STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035176	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beatitudes Campus	1712 West Glendale Avenue Phoenix, AZ 85021

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical record, and facility records, policy, and procedures, the facility failed to protect the rights of one resident (#60) to be free from verbal abuse by a staff member. The deficient practice could result in psychosocial harm.-Findings include:Resident #60 was admitted to the facility on [DATE], with diagnoses that included enterocolitis due to clostridium difficile, urinary tract infection, type 2 diabetes mellitus with foot ulcer, pressure ulcer of sacral region, and muscle weakness.An admission minimum data set (MDS) assessment dated [DATE], revealed Resident #60 had a brief interview for mental status (BIMS) score of 15, indicating intact cognition.A facility self-report received by the state agency on April 28, 2024, at 9:56 P.M. revealed that at 9:30 P.M. on the same date, that a certified nursing assistant (CNA / Staff #106) called the Director of Nursing (DON / Staff #90) and stated that a nurse (Staff #99) was yelling at Resident #60 and waving her middle finger in his face. Additionally, that Staff #99 was suspended immediately.A time punch report for Staff #99 revealed that on April 28, 2024, that Staff #99 clocked in at 6:49 P.M. and clocked out at 10:30 P.M.Review of the clinical record revealed no evidence of a progress note or assessment dated [DATE], describing an incident between a staff member and Resident #60.A facility investigation report dated April 28, 2024, revealed that on April 28, 2024, that Staff #106 reported that a Licensed Practical Nurse (LPN / Staff #99) was verbally abusive to Resident #60. Staff #106 reported that Staff #99 waived her middle finger in the resident's face and called him a motherfucker. Staff #99 was suspended immediately. The investigation report revealed that on April 30, 2024, facility staff conducted an interview with Resident #60 that revealed that Resident #60 had called the nurses station because he wanted medication, and the CNA was in the room changing Resident #60. The resident stated that the nurse came in talking all crazy, and the resident asked the nurse why are you saying all this. Resident #60 reported that the nurse said you just want us to wash your ass and that the nurse gave Resident #60 the middle finger and then the nurse picked up a hand weight. The facility investigation revealed that facility staff interviewed the CNA (Staff #106) who stated that she went into Resident #60's room, and the nurse (Staff #99) told Staff #106 that Resident #60 wanted medication and wanted to be cleaned up, and that Staff #99 then entered Resident #60's room and stated to Resident #60 that he needs to get his shitty ass up and get in the shower, and that Staff #99 was cursing at Resident #60 and gave Resident #60 the middle finger. Staff #106 stated that she was motioning to Staff #99 to leave the room, and then pushed Staff #99 towards the door to get her out of the resident's room. Staff #106 stated that when Staff #106 and Staff #99 were in the hallway, Staff #99 got in Staff #106's face and that then Staff #106 told Staff #99 she needed to leave. Staff #106 stated that Staff #99 picked up a hand weight, and Resident #60 picked up the other hand weight and asked Staff #99 if she was going to hit him with that.The facility investigation report revealed that Staff #99 denied using the middle finger but does admit to pointing at the (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident and that her behavior was unprofessional. Additionally, the facility investigation concluded that the allegation of verbal abuse was substantiated.An interdisciplinary note dated May 1, 2024, revealed that Resident #60's family member had called and was upset that she was not contacted regarding an incident this week.A provider note dated May 4, 2024, revealed that Resident #60 stated his mood was a little down because he had an incident with a night nurse earlier in the week. The resident continued to state that his anxiety was high and now worse since the incident, and that he was thinking about moving to another facility.A Human Resources Change Request Form dated and effective May 8, 2024, revealed that Staff #99 was involuntarily terminated due to a resident complaint substantiated.A telephonic interview was attempted with Staff #106 on September 3, 2025, at 1:59 P.M., however both of the staff's phone numbers were out of services.A telephonic interview was attempted with Staff #99 on September 3, 2025, at 2:00 P.M., and a voicemail was left for a return call. The staff did not return the phone call.A telephonic interview was conducted with an LPN (Staff #8) on September 3, 2025, at 2:22 P.M, Staff #8 stated that she recalled the incident with Staff #99 and Resident #60. Staff #8 stated she was working that shift and that she received a call from the DON to go and take a statement from the involved parties. Staff #8 stated that she took a statement from Resident #60 and that the resident stated that the nurse had threatened him physically and there was verbal abuse, but that she could not remember the exact details. Staff #8 stated that she then talked to Staff #106, and that Staff #106 corroborated the resident's statements of what happened. Staff #8 stated that when the statements were taken and reported to the DON, that the DON gave the directive for Staff #99 to leave the facility and then Staff #99 left.A telephonic interview was conducted with an LPN (Staff #200) on September 4, 2025, at 8:04 A.M. Staff #200 stated that she recalled the incident, and that she was at the opposite end of the hall in the same unit and heard yelling. She stated that she then saw and heard in the hallway Staff #99 yelling at Staff #106 to stay out of her way, and that Staff #106 was removing Staff #99 from the situation. Staff #200 stated that she had worked with Staff #106 in the past and that Staff #106 was always enjoyable to work with and was good with residents so that when Staff #106 came to her with the concern, Staff #200 knew it was serious. Staff #200 stated that Staff #106 approached her and said that Staff #99 was using curse words toward Resident #60, and was being very disrespectful and degrading to the resident. Staff #200 stated that she called the DON, and that the DON stated that Staff #99 needed to leave the facility. Additionally, prior to that incident, Staff #200 stated that she had heard Staff #99 openly voice opinions about Resident #60 at the nurses station, and that Staff #99 stated that Resident #60 was disgusting, and that Staff #200 had to tell Staff #99 not to speak like that about residents. Also, Staff #200 stated that for weeks prior to the incident, Staff #99 had asked Staff #200 to care for Resident #60 and pass his medications even though the resident was on Staff #99's assigned rooms and not on Staff #200's assigned rooms, because Staff #99 did not like Resident #60. Staff #200 stated that Staff #99 was not even supposed to be in Resident #60's room because Staff #200 had taken over the resident's care.A telephonic interview was attempted with Resident #60 on September 4, 2025, at 1:10 P.M. The phone number was not in service.An interview was conducted with the Administrator (Staff #65) on September 5, 2025, at 10:23 A.M. The Administrator stated that abuse could include different types such as physical, verbal, sexual, financial, or emotional. The Administrator stated that if a staff member used derogatory or threatening gestures such as giving the middle finger to a resident, that would be abusive. The Administrator stated that she could not recall the incident between Staff #99 and Resident #60. The Administrator reviewed the facility investigation of the incident, and the interview continued again at 10:54 A.M. The Administrator stated that after reviewing the investigation (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	file, that there was an accusation of a staff cursing and using the middle finger gesture toward a resident and that there were resident and staff interviews conducted as part of the investigation. The Administrator stated that the facility concluded the investigation with substantiating the allegation of verbal abuse.Review of the facility policy titled Abuse, Neglect, and Exploitation, undated, revealed that it is the policy of the facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Verbal Abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical record, and facility policy, the facility failed to ensure a thorough investigation was conducted and recorded, and that a resident (#66) was assessed for injury regarding an allegation of abuse. The deficient practice could lead to continued physical and psychosocial harm of a resident, and/or a missed injury and delay of care.-Findings include:Resident #66 was admitted to the facility on [DATE], with diagnoses that included Parkinson's disease, tremor, type 2 diabetes mellitus, hypertension, peripheral vascular disease, cervicalgia, pain in thoracic spine, and pain in left knee.An admission minimum data set (MDS) assessment dated [DATE], revealed the resident had a brief interview for mental status (BIMS) score of 13, indicating intact cognition.A facility self-report to the state agency received August 3, 2023, at 10:18 A.M. revealed that Resident #66 reported an allegation of abuse from a certified nursing assistant (CNA / Staff #80), while she was getting the resident ready for the day prior to breakfast. The incident occurred on August 3, 2023, at around 8:30 A.M. Per the report, the resident was interviewed and stated that Staff #80 was rough with him and tossed him around and that Staff #80 gave him bruising to the left forearm. The clinical record was reviewed, and there was no evidence of any progress notes or assessments to indicate that the resident had been assessed for injury on August 3, 2023, after an allegation of staff to resident abuse.An admission MDS assessment dated [DATE], revealed that Section M Skin Conditions was completed by a licensed staff on August 14, 2023. Section M revealed that the resident had no unhealed pressure injuries, no venous or arterial ulcers, no foot problems, no surgical wounds, no burns, no skin tears, no moisture associated skin damage, and no open lesions other than ulcers, rashes, or cuts. The assessment did not reveal questions whether the resident had discolored skin, edema, or bruising. A formal request was submitted on September 4, 2025, for the facility to provide any evidence in the clinical record that Resident #66 had any skin assessment completed on August 3, 2025. The Administrator (Staff #65) signed a statement that revealed a skin assessment was conducted as part of the MDS assessment dated [DATE].A telephonic interview was conducted on September 3, 2025, at 12:45 A.M with a CNA (Staff #52), who stated that she recalled the allegation of abuse from Resident #66 regarding Staff #80. Staff #52 stated that Resident #66 liked things done in a very slow and particular way and to be done at eye level, and that she thought the incident was just a misunderstanding. A telephonic interview was attempted with a licensed practical nurse (LPN / Staff #87) on September 3, 2025, at 1:48 P.M. The number provided was the wrong number.An interview was conducted with the Director of Nursing (DON / Staff #57) on September 3, 2025, at 11:50 A.M. The DON stated that in a case of alleged physical abuse, that staff are expected to report the incident immediately, to protect the residents and make sure they are safe by separating the resident from the alleged abuser, and that the facility staff would initiate an investigation. Additionally, the DON stated that in a case of alleged physical abuse, that the nurse would do a skin assessment and ask the resident if they are in pain to assess for possible injury. The clinical record for Resident #66 was reviewed together, and the DON stated that she could not find any evidence that indicated that Resident #66 had a skin assessment completed on August 3, 2023.An interview was conducted with the Administrator (Staff #65) on September 5, 2025, at 10:23 A.M. The Administrator stated that in the instance of alleged abuse, an investigation is completed by staff to determine what happened. The Administrator stated that a thorough investigation is conducted by staff asking good, curious questions, such as asking the resident how they feel, and getting statements from the alleged perpetrator and other possible witnesses. The Administrator stated that if it is a physical abuse allegation, then staff would look at the resident's skin and do an assessment to help determine if (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	something occurred. The Administrator stated that the nurse's assessment for injury of the resident should be in the clinical record. The Administrator reviewed the facility's investigation file regarding the alleged abuse of Resident #66 and stated that she could not remember the incident, but that it looked like the CNA was getting Resident #66 dressed and that Resident #66 felt that the CNA was rough with him. The Administrator stated that Resident #66 stated that the CNA grabbed him by the hand and tossed him around on the bed, put his socks on and yanked them up, and that the CNA pulled on his legs and yanked his hands, and that the resident stated to the CNA don't abuse me like that. The Administrator stated that she could not tell if a skin assessment should have been done for Resident #66 after reviewing the incident.Review of the facility policy titled Abuse, Neglect and Exploitation, undated, revealed that abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Procedures for investigation include: focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and providing complete and thorough documentation of the investigation. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation, including examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure resident assessments for two residents were encoded and transmitted according to regulatory requirements. The deficient practice can impact the facility's ability to monitor changes to residents' health data over time. Based on clinical record review, interviews, facility policy and procedure, the facility failed to ensure Minimum Data Sets (MDS) for two residents (#3 and #12) were encoded and transmitted according to regulatory requirements. The deficient practice can impact the facility's ability to monitor changes to residents' health data over time. Findings Include:-Regarding Resident #3Resident #3 was admitted to the facility on [DATE] with diagnoses that included unspecified injury of the head, and difficulty walking.The quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview Mental Status (BIMS) score of 11, indicating moderate impairment in cognition.The Nursing Home Tracking Item Set MDS, dated [DATE], was completed and attested to on the same date for death reporting. The resident's MDS 3.0 Assessment Summary report, retrieved September 5, 2025 at 9:03 a.m., revealed the June 4, 2025 Death in Facility Tracking report has a status of: In process. Facility documentation did not support that the document was finalized, encoded, or transmitted. The resident's MDS 3.0 Assessment Summary report, retrieved September 5, 2025 at 10:39 a.m., revealed the June 4, 2025 Death in Facility tracking report has a status of: In process. Facility documentation did not support that the document was finalized, encoded, or transmitted. The resident's MDS 3.0 Assessment Summary report, retrieved September 5, 2025 at 1:47 p.m., revealed the June 4, 2025 Death in Facility discharge report has a status of: Finalized. Facility documentation does not support that the document was encoded or transmitted. -Regarding Resident #12Resident # 12 was admitted to the facility on [DATE] with diagnosis that included Chronic Obstructive Pulmonary Disease (COPD), anxiety, and resistant hypertension. The quarterly MDS dated [DATE] revealed the resident had a (BIMS) score of 14, indicating the resident was cognitively intact. The verifying assessment completion Registered Nurse (RN) signed the assessment as complete on August 27, 2025. The resident's MDS 3.0 Assessment Summary report, retrieved September 5, 2025 at 9:16 a.m., revealed the August 3, 2025 quarterly review assessment, has a status of: Finalized. The facility documentation does not support that the assessment was encoded or transmitted. The resident's MDS 3.0 Assessment Summary report, retrieved September 5, 2025 at 1:43 p.m., revealed the August 3, 2025 quarterly review assessment, has a status of Finalized. The facility documentation does not support that the assessment was encoded or transmitted.A panel discussion was conducted with the Director of Nursing (DON/Staff #57) and the RN MDS Coordinator (Staff # 39) on September 5, 2025 at 10:30 a.m. The panel revealed a purpose of the completion and submission of the Minimum Data Set (MDS) is to assess the resident for risk that the resident may have, so it can be addressed in the resident's Plan of Care. The panel refers to the Resident Assessment Instrument (RAI) manual as their reference to aid in the completion of MDS documentation. The DON ensures that all parties that are participants in the MDS assessment process have the knowledge to complete an accurate and thorough assessment. The DON described knowledge and competency is obtained through training and huddle meetings, but stressed communication is key. The panel described one unique function of the RN in the is to verify the overall completeness of the MDS and then attest once completeness was verified. The panel agreed that the deadline for MDS submission is 14 days but that the facility is aware that the Center for Medicare Services (CMS) does provide a grace period for facilities. The panel shared that the facility has been in transition for a MDS nurse coordinator, and that the current coordinator has almost been active at the facility for two weeks. The DON also shared the facility was also undergoing transition with their (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	electronic health record system upgrade. While dealing with the transitions, the DON reported that the facility conducted an inhouse audit of the Assessment Reference Dates last week, and then notified the Interdisciplinary Team (IDT) of the findings. The panel defined ARD as the last day of that period of time, that the MDS assessment covers for that particular assessment. The DON revealed other ways the facility has been proactive in improving the facility's MDS assessment process also included the discussion of the issue in Quality Assurance Performance Improvement (QAPI) meetings around June/July 2025. The DON reviewed the clinical record for resident #3, and revealed the submission of the documentation failed to meet facility expectation. The DON identified that the documentation was still in active status. The DON voiced being unable to give a definitive rationale for the former coordinator failure to transmit the documentation. The DON speculated that it may have possibly been a technical issue, due to the facility undergoing training in the new electronic record system. After review of resident # 12 clinical record, the DON revealed that the documentation was not submitted in a timely manner, and identified part of the cause was being without a MDS coordinator for a few weeks. While the facility was in-between MDS coordinators, the DON also identified that there was an issue in gaining access in order to transmit the assessments. The DON explained that the electronic record system provides the staff alerts and reminders for MDS documentation submission time tables. The DON voiced the benefit of the alert system, is that it assists the staff in ensuring MDS documentation is submitted on time. The DON revealed being the backup system for MDS submission, and performing audits to ensure compliance. As to why their alert system and safeguards failed for these two residents, the panel was unable to speculate, but does intend to use the experience to help improve the process. The panel agreed that the facility was out of the grace period for transmittal for the two identified residents, but intends on immediately rectifying the discoveries as soon as the panel discussion concludes. An interview was conducted with the Executive Director (ED/Staff #65) on September 5, 2025 at 12:25 p.m. The Executive Director revealed that the facility already had a Performance Improvement Plan (PIP) in place for the submission of MDS documentation. The ED revealed challenges that caused the facility to require a PIP plan for MDS included: the overhaul and upgrading of the electronic health record system, the resignation of the RN MDS coordinator, and the failure to connect with the facility's assigned RAI coordinator. The ED revealed having saved email documentation of RAI correspondence attempts, all of which went unanswered. The ED expressed feelings of hope back then that assistance from the RAI coordinator could have been a valuable resource to provide aid and guidance through their transitions. The ED explained that the facility has been very proactive in trying to fix transitional glitches in the MDS system process. The ED identified those proactive measures included: the hiring of a Director of Nursing with MDS Coordination experience, a recent new-hire of a full time RN MDS coordinator, electronic record audits of the complete facility, and addressing the issue during QAPI. The facility's Comprehensive Care Plans Policy, copyright 2023), revealed that the care plan will be developed within 7 days after completion of the comprehensive MDS assessments. The facility's MDS 3.0 Completion Policy, copyright 2024, revealed that quarterly assessments are completed using an ARD no greater than 92 days from the most recent assessment (counting ARD to ARD). The Death Tracking Record, according to policy does not require a RN Coordinator's signature. In addition, the tracking record is expected to completed no later than the discharge date plus 7 calendar days. The policy mandates the facility to ensure that all assessments are to be transmitted to the designated CMS system within 14 days of completion.

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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. Based on observations, staff interviews, United States Food and Drug Administration (FDA) recommendations and policy review, the facility failed to ensure food and drinks were palatable and maintained at an appetizing temperature. The deficient practice could result in the potential of bacterial growth in susceptible conditions, also known as the ‘danger zone'.Findings include:A review of food temperatures from the last 30 days was conducted and revealed that on August 26, 2025, 4th-floor lunch temperatures at 12:00 PM were as follows:- Beet and Feta Salad: 48.3 degrees F- Honey Glazed Pork Tenderloin: 133.1 degrees F- Pina Colada Cheesecake: 51.1 degrees FHowever, that same review revealed that on August 26, 2025, the 3rd-floor lunch temperatures at 12:00 PM were as follows:- Beet and Feta Salad: 37.6 degrees F- Honey Glazed Pork Tenderloin: 173.8 degrees F- Pina Colada Cheesecake: 41.6 degrees FDuring an initial interview with Resident #69 conducted on September 2, 2025, at 9:01 AM, she stated that they do not get their breakfast and lunch meals hot.During another initial interview with Resident #18 conducted on September 2, 2025, at 9:11 AM, he stated that the food provided by the kitchen has no taste and is not hot.On September 3, 2025, an observation was conducted of the lunch tray assembly.At 11:00 AM, the dietary staff was observed taking initial temperatures of the food that was to be taken to the assigned floor.At this time of the observation, an interview was conducted with the Nutrition Care Manager (Staff #47). Staff #47 advised that each floor receiving long-term care services, floors 3 and 4, will undergo an initial temperature check before being escorted to their assigned floor. Staff #47 also stated that each floor has its own hot box for transport; individual carts that hold cold items, serving utensils, and a disinfecting bucket.At 11:42 AM, the prepared food and the test tray had been transferred to the 4th floor via a hot box to be placed into the 4th floor steam table for plate assembly.At 12:45 PM, all residents on the 4th floor received their plates, and a test tray had been made from the food located in the 4th-floor steam table.At this time, the test tray temperatures were taken. The holding temperatures were as follows:- Pork: 126 degrees F- Vegetables: 133 degrees F- Sandwich Melt: 154 degrees F- Beans: 122 degrees F- Cottage Cheese: 57 degrees F- Watermelon Puree: 56 degrees FDuring this observation, an interview was conducted with Staff #47, who stated that the holding temperatures for hot items are expected to be maintained at 140 degrees F and 41 degrees F for cold items, as stated per facility policy, due to the risk of exposure to food-borne illnesses.However, Staff #47 had also stated that the temperatures taken for the 7 individual lunch items are considered safe and palatable to her standards, despite the facility policy.Another interview was conducted with Resident #33 on August 4, 2025, at 8:46 AM. Resident #33 stated that the food for both lunch and dinner is underwhelming and had been served to him at what they considered a cold-to-the-touch temperature.A facility policy titled ‘Food Safety Requirement' revealed that staff shall monitor food temperatures while holding for delivery to ensure proper hot and cold holding temperatures are maintained, and to refer to the current FDA (Food and Drug Administration) Food Code andfacility policy for food temperatures.Per the FDA Food Code, holding temperatures for cold foods should be held at 41 degrees F or below, and hot foods should be held at 135 degrees F or above. These are minimum requirements for Time/Temperature Control for Safety (TCS) foods to slow the growth of bacteria and prevent foodborne illness.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, United States Food and Drug Administration (FDA) recommendations, and policy review, the facility failed to ensure that prepared food was stored in accordance with professional standards for food safety. The deficient practice could result in the potential of bacterial growth in susceptible conditions, also known as the 'danger zone'. Findings include:On September 2, 2025, an initial observation of the facility kitchen was conducted with the Nutrition Care Manager (Staff #47).At 8:41 AM, a walk-through of Refrigerator #1 revealed no evidence of a label of creation date or a use-by date for a food item that had been identified by Staff #47 as Jell-O.At 8:44 AM, a walk-through of Refrigerator #2 revealed raw meats had no evidence of a label of when it was taken out of the freezer or a use-by date. During this walk-through, an interview was conducted with Staff #47, who advised that staff are expected to review the menu and encouraged to defrost necessary raw meat products three days before their preparation date. Staff #47 also advised that she was unsure when the raw meat products were put into the refrigerator for defrosting, but stated her assumption that the dietary staff had kept track. At 8:47 AM, a walk-through of the Freezer revealed two opened bags of what Staff #47 identified as rolls and biscuits, which had no evidence of a label of when they were opened or a use-by date. This walk-through also revealed that an open bag of what Staff #47 identified as fish filets had no evidence of a label of when it was opened or a use-by date. During this walk-through, Staff #47 also advised that the expectation for staff is to ensure the placement of an open date and use-by date for any opened items placed in the freezer.At 8:51 AM, a walk-through of the dry storage revealed that an open bag of what Staff #47 identified as brown rice had no evidence of a label of when it was opened or a use-by date. Staff #47 also identified that an open bag of white rice had no evidence of a label of when it was opened or a use-by date. Staff #47 also identified that an open box of lasagna pasta had no evidence of a label of when it was opened or a use-by date. During this walk-through, Staff #47 advised that the expectation in the dry storage is that any item that is opened and returned to the storage for further use is to be labeled with the date it was opened and a use-by date. At 8:59 AM, Staff #47 advised that not labeling food items stored within the kitchen is not within the facility's expectations and that the lack of a label can pose the risk of preparing meals with expired food items.On September 3, 2025, a secondary observation of the facility kitchen was conducted with the Nutrition Care Manager (Staff #47).At 9:51 AM, a walk-through of Refrigerators #1 and #2, the Freezer, and the Dry Storage revealed that the fish filets were still located in the Freezer with no evidence of a label of when it was opened or a use-by date. The walk-through also revealed that the Jell-O had no evidence of a label of creation date or a use-by date, and that these were no longer in Refrigerator #1. The walk-through also revealed that the raw meats with no evidence of a label of when it was taken out of the freezer or a use-by date were still located in Refrigerator #2. The walk-through also revealed that the brown rice, the white rice, and the lasagna pasta that had no evidence of a label of when it was opened or a use-by date were no longer located in the Dry Storage.A facility policy titled ‘Food Safety Requirement' revealed that practices to maintain safe refrigerated storage included separating raw foods from each other and storing raw meats on shelves below other refrigerated items so that the meat juices do not drip on them; and to label, date and monitor refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen/discarded.