident's feeding pump remained off and the resident remained with his eyes closed. Another observation at 3:04 PM revealed Resident #65's feeding pump was on and running at 50ML per hour and the formula bag had been dated 12/12/23 at 2:45 PM. Resident #65 has his eyes open at that time but he was not able to answer any questions related to his gtube and appeared to only answer simple questions. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 12/13/23 at 1:45 PM of Resident #65 revealed his feeding pump was turned off. LVN A was standing in front of the resident's room by her medication cart and she was asked about Resident #65's gtube down time and she stated she was waiting for 2:00 PM to connect him again. The LVN stated she was new and had only been working alone on that hall for three days and she thought she had read the orders as Resident #65's down time being from 8:00 AM to 2:00 PM therefore she had been disconnecting the gtube at 8:00 AM and connecting him back at 2:00 PM since Monday, 12/10/23. Observation on 12/13/23 at 3:49 PM of a witnessed weight for Resident #65 revealed he had not sustained any weight loss from his baseline weight. Interview on 12/14/23 at 2:24 PM with the DON revealed she was not aware LVN A had been not been connecting Resident #65 to his gtube at 12:00 PM per the physician orders. The DON said risks of not connecting residents' gtubes at the proper time could cause them to miss nourishment. Interview on 12/13/23 at 4:21 PM with the Dietitian revealed she was not aware staff were not reconnecting Resident #65's gtube per the physician orders. She stated based on the information given the resident only missed about 100ML of formula so it would not have been a significant amount but over a long period of time it could cause weight loss. 2. Review of Resident #64's face sheet, dated 12/14/23, reflected the resident was a [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included Gastrostomy (an opening in the stomach at the abdominal wall made surgically to introduce food), dysphasia (speech disorder), and eating disorder. Review of Resident #64's quarterly MDS assessment dated [DATE], revealed Resident #64 had a BIMS score of 02 which indicated severe cognitive impairment. Further review revealed Resident #64 nutritional approaches were feeding tube and mechanically altered diet. Review of Resident #64's care plan, revised date 08/14/23, reflected: Problem: The resident requires tube feeding. Gtube in place with enteral feedings ordered to supplement oral intake. Goal: The resident will be free of aspiration through the review date. The resident will maintain adequate nutritional and hydration status aeb weight stable, no s/sx of malnutrition or dehydration through review date. The resident will remain free of side effects or complications related to tube feeding through review date. Interventions: The resident needs total assist with tube feeding and water flushes. See MD orders for current feeding orders. The resident is dependent with tube feeding and water flushes. See MD orders for current feeding orders. Problem: The resident has a swallowing problem r/t dysphagia diagnosis. Gtube in place. Goal: The resident will not have injury related to aspiration through the review date. Interventions: Diet to be followed as prescribed. Resident to eat only with supervision. Problem: The resident has nutritional problem or potential nutritional problem r/t mechanical soft diet with thin liquids ordered. Resident has Gtube in place dx of dysphagia and to supplement oral intake. Goal: The resident will maintain adequate nutritional status as evidenced by maintaining weight, no s/sx of malnutrition, and consuming at least (50) % of at least (2) meals daily through review date. Interventions: Provide, serve diet as ordered. Monitor intake and record q meal. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #64's physician orders dated 10/23/23 revealed: Enteral Feed Order three times a day for nutrition. Jevity 1.5 tube feed bolus feeding via peg tube, 3 cans/day between meals at 10AM, 3PM, and 8PM. Start Date: 10/23/23. Review of Resident #64's physician orders, dated 09/28/23 revealed: Enteral Feed Order every 6 hours Flush tube with 30mL before and after each bolus feed. Start Date: 09/28/23. Review of Resident #64's December 2023 MAR revealed: Enteral Feed Order three times a day for nutrition. Jevity 1.5 tube feed bolus feeding via peg tube, 3 cans/day between meals at 10AM, 3PM, and 8PM. Start Date: 10/23/23. However, hours on the MAR reflected: 0900 (9:00AM), 1700 (5:00PM) and 2100 (9:00PM). Review of Resident #64's progress notes by the Dietitian on 12/11/23 at 13:28 [1:28PM] reflected: Note Text: RD weight change f/u - Resident's CBW of 118.8# indicates sig wt loss of -8% x30d. Wt stable x90d. UBW since admission has been 120#. Gained 7# last month then dropped from 129# to 118.8# x 3wks. Current diet order of reg/mech soft/thin. Feeds self in DR and eats 50-100% of meals. Supplemental enteral feedings also give. Jevity 1.5 bolus 3x/day with 30 ml flush before and after each bolus. Med reviewed- . Noted appetites stimulant. No new/recent labs for review. No wound noted. Per nurses' notes, some bolus feedings have been held d/t resident eating 100% of meal. Usually eats well per staff but does have some behaviors that may affect intake. Today resident was asleep at lunch table and needed encouragement/cueing from staff. Discussed w/nurse providing bolus no matter meal intake to help w/weight maintenance. Overall weight has not dropped below wt since admission. Recommend decreasing bolus feeding to BID d/t good appetite and po intake 75-100% of most meals, give no matter meal intake to ensure wt is maintained. Will provide additional 710kcal and 30g protein. Goals to maintain wt +/- 4%, to continue tolerance of bolus feedings and to honor food prefs as able. RD will continue to monito and f/uprn. Interview on 12/12/23 at 1:49 PM with Resident #64 revealed she had a g-tube and would get bolus feedings but could not recall when the last time she was provided with a bolus feeding. Resident #64 stated she could also eat food, and she had no concerns regarding her weight. Review of Resident #64's December 2023 MAR revealed the resident was provided with her bolus feeding on 12/13/23 at 9:00 AM by LVN F. Review of Resident #64's progress notes on 12/13/23 at 1:28 PM revealed no bolus feeding or refusal by Resident #64 documented. Interview on 12/13/23 at 1:48 PM with LVN F revealed she was the nurse for Resident #64. LVN F stated Resident #64 had a g-tube and could also eat food orally. A request to observe Resident #64's bolus feeding at 3PM was made; however, LVN F stated Resident #64's next bolus feeding was at 5PM. She stated Resident #64 had a bolus feeding at 9AM; however, she did not provide it to the resident due to resident's breakfast meal intake was 100%. LVN F reviewed Resident #64's orders and stated the resident's orders reflected bolus feedings at 10AM, 3PM and 8PM in between meals but the MAR reflected different hours. LVN F stated she would get clarification on the times. LVN F was asked if they had an order to hold bolus due to meal intake, and she stated no but would get clarification . LVN F stated Resident #64 is known to refuse her bolus feedings due to being full. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #64's progress notes dated 12/13/23 at 2:20PM by LVN F revealed PT [Resident #64] ate 100% of breakfast this am. Pt did not want bolus feeding d/t eating 100% of breakfast. Pt also [are] 90% of lunch. Effective Date 12/13/23 at 13:53(1:53PM). Observation and interview on 12/13/23 at 4:15 PM revealed Resident #64 lying in bed. Resident #64 was asked if she was provided with her bolus feeding this morning at 9:00AM, and she stated no . Resident #64 stated she had not refused her bolus feeding. Interview on 12/13/23 at 4:35 PM with ADON E revealed she was notified by LVN F regarding Resident #64 physician order did not reflect the correct times on the resident's MAR. She stated it was the responsibility of the Dietitian to provide the corrects times and the nurse who received the recommendations was responsible to put in the orders in PCC (electronic resident record system). She stated it was the responsibility of the ADONs to ensure the orders are put in correctly in PCC. ADON E stated Resident #64 should be provided with her bolus feedings as ordered. She stated staff could only hold bolus feedings when they have a physician order . ADON E stated if Resident #64 refused her bolus feeding it should be documented the bolus feeding was offered and refused in the progress notes. ADON E stated the Dietitian recommendation should had been worded differently. She stated they should have orders to hold feedings if Resident #64 eats 50% or more of her meals. ADON E stated Resident #64 could had been refusing her bolus feedings due to bolus times interfering with her mealtimes. When asked about the potential risk of not providing Resident #64's bolus feeding as ordered, she stated there was no risk due to Dietitian reviewed the orders and made no changes. She stated the Dietitian did not provide any concerns regarding the resident's weight. Follow up interview on 12/14/23 at 9:10AM with LVN F revealed yesterday morning (12/13/23) she did not offer Resident #64's bolus feeding at 9AM due to resident eating 100% of her breakfast. LVN F stated she was unaware of Resident #64's orders not being accurate in the resident MAR until she reviewed it yesterday. LVN F stated after reviewing the orders and the MAR she notified ADON E and new orders were put in. LVN F stated the dietitian provided the orders and the nurse who received the orders put in the wrong times in the MAR. LVN F was asked if they had orders to hold bolus feedings if Resident #64 ate 50% or more of her meals, and she stated prior to yesterday (12/13/23) afternoon they did not. LVN F stated the potential risk of not having the correct times could interfere with resident's mealtimes and bolus feeding times. She stated she was unaware if Resident #64 had any weight loss; however, Resident #64 did eat 100% of her meals. Observation on 12/14/23 at 10:27AM of Resident #64 witnessed weight check revealed the resident's current weight was 124.2lbs. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/14/23 at 12:56 AM with the Dietitian revealed Resident #64 was one of her patients she oversaw since she had a g-tube. The Dietitian stated the last time she visited Resident #64 was on Monday 12/11/23. She stated she provided the facility with her recommendations regarding Resident #64's bolus feedings. She stated the recommendations she provided was to give 3 bolus feedings a day in between meals due to weight loss concerns. She stated the bolus feeding hours were 10AM, 3PM and 8PM. She stated Resident #64's weight was 129 pounds and then dropped to 118.8 pounds in November 2023 . The Dietitian stated yesterday (12/13/23) she was asked to change the orders due to Resident #64 eating 100% of her meals. She stated prior to yesterday (12/13/23) she was notified by staff that Resident #64 was eating 100% of her meals and they were holding the bolus feedings due to resident refusal; however, she told them not to hold the bolus feedings. The Dietitian stated she was unaware of the times that were put in Resident #64's MAR. She stated she did not have access to Resident #64 MAR. She stated she only provided her recommendations to the DON and they are responsible to put in the orders in the system. The Dietitian stated Resident #64 had a weight check today (12/14/23) and her weight went up to 124.2 pounds. The Dietitian stated there was no risk to the resident due to Resident #64 eating more than 50% of her meals. Interview on 12/14/23 at 2:32PM with the DON revealed when the Dietitian provides recommendation her nurses are responsible to put them in the system. She stated she was made aware of Resident #64's Dietitian bolus feeding recommendations times and the MAR times were a little off. She stated their system did not provide the hours that the recommendation times were given. She stated the Dietitian was made aware yesterday (12/13/23) regarding the bolus feeding times and resident meal intake which the Dietitian was not concerned about due to Resident #64 eating 100% of her meals. She stated the Dietitian provided new recommendations to hold bolus feedings if the resident eats more than 50% of her meals. The DON stated prior to the order being changed, her expectations are for her staff to follow the bolus feedings recommendations. She stated the potential risk would be the resident missing nutrients which could cause skin breakdowns. Review of the facility's policy titled Enteral Tube Medication Administration revised on 10/01/19 reflected the following: Policy The facility assures the safe and effective administration of enteral formulas and medications via enteral tubes. Selection of enteral formulas, routes, and methods of administration, and the decision to administer medications via enteral tubes are based on nursing assessment of the resident's conditions, in consultation with the physician, dietitian, and consultant pharmacist 44140

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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** 32227 Based on observation, interview and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate administering of drugs and biologicals to meet the needs of each resident for 1 of 5 residents (Resident #27) reviewed for insulin administration. LVN A failed to administer Resident #27's insulin according to physician's orders. This failure could place residents at risk for diminished quality of care. Findings included: Review of Resident #27's MDS dated [DATE] revealed the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included heart failure, hypertension (high blood pressure), end stage renal disease, and diabetes mellitus. Resident #27 had a BIMS of 14 (cognition intact). Review of Resident #27's care plan initiated 05/22/23 revealed he had diabetes mellitus and interventions included to give diabetes medications as ordered by the doctor. Review of Resident #27's December 2023 Order Summary Report reflected an order for Novolog Solution 100 unit/ML (Insulin Aspart); inject 2 units subcutaneously before meals for diabetes. Observation and interview on 12/13/23 at 9:20 AM revealed Resident #27 was in his room sitting in his wheelchair, and he stated he had already eaten breakfast. At that time, LVN A entered Resident #27's room to administer his insulin and apologized for being late. Resident #27 stated normally his insulin was administered before his meals. Interview on 12/14/23 at 1:45 PM with LVN A revealed Resident #27 should have been administered his insulin prior to his meals but she got busy with other things and fell behind on her medication pass. Interview on 12/14/23 at 2:27 PM with the DON revealed she was not aware Resident #27's insulin had been given after breakfast. The DON further stated risks of not getting insulin at the ordered time could cause his diabetes to not be treated accurately including having high blood sugars. Review of the facility's Medication Administration policy, implemented on 10/23/22, reflected the following: .Medications are administered by licensed nurses or other staff who are legally authorized to do so in the state, as ordered by the physician

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	676255	A. Building B. Wing	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Worth Transitional Care Center	850 12th Avenue Fort Worth, TX 76104

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors for 1 of 5 residents (Resident #227) reviewed for medication errors. ADON G failed to communicate an order change, which resulted in Resident #227 missing two days of antibiotic therapy. This failure could place residents at risk of their infections worsening, and extending their length of stay in the facility. Findings included: Review of Resident #227's undated Admission Record revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included urinary tract infection, post kidney transplant status, and diabetes. Review of Resident #227's admission MDS, dated [DATE], revealed a BIMS score of 15, indicating he was cognitively intact. His Functional Status indicated he required minimal assistance with his ADLs. Review of Resident #227's care plan, dated 11/06/23, revealed he had a self-care deficit related to recent hospitalization , and had a urinary tract infection. Telephone interview on 12/11/23 at 12:20 PM with ADON G revealed Resident #227 had arrived to the facility around 1:30 PM with no discharge orders, and the discharge orders were not received until around 3:30 PM. The resident's antibiotic order had been crossed out and marked changed. ADON G contacted the Clinical Liaison to inquire about the antibiotic and was told it had been changed. ADON G stated she would not accept a verbal order due to the resident's recent kidney transplant and requested a written order via email. ADON G stated she could not access Resident #227's EHR until after 8:00 PM because the admissions team had not created it, and therefore could not input orders for the resident. ADON G stated she left at the end of her shift without being able to access the EHR and ADON H had to input all the orders. ADON G stated she could not check her email while on the floor because she was working as a charge nurse and not an ADON. Telephone interview on 12/14/23 at 10:28 AM with the Clinical Liaison revealed she had noted the antibiotic on Resident #227's discharge orders was very expensive and asked the physician if there was a more cost-effective antibiotic they could use. She received the order change and notified ADON G of the change verbally as well as an email with a copy of the changed order. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/14/23 at 11:00 AM with the DON revealed she was made aware on 11/06/23 that Resident #227 had missed his antibiotics since admission on 11/03/23, for a total of six doses. She contacted ADON G to inquire about what had occurred to create the error, and ADON G relayed the events from 11/03/23. The DON asked ADON G why she had not checked her email for the new order before leaving work since she was expecting the order change to come via email. ADON G stated she was working as a floor nurse not an ADON. The DON stated staff were not allowed to check their email on the floor but leadership could. Leadership had access to their email via phone and any computer they logged into, ADON G simply refused to check because she was making a point of having to work on the floor. Interview on 12/14/23 at 11:12 AM with the Regional Nurse Consultant revealed she had been notified on 11/06/23 that there had been a medication error involving Resident #227, and she was asked to investigate it since it involved an ADON. She stated she interviewed ADON G who relayed the events. When ADON G was asked why she did not follow-up on the email, when she was expecting an important order to come, ADON G stated she could either work as a floor nurse or as an ADON, but not both at the same time. When asked why she did not pass on the verbal order to ADON H at least, ADON G stated she did not consider the verbal order as valid. The Regional Nurse Consultant stated ADON G could have checked her email after her she was relieved by ADON H, but either chose not to or forgot to. ADON G was terminated at the end of the investigation. The Regional Nurse Consultant stated the physician was made aware of the days of missed antibiotics and added additional days of antibiotic therapy, resulting in extending the resident's stay in the facility by three days. Telephone interview on 12/14/23 at 11:40 AM with ADON H revealed she had never been made aware that Resident #227 was supposed to be receiving IV antibiotics. She stated when she took report from ADON G she seemed very frustrated because she had two admissions and she could not document anything on Resident #227 because his chart had just been put in by the admission team. ADON H stated she told ADON G to just go home, and she would input the orders for Resident #227. ADON H stated they had both been working multiple extra shifts due to staffing issues. Interview on 12/14/23 at 12:00 PM with Resident #227 revealed he had been told his antibiotics were not at the facility when he inquired about them on 11/03/23, and was told the same thing on 11/04/23. On 11/06/23, someone from administration came to talk to him and explained the error that had occurred, and took full responsibility for the mistake. Resident #227 stated he was not happy about having to spend extra days in the facility, but he understood that mistakes happened and was very happy with the rest of his care at the facility. The Administrator was unable to locate a policy addressing this situation. Review of the facility's Medication Administration and Admission policies did not address this specific situation.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 32227 Based on observation, interview and record review, the facility failed to ensure the facility provided food that was palatable, for one of one observed meal reviewed for dietary services. The facility failed to serve food that had a palatable texture during the lunch meal on 12/13/23. This failure could affect residents by placing them at risk of weight loss, altered nutritional status, and a diminished quality of life. Findings included: Review of the facility's menu on 12/13/23 revealed the planned lunch consisted of crispy pork loin, orzo, buttered beets, wheat roll, margarine, baked pineapple, coffee or tea, and garnish carrot curl. Observation on 12/13/23 at 12:39 PM of the mechanical soft texture test tray with three surveyors, the Dietitian and Dietary Manager revealed the food was warm; however, the orzo (pasta) and pork loin were both bland and flavorless. A confidential interview with seven alert and oriented residents revealed the pasta and pork were both tasteless and most meals were being served that way. They stated the taste of the food was not getting any better even when they would complain about it. Review of the resident council meeting minutes 11/11/23 reflected the following: states that they're tired of eating cold food, wants to eat from steam table. Interview on 12/13/23 at 3:35 PM with the Dietitian and Dietary Manager revealed they had not received any complaints regarding the food being bland. They stated the complaints they mostly received were about cold food. Review of the facility's Food Service Manual policy, dated September 2012, reflected: Each resident receives food prepared by methods that conserve nutritive value, flavor and appearance and food that is palatable, attractive and at the proper temperature. 44140

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44140 Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for one of one kitchen reviewed for food and nutrition services. Cook E failed to wear a hair restraint while in the facility's kitchen on 12/12/23. These failures could place residents at risk for food contamination and foodborne illness. Findings included: Observation on 12/12/23 at 8:40 AM revealed [NAME] E not wearing a hairnet while putting away food items. Observed [NAME] E's hair to be down and her hair length was approximately over her shoulder. Interview on 12/12/23 at 8:53 AM with [NAME] E revealed she had been employed for seven months. She stated the first thing the staff were required to do upon entering the kitchen was to put on a hairnet restraint. She stated she got busy and forgot to put on a hairnet, which was her reason she was not wearing a hairnet, while putting away food items. She stated the potential risk of not wearing a hairnet could be hair falling inside the food. Interview on 12/12/23 at 8:55 AM with Dietary Manager revealed all staff must wear a hairnet upon entry of the facility. He stated all staff were responsible for ensuring they were wearing a hairnet. He stated the risk of not wearing a hairnet would be hair falling on the food. Review of the facility's Food Service Manual policy, dated September 2012, reflected: Food Protection: (a) Hairnets, headbands, caps or other effective hair restraints shall be worn to keep hair from food and food-contact surfaces . Review of the Food Code Manual 2022 Food Code U.S Food and Drug Administration, dated 01/18/23, reflected: 2-402 Hair Restraints 2-402.11 Effectiveness. (A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES.