STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676389	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Matador Health and Rehabilitation Center	805 Harrison St Matador, TX 79244

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813 Based on observation, interview, and record review the facility failed to conduct a comprehensive and accurate assessment of each resident using the resident assessment instrument (RAI) specified by CMS for 1 of 14 residents (Resident #31) whose records were reviewed for assessments. Resident #31 was on CPAP therapy while in the facility and it was not addressed in his MDS. This failure to ensure comprehensive and accurate assessments could affect residents by placing them at risk for not receiving correct care and services. Finding include: Record review of Resident #31's face sheet dated 8-12-2024 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses to include dementia (a group of thinking and social symptoms that interferes with daily functioning), atrial fibrillation(an irregular, often rapid heart rate that commonly causes poor blood flow), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), obstructive sleep apnea (a sleep disorder that involves cessation or significant decrease in airflow in the presence of breathing effort), and venous insufficiency (improper functioning of the vein valves in the leg, causing swelling and skin changes). Record review of Resident #31's admission MDS completed 6-24-2024 listed him with a BIMS of 15 indicating he was cognitively intact, and he had a functionality from being independent with some of his activities of daily living to requiring substantial/maximal assistance with his activities of daily living. Section O Special Treatment, Procedures, and Programs: -Respiratory Treatments G-Non-Invasive Mechanical Ventilator (BiPAP/CPAP)- neither while not a resident or while a resident is mark as the resident having either one of these therapies. Record review of Resident #31's care plan with admitted [DATE] revealed the following: (continued on next page)

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

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focus: The resident has COPD and uses O2 PRN and should use CPAP at night. Date initiated 7-1-2024. Record review of Resident #31's order summary report with active orders as of 8-12-2024 revealed the following order: CPAP to be worn at HS, every night shift. Active Date - 6-19-2024 Record review of Resident #31's TAR (Treatment Administration Record) for 6-2024 revealed that Resident #31 received CPAP therapy nightly from 6-19-2024 through 6-24-2024, 6 days prior to the 6-24-2024 admission MDS assessment. During an observation and interview on 08-12-2024 at 10:52 AM Resident #31 was noted to have a CPAP machine on his bedside dresser that Resident #31 reported he had for years and he used daily. Resident #31 reported that the facility helped him with all his needs to include the CPAP and the care of the CPAP equipment such as cleaning, adding water, replacing the tubing. During an interview on 08-13-2024 at 01:45 PM the DON reported that the facility was currently completing all MDS's offsite due to the sudden loss of their ADON/MDS nurse. They both confirmed that in the meantime they have been having to scramble to cover the MDS's and care plans. During an interview on 08-13-2024 at 01:56 PM the DON reported that if a resident does not have their CPAP addressed on the MDS she would not know if it would affect the resident in any way because she does not know enough about the MDS's to answer any questions. During an interview on 08-13-2024 at 02:06 PM the CMDS Coordinator reported that she had not dealt with Resident #31's MDS when the CPAP therapy was missed, that that was completed by the facility's ADON/MDS Coordinator of which she (the CMDS Coordinator) did not know why the ADON/MDS Coordinator missed the CPAP. The CMDS Coordinator did report that the CPAP should have been addressed on the admission MDS if the CPAP was documented in Resident #31's chart. The CMDS Coordinator reported that the MDS affects the care plan and that if the MDS was not accurate then the care plan will not be accurate and the care plan drives the resident's care. The CMDS Coordinator reported that the policy followed for the MDS was the RAI manual. Record review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1. 17, dated October 2019 revealed the following: Section O0100 Special Treatment, Procedures, and Programs- o O0100G, Non-invasive Mechanical Ventilator (BiPAP/CPAP) Code any type of CPAP or BiPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask/device enables the individual to support his or her own spontaneous respiration by providing enough pressure when the individual inhales to keep his or her airways open, unlike ventilators that breathe for the individual. If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here. This item may be coded if the resident places or removes his/her own BiPAP/CPAP mask/device.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident’s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813 Based on interview, and record review the facility failed to conduct a periodic comprehensive assessment of each resident's functional capacity for 3 of 14 residents (Residents #7, #9, and #20) whose records were reviewed for assessments. The facility failed to complete a comprehensive assessments for Resident #7, #9, and #20 every 3 months. This failure could place residents at risk for not getting an accurate assessment and could result in lack of care. Findings include: Resident #7 Record review of Resident #7 face sheet dated 8-13-2024 revealed she was admitted on [DATE] with diagnoses to include Alzheimer's (a progressive disease that destroys memory and other important mental functions), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), convulsions (a sudden, violent, irregular movement of a limb or of the body caused by involuntary contraction of the muscles and associated especially with brain disorders such as epilepsy), hypertension (a condition in which the force of the blood against the artery walls is too high), diabetes(a chronic condition that affects the way the body processes blood sugar (glucose), and malnutrition (lack of proper nutrition). Record review of Resident #7's last completed MDS dated [DATE] listed her with a BIMS score of 00 indicating she was severely cognitively impaired, and she had a functionality of being dependent on staff for all her activities of daily living. Record review of Resident #7's MDS tracking record revealed the last completed MDS was a quarterly completed on 4-26-2024. The next MDS listed was a quarterly 7-27-2024 that was in progress and listed as 3 days overdue. Resident #9 Record review of Resident #9's face sheet dated 8-12-2024 revealed she was admitted [DATE] with diagnoses to include chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), 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), hypertension (a condition in which the force of the blood against the artery walls is too high), and malnutrition (a condition in which the force of the blood against the artery walls is too high). (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #9's last completed MDS dated [DATE] listed her with a BIMS score of 12 indicating she was moderately cognitively impaired, and she had a functionality of requiring supervision/touching assistance with most of her activities of daily living. Record review of Resident #9's MDS tracking record revealed the last completed MDS was a quarterly completed 3-20-2024. The next MDS listed was a quarterly 6-20-2024 that was in progress and listed as 40 days overdue. Resident #20 Record review of Resident #20 face sheet dated 8-14-2024 revealed he was admitted to the facility originally on 4-4-2023 and readmitted on [DATE] with diagnoses to include diabetes (a chronic condition that affects the way the body processes blood sugar (glucose), hypertension (a condition in which the force of the blood against the artery walls is too high), peripheral vascular disease (a circulatory condition in which narrowed blood vessels recue blood flow to the limbs), malnutrition(lack of proper nutrition), and intermittent explosive disorder(a behavioral disorder characterized by explosive outburst of anger and/or violence, often to the point of rage that are disproportionate to the situation at hand),. Record review of Resident #20's last completed MDS dated [DATE] listed him with a BIMS score of 9 indicating he was moderately cognitively impaired, and he had a functionality of requiring supervision/touching assistance with most of his activities of daily living. Record review of Resident #20's MDS tracking record revealed the last completed MDS was an admission completed 3-31-2024. The next MDS listed was a quarterly 6-30-2024 that was in progress and listed as 30 days overdue. During an interview on 08-13-2024 01:45 PM the DON reported that the facility was currently completing all MDS offsite due to the sudden loss of their ADON/MDS nurse. They both confirmed that in the meantime they have been having to scramble to cover the MDS's and care plans. During an interview on 08-132024 at 02:14 PM the CMDS Coordinator reported that all late MDS assessments were currently due to the situation with the ADON/MDS Coordinator which resulted in the facility contacting her facility to ask for assistance with MDS coordination, that any late MDS is currently due to her facility waiting on additional information from this facility such as therapy notes for a resident so they can finish the MDS and submit it. The CMDS Coordinator reported that all the late MDS's will result in issues such as late plans of care, late care plans, and will result in delay of facility reimbursement. The CMDS Coordinator reported that she does not feel this will affect the residents care because she personally knows the two owners of this facility and they would not let the resident do without what they need because of the delayed reimbursements. During an interview on 08-13-2024 at 02:06 PM the CMDS Coordinator reported that the policy followed to complete the MDS to include timing for the MDS to be completed was the RAI manual.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31882 Based on record review and interview the facility failed to perform preadmission screening for individuals with a mental disorder and individuals with intellectual disability prior to admission for 2 (Resident #18 and #20) of 16 residents reviewed for preadmission screenings. A. The facility failed to perform a PASRR for Resident #18 until 4 months after admission. B. The facility failed to perform a PASRR for Resident #20 until 2 months after admission. This failure could place residents at risk of receiving inadequate care. Findings Included: Record review of Resident #18's admission record dated 08/13/24 revealed Resident #18 was an 81year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to dementia (a group of thinking and social symptoms that interferes with daily functioning), anxiety (a feeling of worry, nervousness or unease), depression (a mood disorder that affects how a person thinks feels and acts) and anemia(a condition in which the blood does not have enough healthy red blood cells and hemoglobin) Record review of Resident #18's MDS completed 04/29/24 section C revealed a BIMS score of 8 indicating cognition was moderately impaired. Section E revealed Resident #18 had no behaviors. Record review of Resident #18's care plan completed on 04/22/24 revealed Resident #18 used a wheelchair for mobility and was incontinent. Record review of Resident #18's PASRR Level 1 Screening revealed it was completed on 08/13/24. Record review of Resident #20's admission record dated 8/13/24 revealed Resident #20 was a 64-y o male admitted to the facility on [DATE] with diagnoses of diabetes (a group of diseases that result in too much sugar in the blood), anemia (a condition in which the blood does not have enough healthy red blood cells and hemoglobin) and (hypertension (a condition where the pressure in your blood vessels is consistently higher than normal). Record review of Resident #20's quarterly MDS completed 06/30/24 section C revealed a BIMS score of 9 indicating cognition was moderately impaired. Section E revealed Resident # 20 had no behaviors. Record review of Resident #20's care plan completed on 03/25/24 revealed Resident #20 used a walker for mobility, was hard of hearing and at risk of depression due to his situation. Record review of Resident #20's PASRR Level 1 Screening revealed it was completed on 06/24/24. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/13/24 at 9:26 am, the ADM stated she was responsible for ensuring PASRRs on new admits were completed. She stated PASSR's were to be done immediately at admission or before admission. She stated both Resident #18 and Resident #20 came from the community and not from a hospital setting when admitted . She stated the PASSR's were done late. She stated a possible negative outcome of not having PASSRs completed prior to or at admission could result in not getting needed services. Record review of the undated facility policy titled Preadmission Screening and Resident Review revealed the policy of this facility is to ensure all residents are screened and appropriately addressed via the PASSR process as outlines by regulations. The facility designated staff will review all potential admission for possible positive PASSR conditions and ensure that CMS Preadmission guidelines are followed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813 Based on interview and record review, the facility failed to implement a comprehensive care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for 1 (Resident #31) of 14 Residents reviewed for comprehensive care plans. -The facility failed to include a care plan for Resident #31's smoking. This failure could affect residents in the facility receiving care per comprehensive person-centered care plans resulting in resident not being able to attain or maintain their highest practicable physical, mental, and psychosocial well-being. Finding include: Record review of Resident #31's face sheet dated 8-12-2024 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses to include dementia (a group of thinking and social symptoms that interferes with daily functioning), atrial fibrillation(an irregular, often rapid heart rate that commonly causes poor blood flow), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), obstructive sleep apnea (a sleep disorder that involves cessation or significant decrease in airflow in the presence of breathing effort), and venous insufficiency (improper functioning of the vein valves in the leg, causing swelling and skin changes). Record review of Resident #31's admission MDS completed 6-24-2024 listed him with a BIMS score of 15 indicating he was cognitively intact, and he had a functionality from being independent with some of his activities of daily living to requiring substantial/maximal assistance with his activities of daily living. Record review of Resident #31's care plan with admitted [DATE] revealed no care plan for smoking. Record review of Resident #31's Smoking Assessment completed 6-17-2024 revealed the following: D. Frequency 4. How often does the resident smoke per day? 2-5 times During an interview on 08-12-2024 at 10:52 AM Resident #31 confirmed that he was a smoker. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08-13-2024 at 01:45 PM the DON reported that the facility was currently completing all MDS's offsite and that she (the DON) has been attempting to complete care plans due to the sudden loss of their ADON/MDS nurse. They both confirmed that in the meantime they have been having to scramble to cover the MDS's and care plans. The Administrator reviewed Resident #31's chart and confirmed that he had no care plan for smoking. The DON reported that she has been learning how to complete the care plans since July 4th, 2024, with no training and reported that it probably was her fault that the smoking care plan was missed. The DON confirmed that smoking should be in a resident's care plan, that missing this smoking care plan would not be an issue due to this resident was independent and does not need any help. The DON reported that if the smoking is not addressed in the care plan, then direct care staff will not know how to address the resident's needs. The DON reported that if a resident wishes to smoke and the facility wishes to keep that resident safe then the facility needs to address that need on that resident's care plan. During an interview on 08-13-2024 at 01:58 PM the Administrator reported that since Resident #31 was an independent person not addressing his smoking on his care plan really was not a problem but if the resident was not independent then it would be a problem and that could affect a resident negatively if they did not receive the proper care. Record review of the facility provided policy titled Comprehensive Care Plans undated, revealed the following: 2. The comprehensive care plan will describe the following: a. The services that are to be furnished to attain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813 Based on observation, interview, and record review the facility failed to review the risks and benefits of bed rails with the resident or resident's representative and obtain informed consent prior to installation of bed rails for 4 (Residents #5, #13, #24, and #25) of 14 residents reviewed for bedrails. The facility failed to inform Residents #5, #13, #24, and #25 or their representatives of the use of bed rails and obtain consent for the use of bed rails. This failure could place all residents with bed rails at risk for injuries such as abrasion, fractures, and entrapment. Finding include: Resident #5 Record review of Resident #5's clinical record revealed an [AGE] year-old female admitted to the facility originally on 6-8-2022 and readmitted on [DATE] with diagnoses to include atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), polyosteoarthritis (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 cant exchange oxygen and carbon dioxide properly), muscles spasms(an involuntary and forceful contraction of a muscle or group of muscles that can't relax), muscle weakness (a lack of muscle strength), and pain in shoulder. Record review of Resident #5's clinical record revealed her last MDS was a quarterly completed 6-25-2024 which indicated her BIMS score was 10 indicating she was moderately cognitively impaired, and she had a functionality of requiring set-up/clean-up with most activities of daily living. Record review of Resident #5's order summary report with active orders as of 8-13-2024 revealed the following order: May have a grab-bar for bed mobility. - Active 08-12-2024 Record review of Resident #5's care plan with date of admission 2-15-2023 revealed the following: Focus: Resident uses a positioning bar on the right side of her bed for increased bed mobility and positioning. Date initiated 10-26-2022. Intervention: Ensure consent is on chart prior to initiating . During an observation on 08-12-2024 at 10:50am Resident #5 was not present. Noted a bed rail on the right side of Resident #5's bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08-12-2024 at 02:23 PM Resident #5 stated that she was able to get in bed with the assistance of her bed rail but has gotten weaker since the last CHF flare up. Resident #13 Record review of Resident #13's clinical record revealed a [AGE] year-old male admitted to the facility originally on 4-18-2023 and readmitted on [DATE] with diagnoses to include displaced fracture (a type of complete fracture that occurs when the ends of a broken bone are out of alignment), osteoarthritis (a type of arthritis that occurs when flexible tissue at the ends of bones wears down), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), intermittent explosive disorder (a behavioral disorder characterized by explosive outburst of anger and/or violence, often to the point of rage that are disproportionate to the situation at hand), muscle wasting (the loss of muscle mass and strength due to disease, injury, or lack of use), and muscle weakness (a lack of muscle strength). Record review of Resident #13's clinical record revealed his last MDS was a quarterly completed 6-25-2024 which indicated his BIMS score was 12 indicating he was moderately cognitively impaired, and he had a functionality of requiring partial/moderate assistance with most activities of daily living. Record review of Resident #13's order summary report with active orders as of 8-13-2024 revealed the following order: May have a grab-bar for bed mobility. - Active 08-12-2024 Record review of Resident #13's care plan with date of admission 8-1-2024 revealed the following: Focus: May have grab bars on bed to promote independence with bed mobility as needed. Date initiated 8-12-2024. During an observation on 08-12-2024 at 10:52 AM Resident #13 was lying in his bed. Resident #13 had bedrails on the side of his bed. During an interview on 08-13-2024 at 09:39 AM Resident #13 revealed that he used his bedrails to help himself turn over. Resident #13 stated that he does need assistance transferring into his w/c from staff. Resident #24 Record review of Resident #24's clinical record revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses to include dementia (a group of thinking and social symptoms that interferes with daily functioning), osteoarthritis (a type of arthritis that occurs when flexible tissue at the ends of bones wears down), history of fractures, fall history, and hypertension (a condition in which the force of the blood against the artery walls is too high). (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #24's clinical record revealed his last MDS was a quarterly completed 6-3-2024 which indicated his BIMS score was 04 indicating he was severely cognitively impaired, and he had a functionality of requiring supervision/touching assistance to partial/moderate assistance with most activities of daily living. Record review of Resident #24's order summary report with active orders as of 8-13-2024 revealed the following order: May have a grab-bar for bed mobility. - Active 08-12-2024 Record review of Resident #24's care plan with date of admission 9-19-2022 revealed the following: Focus: May have grab bars on bed to promote independence with bed mobility as needed. Date initiated 8-12-2024. During an observation and interview on 08-12-2024 at 10:51 AM Resident #24 sat up in his bed with the assistance of a bedrail on the side of his bed. Resident #13 did not voice any concerns and stated, I'm fine, and did not need anything at this time. Resident #25 Record review of Resident #25's clinical record revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include hemiplegia (partial paralysis), diabetes (a chronic condition that affects the way the body processes blood sugar (glucose), morbid obesity (a disorder involving excessive body fat that increase the risk of health problems), cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), and hypertension, (a condition in which the force of the blood against the artery walls is too high). Record review of Resident #25's clinical record revealed her last MDS was a quarterly completed 6-20-2024 which indicated her BIMS score was 15 indicating she was cognitively intact, and she had a functionality of requiring partial/moderate assistance with most activities of daily living. Record review of Resident #25's order summary report with active orders as of 8-13-2024 revealed the following order: May have a grab-bar for bed mobility. - Active 08-12-2024 Record review of Resident #25's care plan with date of admission 12-29-2022 revealed the following: Focus: May have grab-bars on bed to promote independence with bed mobility as needed. Date initiated 8-12-2024. During an observation and interview completed on 08-12-2024 at 10:31 AM Resident #25 was in her room in her bathroom in her wheelchair initially. Resident #25's bed was made with bilateral 1/8 bedrails up and locked in place. Resident #25 reported that she used her bedrails to steady herself in bed and that she had been trained on the use of the bedrails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08-14-2024 at 08:27 AM the administrator reported that the facility did not have the proper consent forms for the four residents reviewed for bedrails. The administrator verified that they did have orders for the bedrails, ongoing monitoring for the bedrails via care plans and review at each care plan meeting but that the consents were not completed prior to installation or the resident moving to a bed with bedrails. The Administrator reported that residents or resident representatives who were not educated on the risks and given the opportunity to consent would be at risk for injuries and harm. During an interview on 08-14-2024 at 08:58 AM the DON verified that all 4 residents did not have a consent for the use of a bedrail and reported that a resident could be affected negatively and have an injury especially if they were not educated on the risk and use of a bedrail. Record review of the facility provided polity titled Bed Rails undated, revealed the following: Procedures: 2. Review the risk and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. 47854

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 31882 Based on interview and record review, the facility failed to use the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week for 18 days out of 31 (05/28/23, 06/03/23, 06/04/23, 06/10/23, 06/11/23, 06/17/23, 06/18/23,06/24/23) 07/6/24, 07/13/24, 07/20/24, 07/21/24, 08/03/24, 8/10/24 and 8/11/24) days reviewed for RN coverage. The facility failed to ensure they had RN coverage 8 hours a day, 7 days a week for the following days: 05/4/24, 05/5/24, 05/11/24, 05/18/24, 05/19/24, 05/25/24, 05/26/24, 06/23/24, 06/29/24, 06/30/24, 07/04/24, 07/6/24, 07/13/24, 07/20/24, 07/21/24, 08/03/24, 8/10/24 and 8/11/24. This failure could place residents at risk for inconsistency in care and services. Findings include: Record review of the facility's employee roster undated revealed there were five RN's employed at the facility. Record Review of time sheet provided by the Administrator for the time period 05/01/24-08/11/24 revealed the following dates did not have RN coverage for at least 8 hours a day for the following days: 05/4/24, 05/5/24, 05/11/24, 05/18/24, 05/19/24, 05/25/24, 05/26/24. 06/23/24, 06/29/24, 06/30/24, 07/04/24, 07/6/24, 07/13/24, 07/20/24, 07/21/24, 08/03/24, 8/10/24 and 8/11/24. During an interview on 08/12/24 at 3:45 pm, the DON stated the administrator and DON were responsible for RN coverage. She stated she only clocks in for her shift and does not clock out. She stated she cannot prove that she was in the facility for 8 hours each day she clocked in. She stated the consequences of not having an RN in the building could cause poor care for the residents. During an interview on 08/13/24 at 1:55 pm, the Administrator stated the DON only clocks in for accountability to the owner. She stated she could not prove the DON was in the facility for 8 consecutive hours or more on the days she just clocked in. A policy was requested from the ADM but never furnished.

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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 ensure drugs and biologicals were stored and labeled in accordance with currently accepted professional principles when applicable on 1 (Hall 100 and half of Hall 300) of 2 medication carts reviewed. Two Loose pills found in the medication drawers of the medication cart for Hall 100 and half of Hall 300. This failure could result in residents not receiving an accurate dose of medication as well as not being maintained at their best therapeutic level. Findings include: Observation and interview on 08/12/24 at 11:07 AM revealed 2 loose pills in the bottom of medication drawer in medication cart for Hall 100 and half of Hall 300. LVN B was able to identify the pills, the red pill was identified as Plavix. The yellow pill was identified as Bethanechol Chloride unsure who the medications belonged to. Interview on 08/12/24 at 11:16 AM with LVN B revealed that a negative outcome for having lose medications in the medication carts would be that the medication could be mistaken for something else. Interview on 08/14/24 at 03:09 PM with DON revealed that a negative outcome for having lose medications in the medication carts would be that staff could assume what they are and give to a resident, and they are no longer clean. DON stated that she was aware of the loose medications and a in-service/training has been provided to the staff. Record review of facility policy titled, Storage of Medications , undated, states the following, but not limited to: Purpose: Ensure that medications are stored in a safe, secure, and orderly manner. Procedure: 1. Medications are stored in the containers in which they are received. .3. No discontinued, outdated, or deteriorated medications are available for use in this facility. All such medications are destroyed. 47854

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 31882 Based on interview and record review, the facility failed to employ sufficient staff with appropriate competencies and skill sets to carry out the functions of the food and nutrition service for the facility's only kitchen reviewed for dietary services. The facility failed to ensure the designated Dietary Manager completed the required dietary managers certification course or had any other qualifying credentials. This failure could place residents at risk for the spread of foodborne illness and residents not having their nutritional needs met. The findings include: Record review of the personnel file for the Dietary Manager revealed she was hired on 10/31/23 as a cook. There was no documentation in the personnel file that indicated that she had completed the required training for Dietary Manager and was a Certified Dietary Manager. Record review of the facility's Dietician documentation revealed that the Dietician was contracted and not full-time. In an interview on 8/12/24 at 10:15 am, the DM stated she was hired as a cook in the kitchen and had been the DM for about 2 months. She stated her duties as dietary manager were to supervise the kitchen staff and ensure all dietary functions were carried out. tShe stated she was not working on her certification for the DM as she cannot afford to pay for it and the owner will not pay for it. She stated she has never been employed as a DM before and does not have a degree in food service. In an interview on 8/12/24 at 12:40 pm the RD stated the owner has a DM certificate. She stated she had never been in the building. She further stated she had never seen the owner in the kitchen. In an interview on 8/12/24 at 1:45 pm, the RD stated she is only allowed by the owner to provide 20 hours a week of dietary consultation. In an interview on 8/13/24 at 9:40 am the ADM stated the Dietary Manager was not a certified DM and had not taken the required DM course. The ADM stated the DM must pay for the certification herself and she does not have the money to do it. She stated the owner will allow the staff to do it at their expense. The ADM stated the owner's wife is a DM. When asked if the owner's wife was in the kitchen supervising the kitchen, she said no. She stated she expected the Dietary Manager to become certified. The ADM stated she expected the DM to be certified to manage the kitchen effectively. The ADM stated the consequences of not being certified could be poor resident satisfaction with meals and not being knowledgeable about important dietary issues. In an interview on 8/13/24 at 9:55 am, the DM stated she had never met the owner's wife who had a DM certificate. She stated the owner's wife had never been in the kitchen or trained staff. The DM stated the owner's wife orders coffee for the facility and reviews the kitchen budget. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 8/14/24 at 8:28 am Dietary Aide B stated she had never seen the owner's wife in the kitchen and the DM runs the kitchen. In an interview on 8/14/24 at 8:30 am CNA C stated she had never seen the owner's wife in the kitchen and the DM runs the kitchen. Record Review of the undated facility policy titled Dietary Service revealed if a qualified dietician is not employed full time the facility will designate a person to serve as a Director of Food Service. The director of food service must be at least a person who has completed a state agency approved 90 hour course in food service supervision.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 31882 Based on observation, interview, and record review, the facility failed to ensure the meals served reflected the nutritional needs of residents in accordance with established national guidelines for all residents when the facility failed to ensure menus were followed all residents for 1 of 2 meals observed. 1. The facility did not serve a biscuit or any bread products to any residents for the lunch meal on 8/12/24 as directed by the menu. These failures could place all residents who received food from the kitchen, at risk for decreased meal satisfaction, potential weight loss due to poor meal intake, not having their nutritional needs met, and a decline in health status, Findings included: Record review of the diet spreadsheet, approved by the facility Dietitian, for Lunch- Monday 8/12/24, Week 1, revealed residents were to receive: honey garlic chicken thighs, cheesy rice, steamed broccoli, strawberry shortcake and 1 biscuit. In an observation on 8/12/24 at 11:55 am, [NAME] A was observed plating and serving lunch. There were no rolls or biscuits on the serving line and no biscuits were served to any residents on any of the noon meal trays prepared for lunch. During an observation on 8/12/24 at 12:20 p.m., of the lunch meal in the dining room and residents who ate in their rooms revealed none of the residents received a biscuit or any bread for the lunch meal as listed on the menu. During an interview on 8/12/24 at 12:40 pm, the RD stated if a food item was on the menu, it should have been served. She stated she expects that if a food is listed on the menu it is served. She stated she has trained the DM for kitchen practices. She stated the consequences of residents not getting what is listed on the menu could be weight loss and lack of nutrients in their diet. During an interview on 8/12/24 at 1:40 pm, the DM stated she was aware that none of the residents received a biscuit for the lunch meal and they should have gotten a biscuit for lunch. She stated she did not know why a biscuit or bread was not served. She stated the consequences of not having all the food items listed on the menu could lead to weight loss and hunger. In an interview on 8/12/24 at 1:45 pm, the RD stated she was aware that there was no biscuit served for the noon meal. The RD stated there should have been a biscuit served at the noon meal. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/12/24 at 1:55 pm, [NAME] A stated none of the residents received a biscuit for the lunch meal and they should have gotten a biscuit for lunch. She stated she just forgot to make the biscuits and did not put bread on the trays. She stated the consequences for the residents could be hunger at the end of the meal. [NAME] A stated she had been trained by the DM for work in the kitchen. Record Review of the undated facility policy titled, Dietary Services revealed the facility menu will meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council Record Review of the undated facility policy titled, Food Service revealed the facility menu will meet the nutritional needs of each resident; provide a well-balanced, flavorful, and varied food service program. All meals will meet USDA guidelines for the major food groups using the nutritional pyramid. Record Review of the undated facility policy titled ' Menus' documented menus will be prepared in advance, be nourishing, palatable, well balanced and will meet the daily nutritional dietary needs of the residents, If the meal service varies from the planned menu, the change and the reason for the change will be noted in the record used solely for recording such changes.

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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** 31882 Based on observation, interview, and record review, the facility failed to store, prepare, and serve food under sanitary conditions in 1 of 1 kitchen when they failed to: A. Ensure stored food was properly labeled, dated, and contained. B. Ensure general cleanliness was maintained. C. Ensure all food service staff used proper hand hygiene and use of gloves during meal preparation. D. Ensure temperatures were taken at the beginning of the meal service. E. Ensure substitution list, cleaning list and temperature logs were utilized. These failures placed all residents who ate food served by the kitchen at risk of cross contamination and food-borne illness. Findings include: Observations on 8/12/24 at 10:25 am, on initial kitchen rounds of the pantry revealed: 1. Crumbs in the bin holding chips 2. 5 bags of cereal, no label or date, not in original box. 3. A bin holding powdered milk was sticky and grimy to the touch. The lid was not secured. 4. Trash, food packets and crumbs were observed in the floor of the pantry Observations on 8/12/24 at 10:30 am, on initial kitchen rounds of the walk-in freezer revealed: 1. A bag of frozen biscuits was unsecured, unlabeled, undated, not in the original box and open to air. 2. A box of chocolate chip cookie dough was unsecured and open to air. 3. A box of rolled dough was unsecured and open to air. 4. A box of breadstick dough was unsecured and open to air. 5. A box of meat patties was unsecured and open to air. 6. Trash, food packets and food particles in the floor of the walk- in freezer. (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 8/12/24 at 10:35 am, revealed the walk-in cooler had trash, food packets and food particles in the floor of the cooler. Observations on 8/12/24 at 10:40 am, of the main kitchen prep area revealed walk-in freezer revealed: the white plastic bins holding thickener, flour, rice and sugar were sticky and grimy to the touch. There was a brown grimy film surrounding the lips of each bin. The sides and tops of each bin were sticky to the touch and food particles were stuck to the tops of each bin. The lids for each bin were not tight fitting and did not seal. The sugar had brown spots inside the bin on the top of the sugar. In an observation and interview on 8/12/24 at 11:40 am, [NAME] A washed her hands, plugged the blender into the electrical outlet and picked up the canister for the mixer. [NAME] A then put gloves on her hands. [NAME] A picked up a bowl and tongs and walked to the food steam table. [NAME] A used the tongs to put the chicken into the bowl. [NAME] A scooped 2 lades of sauce into chicken and walked to the prep table. [NAME] A pureed the chicken then took the lid off the blender with her gloved hands and set the lid on the counter. [NAME] A walked across the kitchen, picked up the loaf of bread and carried it to the prep table where she was blending the chicken. [NAME] A opened the bread wrapper, and pulled out a piece of bread with her gloved hand. [NAME] A put the piece of bread into the blender with her gloved hand. [NAME] A then put the lid on the blender and pureed the chicken. [NAME] A then took off the lid of the blender and pulled out another piece of bread, tore the bread in half with her gloved hands and added a half slice of bread to the blender. [NAME] A blended the chicken. [NAME] A then picked up the other half of the bread with her gloved hand and added it to the blender. [NAME] A did not wash her hands or change her gloves. [NAME] A stated she did not realize she touched the bread with her contaminated hands. She stated she had gloves on. She stated she did not realize she touched other surfaces in the kitchen. She stated she should have changed her gloves. When asked about the consequences to the residents she stated she did not know. In an observation on 8/12/24 at 11:55 am, [NAME] A was observed serving lunch. The temperatures of the foods on the steam table were not taken prior to the first plate being served. In an interview on 8/12/24 at 12:50 pm, [NAME] A stated she did not take temperatures of the food before serving. She stated she takes the temperatures as she cooks. [NAME] A was asked about the biscuits not being served at the noon meal. She stated she forgot. She stated she did not put any bread on anyone's tray. She stated the DM had trained her for her kitchen duties. [NAME] A stated residents would be hungry if they did not get all the menu items listed. In an interview on 8/12/24 at 1:40 pm, the DM stated she was aware that there was no biscuit served for the noon meal. The DM stated there should have been a biscuit served at the noon meal. She stated the consequences of residents not getting a bread at lunch was not enough to eat. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 8/12/24 at 1:45 pm, the RD stated she was aware that there was no biscuit served for the noon meal. The RD stated there should have been a biscuit served at the noon meal. She stated the kitchen does not have a substitution list or a cleaning schedule. The RD stated she is only allowed to provide 15 hours of service a month and she trains when she is in the facility. She stated she looks at cleanliness when she is in the facility. She stated some of the things she looks at was whether the floor and countertops were sticky, whether the shelf holding spices was clean and the spices were closed. She stated she also looks at the hood vent and whether the top of the dishwasher was clean. She stated she was aware there was no substitution list or cleaning list. The RD stated she was aware the kitchen staff had not been taking food temperatures and she had discussed this with the DM. In an observation on 8/13/24 at 9:55 am, the kitchen revealed the same cleanliness conditions in the kitchen and the same food storage issues in the pantry floor, pantry storage Items in the walk-in freezer were still opened to air. There was still trash and food particles in the floor of the walk-in freezer and walk in cooler. The plastic bins holding thickener, rice and sugar still had grime and crumbs on the containers. [NAME] spots were observed in the sugar. In an interview on 8/13/24 at 10:10 AM, the DM stated she did not have a cleaning schedule or a substitution list. She stated she expected staff to clean as they go. She stated right now she is the one cleaning. When told about [NAME] A using her hands to touch the bread while pureeing the chicken, she nodded her head OK. The DM stated she expected all kitchen staff to use tongs and proper hand washing. In a walk-through of the kitchen with the DM, on 8/13/24 at 8:30 am, cleanliness issues were pointed out and observed to still be an issue. Record Review of the undated facility policy titled ' Dry Storage and Supplies ' documented all facility storage areas will be maintained in an orderly manner [NAME] preserves the condition of the food and supplies. We will ensure storage areas are clean, organized, dry, and protected from vermin and insects. Dry bulk food (flour, sugar) is stored in seamless metal or plastic containers with tight covers or bins which are easily sanitized. Containers are cleaned regularly. Opened packages of food are stored in closed containers with tight covers and dated as to when opened. Storeroom floors should be swept and mopped to be maintained in a sanitary manner. Record Review of the undated facility policy titled ' Cleaning ' documented all equipment, food contact surfaces and utensils shall be cleaned whenever contamination may have occurred. Record Review of the undated facility policy titled ' Storage Refrigerators' documented food must be covered when stored, with a date, and label identifying what is in the container. Record Review of the undated facility policy titled ' Daily Food Temperature Control' documented prior to meal service, the cook shall take the temperature of all hot and cold food. Temperatures are recorded on the temperature log form. Record Review of the undated facility policy titled ' Menus' documented menus will be prepared in advance, be nourishing, palatable, well balanced and will meet the daily nutritional dietary needs of the residents, If the meal service varies from the planned menu, the change and the reason for the change will be noted in the record used solely for recording such changes. (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 undated facility policy titled ' Storage of Food in Refrigeration' documented food items that remain sealed from the supplier may be held until the expiration date if unopened. Food returning to storage after cooking or preparing must be covered. Record Review of the undated facility policy titled ' Food Safety' documented all staff will be aware of proper food handling and storage procedures. Food will be served in such a way as to prevent growth of bacteria. All food service staff will wash their hands when moving from one food prep area to another. Temperatures of food will be monitored at each meal. Use sanitized utensils and avoid hand contact. Avoid cross contamination of foods. Food must be covered when stored, with a date.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47854 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection in 1 of 1 dining rooms. -CNA C failed to perform hand hygiene before assisting Resident #32 with eating. This failure had the potential to affects residents in the facility by exposing them to care that could lead to the spread of viral infections, secondary infections, communicable diseases, and feelings of isolation related to poor hygiene. Findings include: Observation on 08/12/24 at 12:18 PM revealed CNA C playing with hair while waiting on Residents food to be delivered to table in the dining room. Observation on 08/12/24 at 12:24pm revealed CNA C playing with hair again and no hand hygiene was performed before touching Resident #32's napkin or silverware to assist Resident #32 with eating her lunch meal. Interview on 08/12/24 at 02:40 PM CNA C revealed that a negative outcome from playing with hair and then feeding a resident could lead to germs being transferred to the Resident. Interview on 08/14/24 at 03:09 PM with DON revealed that a negative outcome for not performing hand hygiene before assisting residents to eat could contaminate the resident's food. Record review of facility policy titled, Hand washing , undated, stated the following, but not limited to: Purpose: Hand washing will be regarded by this facility as the single most important means of preventing the spread of infections. Procedure: 1. All personnel will follow the facility's established handwashing procedures to prevent the spread of infection and disease to other personnel, residents, and visitors. 2. Hands should be washed 20 seconds under the following conditions: . .i. After using the toilet, blowing or wiping the nose, smoking, combing the hair, etc.