STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455467	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Asbury Care Center of Alamo	8223 Broadway San Antonio, TX 78209

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on observations, interviews, and record reviews, the facility failed to treat each resident with respect and dignity and care in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality, for 2 (Residents #29 and #68) of 4 D-Hall residents reviewed for dignity. The facility failed to ensure MA B and LVN C treated Residents #29 and #68 with dignity and respect when they referred to the residents' as feeders. This failure could place residents at risk for psychosocial harm due to diminished self-esteem and quality of life. Findings included: Record review of Resident #29's face sheet dated 01/22/2025 revealed she was a [AGE] year-old-woman with an admitted [DATE] and with diagnosis which included: Cerebral Palsy (movement disorder caused by damage or lack of development to brain areas that control muscle movement) and Dementia (general term for loss of memory, language and other thinking abilities). Record review of Resident #29's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 3 indicating severe cognitive impairment. Record review of Resident #29's Care Plan initiated 06/10/2022 revealed a focus area for limited physical immobility and requires assistance with self care. Interventions include eating with assist of 1, revised 12/18/2024. Record review of Resident #68's face sheet dated 01/22/2025 revealed she was a [AGE] year-old woman admitted on [DATE] with diagnoses which included: Cerebral Vascular Accident (stroke) and Diabetes Mellitus (long-term condition that results in too much sugar in the blood). Record review of Resident #68's Admission MDS assessment dated [DATE] revealed a BIMS score of 03, indicating severe cognitive impairment and assessed as needing a mechanically altered diet texture. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 01/22/2025 starting at 12:20 p.m. revealed 3 residents sitting together at one dining table, and another resident sitting alone at a separate table. There was one CNA seated at the table with the 3 residents, in between residents Residents #29 and #68, and that CNA was feeding Resident #68 and assisting with the feeding of Resident #29. During an interview with MA B on 01/22/2025 at 12:53 p.m. regarding process and timeframes for distributing meal trays, MA B stated the feeders get served last because they need more assistance from staff, and she gestured towards the table where the 3 residents were seated. When asked what she meant by feeders, she stated they were the residents who needed to be fed or needed increased supervision and assistance from staff during meals During an interview with LVN C on 01/22/2025 at 12:57 p.m. regarding process for checking and distributing meal trays to the residents on D-hall, LVN C stated he was new to the facility, this was his 3rd day on the job, and described the process as the Nurse checking each tray to ensure correct order and texture and adaptive equipment was provided. When asked about information contained on the tray cards, LVN C stated the tray cards do not show which residents needed more feeding assistance, but he knew Resident #68 was a feeder. When asked if he had received training in resident rights he stated he had, both at this facility and at previous facilities he has worked. When asked about the term feeders, he stated he has always referred to residents who needed to be fed as feeders. He then asked is that wrong? Record review of MA B and LVN C's training records revealed both staff had received training in Resident Rights. During an interview with the DON on 01/23/2025 at 2:17 p.m., the DON stated that it was not acceptable or respectful of staff to refer to residents as 'feeders, as it described the residents only by their needs, not as individuals. The DON further stated the use of respectful language when speaking to and about the residents was addressed in orientation for all staff and included training in resident rights and dignity. The DON stated all staff receive periodic in-servicing on resident rights and dignity and she has already started in-servicing all the staff about need for use of respectful language when addressing or talking about the residents, including to avoid use of terms such as feeders or referring to older female residents as mama. Record review of the facility policy titled Resident Rights, revised February 2021, revealed the policy statement Employees shall treat all residents with kindness, respect, and dignity and under Policy Interpretation and Implementation Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . be treated with respect, kindness, and dignity. Further review of the Resident Rights policy revealed .staff will have appropriate in-service training on resident rights prior to having direct-care responsibilities for residents.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41651 Based on interview and record review, the facility failed to ensure the residents' right to request, refuse, and/or discontinue treatment for 2 (Residents #38 and #20) of 14 residents reviewed for informed consent, in that: 1. The facility failed to ensure Resident #38's right to informed consent for treatment with the psychotropic medication Sertraline was provided. 2. The facility failed to ensure Resident #20's right to informed consent for treatment with the psychotropic medication Sertraline was provided. These failures could place residents at-risk of receiving treatment without having been informed of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options, and to choose the alternative or option he or she prefers. The findings included: 1. Record review of Resident #38's face sheet dated 01/22/2025 revealed he was an [AGE] year-old man with an admitted [DATE] and diagnoses which included: Metabolic Encephalopathy (brain condition that occurs where there is an imbalance of chemicals in the brain resulting in difficulty thinking clearly), Dementia (general term for loss of memory, language, problem-solving and other thinking abilities), and Unspecified Depression (mental disorder that involves prolonged low mood and loss of interest in activities). Record review of Resident #38's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15, indicating intact cognition, and that he had been assessed as having a diagnosis of depression. Record review of Resident #38's Order Summary dated 01/22/2025 revealed an order for Sertraline HCL Oral Tablet 50 MG (Sertraline HCL) Give 1.5 tablet by mouth one time a day related to DEPRESSION, UNSPECIFIED with an order date of 11/15/2024. Further review of Resident #38's EHR Orders revealed Sertraline was initially ordered on 03/20/2024. Record review of Resident #38's EHR did not reveal an informed consent for Sertraline. During an interview with the DON on 01/23/2025 at 11:35 a.m., the DON noted that sometimes consents are filed in the wrong area, so she conducted a search of the EHR, and provided copy of an informed consent for Sertraline for Resident's #38, which noted verbal consent was obtained from the RP on 03/20/2024 but was not signed by LVN E until 12/20/2024. The DON stated she believed informed consent was obtained on 03/20/2024, but the LVN did not lock it in until later when the mistake was noted. The DON confirmed that verbal consents needed to have the Nurse's signature who obtained the verbal consent at the time the verbal consent was obtained, not many months later, as was the case with Resident #38's consent for Sertraline, making this consent invalid. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #20's face sheet, dated 01/22/2025, revealed she was admitted to the facility on [DATE] with diagnoses including: Generalized Anxiety Disorder, Major Depressive Disorder, and Insomnia Due to Other Mental Disorder. Record review of Resident #20's Quarterly MDS, dated [DATE], revealed the resident had both short-term and long-term memory problems. Record review of Resident #20's care plan, revised 12/12/2024, revealed, The resident uses psychotropic medications. Currently prescribed: .Sertraline. Record review of Resident #20's Order Summary Report as of 01/24/2025, revealed an order dated 09/05/2024, Sertraline HCl Oral Tablet 50 MG (Sertraline HCl). Give 1 tablet by mouth one time a day related to MAJOR DEPRESSIVE DISORDER, RECURRENT, UNSPECIFIED (F33.9). Record review of Resident #20's facility clinical record as of 01/24/2025, revealed an Anti-depressant Medication Informed Consent form had been created in the EMR on 01/24/2025. Further review revealed the consent form had not been signed by the resident or her responsible party. Record review of Resident #20's Medication Administration Record from 09/06/2024 through 01/24/2025, revealed she had received the psychotropic medication, Sertraline, on a daily basis for more than four months without informed consent having been obtained. During an interview with the DON on 01/24/2025 at 10:12 a.m., the DON confirmed that informed consent for the psychotropic medication, Sertraline, had not been obtained and should have been. She stated this was due to an oversight . The DON stated the consent form had been created on 01/24/2025 following an audit of each resident's EHR due to surveyor intervention and stated the facility had attempted to contact Resident #20's responsible party to obtain informed consent for the medication and was awaiting a response at the time of the interview. The DON stated that no additional informed consent forms were missing or incomplete. Record review of the facility policy titled Psychotropic Medication Use dated July 2022 revealed Residents (and/or representatives) have the right to decline treatment with psychotropic medications The staff and physician will review with the resident/representative the risks related to not taking the medications as well as appropriate alternatives.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 33866 Based on interview and record review, the facility failed to ensure the residents' right to formulate an advance directive for 1 (Resident #54) of 14 residents reviewed for advance directives. The facility failed to ensure Resident #54's desire to formulate an advance directive OOH DNR was completed and part of the record. This failure could place residents at-risk of having their end of life wishes dishonored and of having treatments that go against their personal preferences. The findings included: 1. Record review of Resident #54's face sheet dated [DATE] revealed she was an [AGE] year-old woman with an admitted [DATE] and diagnoses which included: Dementia (general term for loss of memory, language, problem-solving and other thinking abilities); End Stage Renal Disease (final stage of chronic kidney disease where kidneys can no longer function on their own); and Dependence on Renal Dialysis (requires dialysis treatment to survive). Further review of face sheet revealed under section Advance Directive DNR/No CPR. Record review of Resident #54's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 03, indicating severe cognitive impairment. Record review of Resident #54's Order Summary dated [DATE] revealed an order for DNR/No CPR dated [DATE]. Record review of Resident #54's Care Plan initiated [DATE] revealed a focus area for RESIDENT/FAMILY HAVE CHOSEN DO NOT RESUSCITATE initiated [DATE] with interventions which included: - Complete out of hospital DNR form with resident /family, send to MD for signature, and place completed form in chart. - Obtain written DNR order from MD - [NAME] chart per facility policy - Review Quarterly to ensure that completed OOHDNR is on chart. Record review of Resident #54's electronic health record did not reveal an OOH DNR form. During an interview with the SW on [DATE] at 9:50am, the SW stated Resident #54 was listed as a DNR on her admission profile, but she was not able to find a DNR for Resident #54 in the electronic record, and noted obtaining a copy of a DNR was part of the admission process and would check to see if it had been included in another packet by mistake. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Follow-up interview with the SW on [DATE] at 11:30 a.m. revealed she confirmed that they did not have a copy of Resident #54's DNR. During an interview with the DON on [DATE] at 10:04 a.m., the DON stated that a DNR order was entered for Resident #54 on [DATE] by MDS D. Interview on [DATE] at 10:07 a.m. with MDS D revealed she confirmed she entered the DNR order for Resident #54 on [DATE], but she stated she was unable to find a copy of the actual DNR order in the electronic health record or other files. During further interview with the DON on [DATE] at 11:01a.m., the DON stated she knew MDS D always had a hard copy of the DNR on hand before she would enter the order in the EHR, and believes what happened was that Resident #54 was sent to theER on [DATE], the day after the DNR had been signed and believes the DNR was placed in the transfer packet to the hospital before a copy was placed in the EHR. The DON further stated that there should have a copy of the DNR available at the facility, and by not having a copy of Resident #54's DNR it could result in confusion regarding her end-of-life choice for DNR, and the DNR potentially not being followed. Record review of the facility policy titled Advance Directives revised [DATE], revealed If the resident or the resident's representative has executed one of more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the residents medical record and a readily retrievable by any facility staff. 41651

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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. 33866 Based on observation, interview, and record review, the facility failed to ensure all drugs and biological were stored in locked compartments for 1 of 2 medication rooms (A-Hall medication room) reviewed for storage, in that: Controlled medications were not kept in a separate, permanently affixed compartment in the medication room. This deficient practice could place residents at risk of misappropriation of medications. The findings were: Observation in the A-Hall (secure unit) medication room on 01/23/2025 at 02:35 p.m. revealed a miniature refrigerator with a locked padlock on the outside of the door. The miniature fridge was not permanently affixed to the counter it was sitting on. Inside the miniature fridge was a small red lock box containing 2 containers of Morphine Sulfate 100mg in dark covers. The small red lock box was locked, but not permanently affixed inside the miniature refrigerator, and was able to be easily removed from the refrigerator. During an interview with the DON on 01/23/2025 at 05:08 p.m., the DON confirmed the small red lock box which contained the controlled medications was not permanently affixed inside the miniature refrigerator, but stated because the small red lock box was locked and the miniature refrigerator was padlocked, she felt that met the requirement of being double locked, and was not aware of the requirement for the controlled medications to be permanently affixed. Record review of the facility's policy titled, Controlled Substances,, dated April 2019, revealed, Controlled substances are stored in the medication room in a locked container, separate from containers for any non-controlled medications. There was no information contained in the policy regarding the storage of controlled substances to be in a permanently affixed compartment. Record review of the Regulation Text for 42 CFR 483.45 (h)(2) Storage of Drugs and Biologicals in the Appendix PP State Operations Manual revealed The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse and prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

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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. 41651 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed, in that: 1. Boxes of food were stored on the floor in the dry goods pantry. 2. Frost and ice accumulated on two boxes of food in the freezer. 3. An open container of jelly, labeled refrigerate after opening, was left out of the refrigerator. These failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness. The findings were: 1. Observation on 01/23/2025 at 11:24 a.m., in the dry goods pantry, revealed a four stacks of food items were in the floor and had not been placed on the pantry shelves. During an interview with the Dietary Manager on 01/23/2025 at 11:48 a.m., the Dietary Manager confirmed that stacks of food items were in the floor, had not been placed on the pantry shelves, and should have been. She stated that a delivery had recently been received and staff had not had time to properly store the food items. 2. Observation on 01/23/2025 at 11:28 a.m., in the walk-in freezer, revealed frost and ice had accumulated atop a cardboard container of onion rings and on a cardboard container of rolls. During an interview with the Dietary Manager on 01/23/2025 at 11:48 a.m., the Dietary Manager confirmed frost and ice had accumulated on the cardboard containers and confirmed the moisture could potentially seep into and contaminate the onion rings and rolls. 3. Observation on 01/23/2025 at 11:30 a.m., revealed an open container of jelly, labeled refrigerate after opening, was sitting on the lower shelf of the kitchen counter. During an interview with the Dietary Manager on 01/23/2025 at 11:48 a.m., the Dietary Manager confirmed an open container of jelly, labeled refrigerate after opening, was sitting on the lower shelf of the kitchen counter, and confirmed it should have been stored in the refrigerator. The Dietary Manager stated all dietary staff were responsible for ensuring boxes of food were appropriately stored off the floor, that frost and ice did not accumulate on food containers in the freezer, and that foods labeled refrigerate after opening should not be left out of the refrigerator and that failing to do so was an oversight. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2017, U.S. Department of H&HS, revealed 3-305.1, Food Storage, (A) Food shall be protected from contamination by storing the food: (1) in a clean, dry location; (2) Where it is not exposited to splash, dust, or other contamination. Review of the Food Code, U.S. Public Health Service, U.S. FDA, 2017, U.S. Department of H&HS, 3-501.16, revealed, Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57oC (135oF) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; P or (2) At 5 C (41 F) or less. Record review of the facility policy, Food Receiving and Storage, revised October 2017, revealed .food in designated dry storage areas shall be kept off the floor .all foods stored in the refrigerator or freezer will be covered, labeled, and dated .

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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** 33866 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 disease and infection for 2 of 6 residents (Residents #45 and #23) reviewed for infection control, in that: 1. LVN A did not wear a gown and gloves while performing an accu-check (process of testing blood glucose level using a lancet to prick a finger to draw blood and analyze with a glucometer), and administering medication to Resident #45 who had been placed on contact isolation precaution. 2. LVN A did not wear gloves while performing an accu-check on Resident #23. These deficient practices could place residents at-risk for infection due to improper care practices. The findings include: 1. Record review of Resident #45's face sheet dated 01/23/2025 revealed he was a [AGE] year old man, initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses which included: Paraplegia (chronic condition that causes paralysis in the lower half of the body, usually due to a spinal cord injury); pressure ulcer of sacral region stage 4 (a severe wound that extends into deep tissues in area at base of spine where it connect to the pelvis); colostomy status (presence of an artificial opening in abdomen that allows stool to pass through), and Type 2 Diabetes Mellitus (chronic condition where the body has trouble controlling blood sugar and using it for energy). Record review of Resident #45's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 indicating intact cognition. Further review revealed Resident #45 was assessed as having an indwelling catheter, colostomy and Diabetes Mellitus. Record review of Resident #45's Care Plan initiated 06/08/2022 revealed a focus area for Enhanced Barrier Precautions due to Chronic Wound and Indwelling Device: Stage IV to sacrum, indwelling catheter. Record review of Resident #45's Order Summary dated 01/23/2025 revealed orders which included: - NovoLOG injection Solution 100 unit/ml (Insulin Aspart) Inject as per sliding scale .subcutaneously before meals and at bedtime for DM2. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 01/23/2025 at 3:49 p.m. outside Resident #45's room revealed a Contact Precautions sign was posted to the right of the door, with a supply unit containing PPE outside the door under the Contact Precautions sign. Further observation revealed LVN A sanitized her hands and glucometer, and without putting on a gown or gloves, entered Resident #45's room, performed an accu-check on Resident #45 using a lancet to prick his finger and glucometer to assess his blood glucose reading, then stepped out of the room back to the medication cart, where she sanitized her hands and disposed of lancet in sharps container. LVN A then checked Resident #45's MAR to determine the correct amount of insulin per sliding scale to administer based on his blood sugar reading, re-entered his room without gown or gloves and administered the insulin. After LVN A administered his insulin, Resident #45 complained of pain and nausea, so LVN A then exited the room to the medication cart, sanitized her hands, and prepared two PRN medications, one for pain, and one for nausea, to administer to him. After preparing the oral medications, LVN A re-entered Resident #45's room, again without gown or gloves to administer his oral PRN medications. During an interview with LVN A on 01/23/2025 at 4:00 p.m., LVN A stated she saw the Contact Precautions Sign, and described those precautions as having to wear a gown and gloves if she was going to be working directly with him and might come into contact with bodily fluids, or he had a fever. LVN A stated that she did wear gown and gloves yesterday when she changed Resident #45's foley catheter, because that was directly working with him and involved body fluids. When asked what the difference was then between Contact Precautions and Enhanced Barrier Precautions (EBP), she stated EBP was basically the same, but was used when an infectious organism was possible, not confirmed and Contact Precautions were for a confirmed infection and he would probably have a fever. LVN A stated she has received training in infection control and has worked at this facility about one year. 2. Record review of Resident #23's face sheet dated 01/23/2025 revealed he was a 65- year-old man initially admitted on [DATE], and most recent re-admission on 01/17/2023, with diagnoses which included type 2 Diabetes Mellitus with foot ulcer. Record review of Resident #23's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 indicating intact cognition, and was assessed as having diagnosis of Diabetes Mellitus. Record review of Resident #23's Order Summary dated 01/23/2025 revealed an order for NovoLOG FlexPen Subcutaneous Solution Pen-Injector 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale .subcutaneously [injected into fatty tissue beneath the skin] before meals and at bedtime related to TYPE 2 DIABETES MELLITUS WITH FOOT ULCER. Observation on 01/23/2025 at 4:08 p.m. revealed LVN A sanitized hands and glucometer, then performed an accu-check on Resident #23 with her bare hands, she did not put on gloves. During an interview with LVN A on 01/23/2025 at 4:12 p.m., LVN A stated she normally does not wear gloves to do accu-checks unless the patient has AIDS or something like that. She noted Resident #23 does not have AIDS so she does not use gloves for his accu-checks. LVN A stated she had received training in infection control. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455467	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Asbury Care Center of Alamo	8223 Broadway San Antonio, TX 78209

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 - Some	Interview on 01/23/2025 at 5:11 p.m. with the DON revealed the DON confirmed that Resident #45 was under Contact Precautions and all staff needed to wear gown/gloves when entering the room, and that included when doing accu-checks and administering medications. The DON further stated that Nurse's should wear gloves whenever the possibility of coming in contact with blood or body fluids is present, and that would include when performing accu-checks for all residents. The DON confirmed that LVN A had received training in infection control. Record review of LVN A Orientation training record revealed LVN A did receive training in infection control, PPE and Contact Precautions on 05/24/2024. Record review of LVN A Performance Competency Checklist in Blood Glucose Monitoring dated 4/10/2024 revealed she was checked under Met for 2. washes hands and puts on disposable gloves. Record review of the facility policy titled Standard Precautions revised September 2022 revealed Gloves (clean, non-sterile) are worn when in direct contact with blood, body fluids, mucous membranes, non-intact skin, and other potentially infected material. Further review revealed Gloves are worn when in direct contact with a resident who is infected or colonized with organisms that are transmitted by direct contact. Record review of the facility policy titled Isolation - Categories of Transmission-Based Precautions revised September 2022 revealed Staff and visitors wear gloves (clean, non-sterile) when entering the room . Gloves are removed and hand hygiene performed before leaving the room. Further review revealed Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455467	A. Building B. Wing	01/24/2025

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 41651 Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public, in that: The lobby area of the secure unit smelled strongly of urine. This deficient practice could result in residents living in, staff working in, and the public visiting in an unpleasant environment. The findings were: Observation on 01/24/2025 at 10:32 a.m. revealed the lobby are of the secure unit smelled strongly of urine. Further observation revealed no obvious cause for the smell and observations of the unit's residents revealed all appeared to be clean and well-groomed with no personal odors. During an interview with LVN C on 01/24/2025 at 10:32 a.m., LVN C confirmed the lobby are of the secure unit smelled strongly of urine and stated the smell resulted in an unpleasant environment for staff and residents. During attempted interviews with residents at various times on 01/24/2025, none were able to be interviewed. During an interview with a resident's visitor on 01/24/2025 at 10:48 a.m., the visitor stated she came to the facility approximately five days per week and that the lobby are of the secure unit usually had an unpleasant odor. During an interview with the Housekeeping Supervisor on 01/24/2025 at 11:12 a.m., the Housekeeping Supervisor stated she was unaware of the odor and would inspect and clean the area. Record review of the facility policy, Homelike Environment, revised February 2021, revealed, Residents are provided with a safe, clean, comfortable and homelike environment . 3. The facility staff and management minimizes, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting. These characteristics include . b. institutional odors .