STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	405025	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centro Medico Wilma N Vazquez Snf	Road 2 Km 39 5 Bo Algarrobo Vega Baja, PR 00693

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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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 20423 Based on observations, it was determined that the facility failed to ensure to have results of the survey conducted by Federal or State surveyors and any plan of correction made respecting the facility during the past preceding years, available for any individual to review upon request; and Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. Findings include: During the initial tours it was observed that the facility's result of the last survey conducted by Federal or State surveyors in 2023 when request was not available and posted for the residents and public. The facility last survey result that they had available was performed in April 2022.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15884 Based on observations, review of fifteen records reviewed (R.R.) records, and interview with social worker (employee #11), it was determined that the facility failed to comply with the requirements with Advance Directives. This deficient practice was identified in 2 out of 15 records reviewed of selected for the initial pool (RR#1, RR#59). Findings include: Review of policy WNV-SNF-Title: Directrices Anticipadas, Advance Directives last update in December 2023, was reviewed on 04/08/2024 at 1:35 PM with Social Worker (employee #11). The policy clearly stated on the procedures that every resident admitted to the facility is oriented by admission personnel in relation to advance directives. In section 6.5 procedures policy establish that in cases where is necessary based on alteration on cognitive status in the resident, that the resident representative accept or refuse medical or surgical treatment facility must notify a physician who will be the professional in charge to take the advance directive. 1. During the review of initial pool sample RR # 1 it was identified that this [AGE] year-old female residents was admitted on [DATE] with a diagnosis of General Weakness. Review of medical record evidence that facility did not have any information related with advance directives and there is no information provided by the admission department to resident relatives concerning to the right to accept or refuse medical or surgical treatment as an option and to formulate an advance directive. Social worker (employee # 11) stated in an interview on 04/09/2024 at 8:25 AM that this resident is not mentally competent and could not formulate advance directives. Social worker also stated that social services department had not been informed that this resident does not have advance directives due to her cognitive status, in order to coordinate with relatives that they establish advance directives for medical decisions. 2. During the review of initial pool sample RR # 59 it was identified that this [AGE] year-old female resident was admitted on [DATE] with a diagnosis of Left Hip Fracture. Review of medical record evidence that facility did not have any information related with advance directives and there is no information provided by the admission department to resident relatives concerning to the right to accept or refuse medical or surgical treatment as an option and to formulate an advance directive. Social worker (employee # 11) stated in an interview on 04/09/2024 at 9:00 AM that this resident present episodes of altered mental status in where she is observed confused and less alert from normal and she is not able to formulate advance directives. Social worker also stated that social services department had not been informed that this resident does not have advance directives due to her cognitive status, to coordinate with relatives that they establish advance directives for medical decisions. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The facility failed to have a mechanism in place to ensure that in cases where there is a change in mental status and could not establish advance directives for medical decisions, relatives or resident representatives were informed of the issue. No information was found documented on the medical record related to medical treatment and care relatives of resident representative make or advance directives formulation.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15884 Based on observations of the physical environment, review of policies procedures and facility staff interview performed on 04/08/2024 through 04/09/2024 to from 8:00 AM through 5:30 PM, it was determined that the facility failed to promote the resident right to receive services in a safe, clean, comfortable, and homelike environment. This deficient practice had the potential to affect 19 out of 21 residents receiving services at areas where the deficient environment and items (equipment) is located. Findings include: During initial observational tour the following was observed related with environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms, and bathrooms: 1. Night tables located on resident rooms 107-A,107-B, and 110, were observed with the front door out of square. 2. The bed, located in room [ROOM NUMBER]-B, was observed with rust on the metal areas of the base. 3. Bedside rest chairs located in rooms 104-B and 110-A were observed with rust on the metal areas. 4. Doors of room [ROOM NUMBER],107, 108 and 110 squeak when open. 5. Weight scale was observed with rust. 6. Floor of rooms 104,107,108 and 110 were observed with dark spots. 7. The area in the wall where the air conditioning is located is observed with paint with pockets of moisture. 8. One of the closet doors located in room [ROOM NUMBER]-B does not have a knob. 9. room [ROOM NUMBER]-A does not have a night table. During the interview on 04/07/2024 at 9:00 AM a resident (initial pool resident #159) located on this area stated that she would like to have a night table to organize her belongings there. 47384 During observational tour of the facicity the following was observed: 10. Resident in room [ROOM NUMBER] A stated that room was too cold. 11. Beds are noted with rust and some broken components (hand rails) throughout the facility. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12. Three commodes were found with broken arm rest and sharp edges on rooms 103, 106, 115. 13. Holding grip next to toilet in room [ROOM NUMBER] was observed loose

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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 0679 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide activities to meet all resident's needs. 20423 Based on observations, and interview with recreative therapist (employee # 10), it was determined that the facility failed to maintain an activity program that contains varied activities to promote and improve resident's physical, mental, and psychosocial well-being for 24 out of 24 admitted residents. Findings include: 1. During the initial observational tour at the facility performed on 04/07/2024 at 8:30 AM it was observed that the monthly activity calendar located in facility main hallway wall was empty and did not contain any activity for the month of April 2024. 2. It was asked to the recreative therapist (employee #10) on 04/08/2024 at 10:00 AM the reason why the monthly activity calendar located in facility main hallway wall was empty and did not contain any activity for the month of April 2024. She stated in an interview that she did not prepare the monthly activity calendar for the month of April 2024 because there are not available materials to coordinate activities that involve arts and crafts. She stated that she sent a requisition to the finances department to buy materials for arts and crafts in the month of February 2024 and until now this department did not inform her if they are going to buy those materials. She stated that the recreation department did not have materials for arts and crafts, she just offers activities who involve lectures, listening to music, watching television, alphabet soup and crosswords. She stated that since October 2023 there is only one recreational therapist on the program. When the program had two recreational therapists it was easier to coordinate recreational activities on weekends and holidays. She stated that at this moment recreational program coordinate only individual recreational activities who involve lecture, listen to music, watch television, alphabet soup and crosswords for weekends and holidays, and she depends on that nursing personnel help residents providing those recreational activities. She stated that this is going to be like this until the facility recruits another recreational therapist.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20423 3. R.R #208 is an [AGE] year-old female admitted on [DATE] to the facility with a diagnosis of Right Total Hip Replacement due to fracture. This resident stated in an interview on 04/07/2024 at 11:00 AM that her weight was not taken when she was admitted to the facility. She stated that the facility food is very good, and she has a good appetite. She stated that she is eating very well, and she is sure that she has not lost weight since admission. She also stated that nursing personnel informed her that they are going to weigh her next Tuesday. 17959 Policy and procedure review on 04/08/2024 at 1:45 PM related to resident weight referred that resident are weight on admission and every Tuesday. 4. R.R.#155 A is a [AGE] year-old female admitted on [DATE] to the facility with a diagnosis of Right Knee Replacement, reviewed on 04/09/24 1:15 PM, during interview with the resident on 04/07/2024 at 9:00 AM she states that she was not weight when arrived. No evidence was found that the resident was weight on 04/04/2024 in the weight log. 5. R.R.#106 is a [AGE] year-old female admitted on [DATE] to the facility with a diagnosis of Right Knee Replacement, review 04/09/24 1:25 PM. During the interview with the resident on 04/07/2024 at 9:15 AM state that she was not weigh when arrived. No evidence was found that the resident was weight on 04/04/2024 in the weight log. 6. R.R.#108 is a [AGE] year-old male admitted on [DATE] to the facility with a diagnosis of Lumbar Stenosis, review on 04/09/24 1:00 PM. During an interview with the resident on 04/07/2024 at 10:35 AM he states that he was not weight when arrived. No evidence was found that the resident was weight on 04/05/2024 in the weight log. 15884 Based on records reviewed (RR), review of policies procedures and facility staff interview performed on 04/07/2024 through 04/09/2023 to from 8:00 AM through 5:30 PM, it was determined that the facility failed to maintain systematic approach on resident weight status during admission such as usual body weight or desirable body weight range while receiving services at the facility. This deficient practice was identified in 6 out of 21 residents receiving services at the facility. (RR #106, #108, #155, #157, #159, and #208). Findings include: The policy WNV-SNF-Title: Peso de Residente, Residents Weight was reviewed on 04/08/2024 at 1:35 PM with Clinical Dietitian (employee #8). Policy clearly stated on the procedures that every resident admitted to the facility weight must be taken when admitted and then every Tuesday on weekly basis. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. RR # 159 is a female resident admitted on [DATE] with a diagnosis of Right Knee Replacement. This resident stated in an interview on 04/07/2024 at 9:25 AM that her weight was not taken when she was admitted to the facility. She stated that she is eating very well, and she is sure that she has not lost weight since admission. She also stated that nursing personnel informed her that they are going to weigh her next Tuesday. 2. RR #157 is a female resident admitted on [DATE] with a diagnosis of Left Knee Replacement. This resident stated in an interview on 04/07/2024 at 10:55 AM that her weight was not taken when she was admitted to the facility. She stated that the facility's food is very good, and she has a good appetite. She stated that she is eating very well, and she is sure that she has not lost weight since admission. She also stated that nursing personnel informed her that they are going to weigh her next Tuesday. During an interview on 04/08/2024 at 10:35 AM clinical dietitian (employee #8) stated that facility policy stated that on the procedures that every resident admitted to the facility weight must be taken when admitted and then on weekly basis. She stated that she had not been informed of the resident's weight during admission or if there was any situation that do not permit to weight residents when admitted receiving services.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 47632 Based interview with the Director of nursing on 04/07/2024 through 04/09/2024 from 8:00 AM to 4:00 PM, it was determined that the facility failed to provide evidence of resident's categorization of dependence needs to be used to determine numbers each type of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans for 21 out of 21 residents. Findings include: 1.Director of Nursing (DON) (employee #2) was interviewed on 04/07/2024 at 8:00 AM and was asked for the categorization of residents admitted to the facility. DON stated that they did not have it available. DON explained that the person in charge of patient categorization is the facility supervisor, and this person has been suspended from duty since 04/05/2024. DON is trying to perform resident categorization; however, she was unsure whether to categorize residents daily or weekly and also does not know the exact procedure performed by nursing supervisor to perform the categorization. On 04/07/2024 at 10:00 AM during the interview with the DON referred when there is no staff in the same area, they look for resources in other hospital departments to cover the needs of the residents. The DON knows they are not complying with Payroll Based Journal, but the priority is to meet the needs of the residents. During survey procedures on 04/07/24 through 04/09/24 facility DON was unable to provide the categorization of residents admitted to the facility.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 47384 Based on observations of the Kitchen, review of policies procedures and facility staff interview performed on 04/08/2024 through 04/09/2024 to from 8:00 AM through 5:30 PM, it was determined that the facility failed to provide each resident with a nourishing, palatable,special dietary needs. Findings include: During observation of the food service it was noted that food was served in Styro foam containers, these containers do not assure that food will get to residents in correct temperatures.

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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 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. 47384 Based on observations of the Kitchen, review of policies procedures and facility staff interview performed on 04/08/2024 through 04/09/2024 to from 8:00 AM through 5:30 PM, it was determined that the facility failed to ensure there is sufficient and qualified staff with the appropriate competencies and skill sets to carry out food and nutrition services for 24 out of 24 residents admitted . Findings include: After review of the personnel roster with Kitchen Supervisor (employee #17), it was determined that facility does not have an Administrative Dietitian or to that effect a Kitchen Manager.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 47384 Based on observations of the Kitchen, review of policies procedures and facility staff interview performed on 04/08/2024 through 04/09/2024 to from 8:00 AM through 5:30 PM, it was determined that the facility failed to ensure there is sufficient and qualified staff with the appropriate competencies and skill sets to carry out food and nutrition services. Findings include: 1. The surveyor requested the kitchen staffing pattern to Kitchen Supervisor (employee #17) on 04/07/2024 at 11:00 AM , after 3 days of survey it was not provided.

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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** 47384 Based on observations of the Kitchen, review of policies procedures and facility staff interview performed on 04/08/2024 through 04/09/2024 to from 8:00 AM through 5:30 PM, it was determined that the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Findings include: 1. During the visual inspection, the defrosting sink was observed that the hoses were covered by cloths. This accumulates water and promotes the generation of bacteria. The facility's policy Lavabo a [NAME] en Fregadero de 3 Compartimientos was provided by Kitchen Supervisor(employee #17) and reviewed on 04/08/2024. During observation of the preparation of the 3 compartment lavatory it was observed that the first compartment was prepared with VEL dish soap,and was not prepared as stated in the policy with a temperature of 110 degrees. The preparation of the third compartment (sanitation compartment) was observed and tested for Arrex consentration and did not reach the 200 ppm measuremet (100 ppm). The facility's policies and procedures regarding the use of the 3 compartment lavatory was not followed to ensure correct sanitation of kitchen utensils. 2. High temperature dish washer wash observed on 04/07/2024 and found unoperational due to lack of cleaning product.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 20423 Based on interview with facility administrator (employee#1), the facility failed to develop a required Facility Assessment. This deficient practice had the potential to affect 21 ot of 21 residents in the facility. Findings include: During the entrance conference performed on 04/07/2024 at 10:00 AM with the Administrator, the surveyors request the facility assessment, at 2:00 PM the Administrator state that he is the administrator of the facility since 1.5 years and he do not find the facility assessment. He is going to initiate and developed the facility assessment.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 47632 Based on interview with the Administrator (employee#1) on 04/07/2024 at 12:13 PM, it was determined that the facility failed to ensure complete and accurate information related with Payroll Based Journal (PBJ) was submitted accordingly with CMS requirements in addition to other verifiable and auditable data in according with specifications established. Findings include: 1. On 04/07/2024 at 12:13 PM the Administrator stated on interview that facility was not reviewing and auditing correctly information related with the PBJ and other verifiable data before transmitting to CMS in order to identify errors that could be corrected before transmission. He stated that he has been involved in the system of data collection and data entry to the computerized system and had identified errors that must be corrected before the final transmission of the information. He also stated that last quarter (2023) data was transmitted with errors, and he communicate with CMS to identify if data could be corrected, but it was impossible. He stated that the facility identified that quantity reported the last quarter (2023) was transmitted with errors related with nursing hours of care and other information were incongruent with days and services provided. However, data errors could not be corrected during this quarter because the errors were identified when data entry and transmission it had already been done.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 17959 Based on observations, review of policies procedures, review of facility documents and facility staff interview performed on 04/7/2024 through 04/09/2024 to from 8:00 AM through 5:30 PM, it was determined that the facility failed to maintain a Quality Assurance and Performance Improvement Program (QAPI). Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care and quality. Findings include: On 04/07/2024 2:00 PM during interview with the Skilled Nursing Facility-(SNF) Administrator (employee #1) on 04/08/2024 at 9:30 AM related to the Quality Committee meetings of Skilled Nursing Facility he stated that the last meeting of the QAPI of the Skilled Nursing Facility was done on July 20 of 2022. He refers to the fact that the SNF did not have a Quality Committee for one year. 1.There is no evidence of later meetings until present. It is important to point out that the person in charge of these functions resigned from her position as the Director of Quality and Risk Management on August 13, 2023, and the position has been vacant since then. During interview with the administrator, he states that since he has been the hospital administrator and of the SNF, they began the review process of the Quality Improvement Program and the Institution Programs for which he has developed initiatives to review quality indicators. The communications with directors, managers, and supervisors on January 3, 2024, about the department's quality processes and indicators reviews, are included. On September 5, 2023, a committee to transform the Institutional Programs was created. We are now in the process of establishing the meetings according to the calendar. On September 6, 2023, I schedule a meeting to give continuity of Quality Improvement Committee. However, as of the day of the survey the facility did not have a QAPI and QAA committee. B. On 09/04/2024 at 10:15 AM on interview with the Quality and Risk Manager Coordinator (employee #7) she stated: " On November 1/2022, I received a letter from the Human Resources Department informing me that effective October 31, 2022, I will be appointed as a full-time Quality and Assurance Coordinator. " this document also indicates that I would be in ninety-day probationary period which would end on January 30, 2023, and I would be evaluated by my immediate supervisor (employee #18) and then I would become a regular employee. I am currently the quality and assurance coordinator of the entire hospital and skilled nursing facility following the resignation of the former employee of the Quality Assurance and Quality Committee on August 13, 2023. "Since the doctor's resignation we have not established a QAPI and QAA committee.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	405025	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centro Medico Wilma N Vazquez Snf	Road 2 Km 39 5 Bo Algarrobo Vega Baja, PR 00693

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 17959 Based on observations, review of policies procedures and facility staff interview performed on 04/7/2024 through 04/09/2024 to from 8:00 AM through 5:30 PM, it was determined that the facility failed to maintain a Quality Assurance and Performance Improvement Program (QAPI). The facility failed to develop, implement, and maintain an effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care and quality of life. Findings include: 1.The SNF failed to collect and maintain data, develop indicators to monitor and improve quality of life, quality of care and safety through an effective QAPI program and was unable tpo provide documentation and evidence of quality indicators the committee had identified, monitored, and evaluated for improvement. In addition, they were unable to provide evidence that key facility staff from each department was in attendance and actively participating in SNF QAPI meeting. The facility did not provide evidence of Annual Monitoring Plan, quality indicators, meetings and other information related to the Skilled Nursing Facility for present year 2024.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 17959 Based on review of policies procedures, facility documents and facility staff interview performed on 04/7/2024 through 04/09/2024 to from 8:00 AM through 5:30 PM, it was determined that the facility failed to maintain a Quality Assurance and Performance Improvement Program (QAPI),Committee failed to conduct Quarterly meetings exclusively for the Skilled Nursing Facility (SNF), and when they did, not all required committee members were in attendance as required by Federal Regulations. Findings include: On 04/07/2024 2:00 PM During interview with the Hospital Administrator and Skill Nursing Facility Administrator (employee #1) on 04/08/2024 at 9:30 AM related to the Quality Committee of meetings of Skilled Nursing Facility he stated that the Skill Nursing Facility did not have a Quality Committe for more than one year. The last meeting of the Quality Improvement Committee of the Skilled Nursing Facility was done on July 20 of 2022.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17959 Based on observations of the physical environment, review of policies procedures and facility staff interview performed on 04/07/2024 through 04/09/2024 to from 8:30 AM through 4:00 PM, it was determined that the facility failed to promote a safe, and sanitary environment to help prevent the development and transmission of communicable diseases and infections. This deficient practice had the potential to affect 21 out of 21 residents receiving services at the facility. The facility failed to ensure promote the cleaning and maintenance, guaranteeing a safe and infection free environment. Findings include: 1. On 04/07/2024 at 8:50 AM a ceiling of resident room [ROOM NUMBER] was observed with yellow spots directly over the resident bed. Bed superior rails were observed with peeling paint. 2. The Occupational Room was visited on 04/08/2024 at 10:35 AM and was observed with dirty floor, dust, and stains. 3. Unlabeled refrigerator, no daily temperature registry, with plastic containers on the interior without lids containing raw meat, supermarket bags, with ice in the borders of the shelves and dust, mold and dirt on the outside. 4. Second refrigerator with bottles of soft drinks, water, groceries, no daily temperature record, entire ceiling with yellow stains from humidity, dust on the outside. 5. Deteriorated cardboard boxes with dust. 6. Trash disposal without bag and without lid containing garbage and plastic bottles. 7. Dusty wheelchairs near the refrigerator. 8. Moldy shelf both inside and outside, dirty, and dusty with different items inside the drawer, edibles such as cookies, glasses, protective gowns, screws, and funnels. 9. The base of the shelves is made of wood and is lined with deteriorated blue adhesive paper and absence of plastic on the edges with exposed wood. 10. Dusty metal chairs. 11. File with abundant presence of mold, paint, and detached material on the file a cardboard box with a sign that says "Enfamil Standard - Flow Soft Nipples" inside loose papers with documentation content were observed. 12. In the interior of a small broken and open box labeled "Cotton Tipped Applicators", slats with mold and dust. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	13. Wooden shelf with different materials and items to use with residents in the craft area. 14. Column in the main entrance area that goes directly to the floor with absence of baseboard, evidence of dust and dirt and absence of paint and cement. 15. Door frame with evidence of open space between frame and column. 16. Computer cables exposed, tied, and caught with binder [NAME] clip. 17. On 04/08/2024 the administrator (employee #1) was visiting the Occupational Therapy area, and he was surprised when visit this area and immediately ordered to provide cleaning and maintenance of the room. 18. No documentation or log registry was provided with documentation related to equipment cleaning disinfection after being used with residents. 19. No evidence of daily log registry temperature of the Occupational Therapy Room. 20. Facility failed to ensure that this Occupational Therapy Room used per residents daily was maintained with rusty equipment, dust and dirty is being used with residents who are on contact and transmission-based precautions. Rusty irregular surfaces are more likely to harbor dangerous bacteria and could contribute to cross contamination or an outbreak if are not properly cleaned disinfected after use.

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Put firmly secured handrails on each side of hallways. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47384 Based on observations of the physical environment, review of policies procedures and facility staff interview performed on 04/08/2024 to from 8:00 AM through 5:30 PM, it was determined that the facility failed to equip corridors with firmly secured handrails on each side. Findings include: Two hand rails on the main corridor between room [ROOM NUMBER] and 110 were observed loose and with plastic cover stiking out of base.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47384 Based on observations of the physical environment, review of policies procedures and facility staff interview performed on 04/08/2024 to from 8:00 AM through 5:30 PM, it was determined that the facility failed to maintain an effective pest control program so that the facility is free of pests and rodents. Findings include: Seven mouse traps were observed on the dry storage, during interview with the Kitchen supervisor (employee #17) stated that some time ago a [NAME] was found and that they requested more mouse traps.