STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455471	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Health & Rehabilitation	1600 Muchison Rd El Paso, TX 79902

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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a notice of rights and services were provided to residents prior to or upon admission and during the resident's stay and ensure receipt of such information, and amendments to it were acknowledged in writing for 1 of 3 Residents (Resident #1) reviewed for Resident Rights. The facility failed to provide Resident #1 with an admission packet and notice of Resident Rights upon admission. This deficient practice could place residents at risk of not being aware of their rights, responsibilities, and the facility's policies.The findings were:Record review of Resident #1's face sheet, dated 09/03/25, revealed [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #1 was diagnosed with psychoactive substance abuse (the harmful or excessive use of substances that alter brain function and affect mood, behavior, and cognition), traumatic brain injury (an injury to the brain caused by an external physical force, such as a blow, hit, fall, or car accident), traumatic subarachnoid hemorrhage (bleeding within the protective layers covering the brain, caused by an injury, which leads to a sudden and severe headache, a severe head injury, and loss of awareness or consciousness) with loss of consciousness. Record review of Resident #1's admission MDS, dated [DATE], revealed there were no BIMS conducted for Resident #1. Was coded for acute onset mental status change of inattention and disorganization thinking. Record review of Resident #1's physician orders, dated 08/08/25, revealed I hereby certify that this resident requires/continues to require nursing facility care for 180 days with an end date of 02/04/26. During a confidential interview on undisclosed date and time, revealed Resident #1 had a TBI two months prior to being admitted into the facility and was accepted into the facility on [DATE]. The Autonomous Person stated Resident #1 was sent to the local hospital for suicidal ideations and placed under an emergency dentation order. The Autonomous Person stated Resident #1 was released from the local hospital as the psych evaluation came back negative and sent back to the facility who accepted him back. The Autonomous Person stated the local police officer and her called the Administrator and placed him on speaker phone and let him know there was no other place for Resident #1 to go and he had already been accepted back into the facility. The Autonomous Person stated the Administrator commented they did not have the security and were not equipped to take care of Resident #1. The Autonomous Person stated she did not understand why they accepted Resident #1 back to the facility after being cleared from the hospital and then wanting to discharge him. During an interview on 09/03/25 at 1:30 PM, with the Family Member, she stated Resident #1 was only at the facility for one day. The Family Member stated the resident was referred to the facility for therapy as he had an accident. The Family Member stated Resident #1 had behaviors according to what the facility told her. The Family Member stated Resident #1 went out of the facility window, was hitting staff, wanted to kill himself, and talked about his gun that she had sold. The Family Member stated the local police was called to the facility and later sent to the hospital. The Family Member stated the hospital cleared Resident #1 and was later accepted back to the facility. The Family Member stated later she received a call from the facility informed her she needed to go to the facility to pick up Resident #1 and take him with her. The Family Member stated the Administrator blamed her for not staying with Resident #1. The Family Member stated she was not given an incident report, and the facility refused to tell her what was going on. The Family Member stated she was told by the Administrator Resident #1 had to be out of the facility by the end of the day on 08/10/25. The Family Member stated she had not received any admission packet nor the resident rights information. The Family Member stated nothing was given to her and did not know what to do. During an interview on 09/04/25 at 3:34 PM with the Administrator, he stated Resident #1 was admitted to the facility late in the evening on 08/08/25. The Administrator stated Resident #1's behaviors did not start until 08/09/25 in the early morning. The Administrator stated he was present the day of all of Resident #1's incidents on 08/09/25. The Administrator stated Resident #1 was screaming and was moved from his room and placed into another room where he was by himself as he was disturbing the other resident that was in the room. The Administrator stated Resident #1 was sent to the local hospital and then returned sometime in the afternoon. The Administrator stated during admission the resident and or the Family Members were not given the admission packet. The Administrator stated because of the behavioral issues that Resident #1 was having it was chaotic that was why the Family Member was not given the admission packet. The Administrator stated the purpose of an admission packet was a packet that had all the information the resident or the families needed to know when residing at the facility. The

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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 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. (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 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to establish and implement admission policies for 1 of 3 residents (Resident#1) reviewed for admission. The facility failed to ensure Resident #1 and/or Resident #1's family members completed a signed admission agreement upon admission to the facility on [DATE]. This deficient practice could place residents at risk of not being made aware of their rights, the facility characteristics and services provided by the facility or policies of the facility. The findings include:Record review of Resident #1's face sheet, dated 09/03/25, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #1 had diagnoses which included psychoactive substance abuse (the harmful or excessive use of substances that alter brain function and affect mood, behavior, and cognition), traumatic brain injury (an injury to the brain caused by an external physical force, such as a blow, hit, fall, or car accident), traumatic subarachnoid hemorrhage (bleeding within the protective layers covering the brain, caused by an injury, which leads to a sudden and severe headache, a severe head injury, and loss of awareness or consciousness) with loss of consciousness. Record review of Resident #1's admission MDS dated [DATE], revealed there was no BIMS conducted for Resident #1. Resident #1 was coded for acute onset mental status change of inattention and disorganization thinking. Coded for mood as little interest or pleasure in doing things, feeling or appearing down, depressed, or hopeless, trouble falling or staying asleep, moving or speaking slowly that other people have noticed or the opposite of being so fidgety or restless, stated as life was worth living, wishing death, or attempts to harm self, and being short tempered and easily annoyed. Record review of Resident #1's orders, dated 08/08/25, revealed, I hereby certify that this resident requires/continues to require nursing facility care for 180 days with an end date of 02/04/26. During a confidential interview on an undisclosed date and time, revealed Resident #1 had a TBI two months prior to being admitted into the facility and then was accepted into the facility on [DATE]. The Autonomous Person stated Resident #1 was sent to the local hospital for suicidal ideations and placed under an emergency dentation order. The Autonomous Person stated Resident #1 was released from the local hospital as the psych evaluation came back negative and sent back to the facility, who accepted him back. The Autonomous Person stated the local police officer and her called the Administrator and placed him on speaker and let him know there was no other place for Resident #1 to go and he already was accepted back into the facility. The Autonomous Person stated the Administrator commented they did not have the security and were not equipped to take care of Resident #1. The Autonomous Person stated she did not understand why they accepted Resident #1 back to the facility after being cleared from the hospital and then wanted to discharge him. During an interview on 09/03/25 at 1:30 PM, with the Family Member, she stated Resident #1 was only at the facility for one day. The Family Member stated he was referred to the facility for therapy as he had an accident. The Family Member stated Resident #1 was having behaviors according to what the facility told her. The Family Member stated Resident #1 went out of the facility window, was hitting staff, wanted to kill himself, and talked about his gun, that she had sold. The Family Member stated the local police were called to the facility and later sent to the hospital. The Family Member stated the hospital cleared Resident #1 and was later accepted back to the facility. The Family Member stated later she received a call from the facility informing her she needed to go to the facility to pick up Resident #1 and take him with her. The Family Member stated the Administrator blamed her for not staying with Resident #1. The Family Member stated she was not given an incident report, and the facility refused to tell her what was going on. The Family Member stated she was told by the Administrator Resident #1 had to be out of the facility by the end of the day on 08/10/25. The Family Member stated she had not received an admission packet nor the resident rights information. The Family Member stated nothing was given to her and she did not know what to do. During an interview on 09/04/25 at 3:34 PM with the Administrator, he stated Resident #1 was admitted late in the evening on 08/08/25. The Administrator stated Resident #1 was sent to the local hospital and then returned sometime in the afternoon. The Administrator stated during admission the resident and or the Family Members were not given the admission packet. The Administrator stated it was chaotic with Resident #1's behaviors that the Family Member was not given the admission packet. The Administrator stated the purpose of an admission packet was a packet that had all the information the resident or the families needed to know when residing at the facility. The Administrator stated the admission Coordinator was responsible for providing the packets during the weekdays and on the weekend the receptionist was

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the resident and the resident's representative(s) of the a transfer or discharge were notified and the reasons for the move were in writing and in a language and manner they understood and a copy of the notice was sent to the a representative of the Office of the State Long-Term Ombudsman and the notice of transfer or discharge required was made by the facility at least 30 days before the resident was transferred or discharged for 1 of 3 residents (Resident #1) reviewed for discharges. 1. The facility failed to provide a 30-day written discharge notice to Resident #1 and/or Resident #1's Responsible Party when he was discharged on 08/10/25. 2. The facility failed to provide the Ombudsman with a notification of Resident #1's discharge on [DATE]. This failure could place residents at risk of improper discharges which could result in experiencing psychosocial harm due to inappropriate discharges and place residents at risk of being discharged without alternate placement and not having access to available advocacy services, discharge/transfer options, and denying them their rights in the appeal process.Findings include:Record review of Resident #1's face sheet, dated 09/03/25, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #1 had diagnoses which included psychoactive substance abuse (the harmful or excessive use of substances that alter brain function and affect mood, behavior, and cognition), traumatic brain injury (an injury to the brain caused by an external physical force, such as a blow, hit, fall, or car accident), traumatic subarachnoid hemorrhage (bleeding within the protective layers covering the brain, caused by an injury, which leads to a sudden and severe headache, a severe head injury, and loss of awareness or consciousness) with loss of consciousness. Record review of Resident #1's admission MDS, dated [DATE], revealed there was no BIMS conducted. Resident #1 was coded for acute onset mental status change of inattention and disorganization thinking. Resident #1 was coded for mood as little interest or pleasure in doing things, feeling or appearing down, depressed, or hopeless, trouble falling or staying asleep, moving or speaking slowly that other people have noticed or the opposite of being so fidgety or restless, stated as life was worth living, wishing death, or attempts to harm self, and being short tempered and easily annoyed. Record review of Resident #1's Care Plan, dated 08/09/25, revealed Resident #1 had impaired cognitive function/dementia or impaired thought processes. Discuss concerns about confusion, disease process, and NH placement. Engage resident in simple structed activities that avoid overly demanding tasks. Monitor and document and report to MD any changes in cognitive function, in decision making, difficulty expressing self, difficulty understanding others. Used antianxiety medications. Document, monitor, and report occurrences of target behavior (pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, etc. (et cetera, which translates to and other things or and the rest in English). Record review of Resident #1's orders, dated 08/08/25, revealed I hereby certify that this resident requires/continues to require nursing facility care for 180 days with and end date of 02/04/26. Record review of Resident #1's Progress Notes, dated 08/10/25, revealed [Resident #1] was discharged home. Medications provided for tonight and tomorrow morning. Pharmacy will deliver his medications tomorrow evening. Family member will come and pick them up. Discharge instructions given including medication administration. Education with list of scheduled meds. Questions were answered. SW tomorrow will arrange home health and will try to get Resident #1 his own wheelchair, with cushion and footrest. 3 in 1 and a hospital bed. Family member was educated on getting a PCP appointment ASAP. Facility number was provided for any questions and to assist in any other need family can have. Record review of Resident #1's Discharge to Home Instructions. dated 08/10/25, revealed the Family Member refused to sign the Discharge to Home Instructions. The following was noted, Instructions given to Family Member, and she refused to sign documentation. Family Member - I did not agree with this. It was their choice. During a confidential interview on an undisclosed date and time, with an Autonomous Person, revealed Resident #1 had a TBI two months prior to being admitted to the facility and then was accepted into the facility on [DATE]. The Autonomous Person stated Resident #1 was sent to the local hospital for suicidal ideations and placed under an emergency dentation order. The Autonomous Person stated Resident #1 was released from the local hospital as the psych evaluation came back negative and sent back to the facility who accepted him back. The Autonomous Person stated the local police officer and had called the Administrator and placed him on speaker, and were letting him know there was no other place for Resident #1 to go and he had already been accepted back into the facility. The

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview, and record review the facility failed to ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 (Resident #5) of 3 residents reviewed for foley catheter. The facility failed ensure Resident #5's indwelling catheter bag was kept from touching the floor. This deficient practice could place residents with indwelling catheters at risk of disease and infection. Findings included:The facility failed to ensure on Resident #5's catheter bag was hooked on his bed instead of lying on the facility floor, on 09/03/25.Record review of Resident #5's face sheet, dated 09/03/25, revealed an admission date of 04/09/25 to the facility. Record review of Resident #5's facility history and physical, dated 04/09/25, revealed a [AGE] year-old male. Resident #5 had diagnoses which included Diabetes Mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired) and Cerebrovascular accident (a stroke). Record review of Resident #5's quarterly MDS, dated [DATE], revealed a moderately impaired cognition, with a BIMS score of 9. Resident #5 was able to recall or make daily decisions. Resident #5 was coded for indwelling catheter. Record review of Resident #5's Care Plan, dated 04/09/25, revealed the resident was on enhanced barrier precautions. Posting at the resident room entrance indicating the resident was on enhanced barrier precautions. Gloves and gown should be donned if any of the following activities are to occur linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity. Had indwelling catheter. Position catheter bag and tubing below the level of the bladder and in a privacy bag. Ensure tubing was anchored to the resident's leg or linens so the tubing was not pulling on the urethra. Record review of Resident #5's orders, dated 06/08/25, revealed change foley catheter using 18 fr. (French, a unit of measurement from the French scale [or Charriere system] used to indicate the external diameter of the catheter tube) and 10 ml bulb as needed. Ensure catheter strap in place and holding. Ensure foley bag was in privacy bag while in bed or wheelchair every shift. Observation on 09/03/25 at 9:03 AM of Resident #5, revealed Resident #5 was in bed covered and lying on his back. On the floor on the right side of the bed was Resident #5's catheter bag. It was noted LVN L was heard looking into Resident #5's room and said, Oh the bag and walked in. LVN L was observed picking up the catheter bag and hooking it to Resident #5's bed. During an interview on 09/03/25 at 2:45 PM with LVN D, she stated it was not okay for catheter bags to be touching the floor as it was cross contamination and not sanitary. LVN D stated it needed to be hooked on to the bed. LVN D stated it was everyone's responsibility to ensure the catheter bags were hung on the bed or wheelchair. During an interview on 09/03/25 at 3:14 PM with RN E, he stated catheter bags were never to be on the floor. RN E stated it was contamination and it needed to be hung on the bed or wheelchair properly. RN E stated it was everyone's responsibly to ensure they were properly hung. During an interview on 09/04/25 at 8:57 AM with ADON B, she stated catheter bags were to be anchored to the bed or wheelchair and not on the floor. ADON B stated it was an infection control issue as well as a dignity thing. ADON B stated she would not want her catheter bag to be on the floor. ADON B stated it was everyone's reasonability to ensure the catheter bags were off the floor and hung on the bed or wheelchair. During an interview on 09/04/25 at 9:54 AM with ADON F, she stated Resident #5 had a habit of always unhooking his catheter bag when he turned or repositioned himself in bed, and it fell onto the floor. ADON F stated Resident #5 was educated on it. ADON F stated the catheter bag should not be on the floor as it was an infection control issue. ADON F stated it was the nurse's responsibility to ensure it was hooked on the bed. During an interview on 09/04/25 at 10:53 AM with NP I, she stated the catheter bags should not be on the floor as it was an infection control issue. NP I stated it was the nurses responsibility to ensure they were hooked onto the bed or wheelchair appropriately and not on the floor. During an interview on 09/05/25 at 9:51 AM with the DON, she stated the catheter bags were not meant to be on the floor and could be a risk of infection. The DON stated it was everyone's responsibly to ensure the catheter bags were placed on the bed or wheelchair correctly.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed provide each resident with the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care for 1 of 3 residents (Resident #1) reviewed for behavioral health services.The facility failed to use the on-call psychiatric service on 08/09/25 to refer Resident #1 for psychiatric services/evaluation after showing increasing signs of behaviors, verbalized suicidal ideation, physical aggression, and agitation on 08/09/25. This deficient practice could place residents at risk of not maintaining a sense of well-being that could affect their health. The findings were:Record review of Resident #1's face sheet, dated 09/03/25, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #1 had diagnoses which included psychoactive substance abuse (the harmful or excessive use of substances that alter brain function and affect mood, behavior, and cognition), traumatic brain injury (an injury to the brain caused by an external physical force, such as a blow, hit, fall, or car accident), traumatic subarachnoid hemorrhage (bleeding within the protective layers covering the brain, caused by an injury, which leads to a sudden and severe headache, a severe head injury, and loss of awareness or consciousness) with loss of consciousness. Record review of Resident #1's admission MDS, dated [DATE], revealed there was no BIMS conducted for Resident #1.Resident #1 was coded for acute onset mental status change of inattention and disorganization thinking. Resident #1 was coded for mood as little interest or pleasure in doing things, feeling or appearing down, depressed, or hopeless, trouble falling or staying asleep, moving or speaking slowly that other people noticed or the opposite of being so fidgety or restless, stated as life was worth living, wishing death, or attempts to harm self, and being short tempered and easily annoyed. Record review of Resident #1's Care Plan, dated 08/09/25, revealed Resident #1 had impaired cognitive function/dementia or impaired thought processes. Resident #1 wanders. Identify patterns of wandering. Anxiety and depression with poor adjustment to the facility. At risk for elopement. Intervene as appropriate. Discuss concerns about confusion, disease process, and NH placement. Engage resident in simple structed activities that avoid overly demanding tasks. Monitor and document and report to MD any changes in cognitive function, in decision making, difficulty expressing self, difficulty understanding others. Used antianxiety medications. Document, monitor, and report occurrences of target behavior (pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, etc. (et cetera, which translates to and other things or and the rest in English). During an anonymous interview on an undisclosed date and time, with an Autonomous Person, revealed Resident #1 had a TBI two months prior to being admitted to the facility and then was accepted into the facility on [DATE]. The Autonomous Person stated Resident #1 was sent to the local hospital for suicidal ideations and placed under an emergency dentation order. The Autonomous Person stated Resident #1 was released from the local hospital as the psych evaluation came back negative and sent back to the facility who accepted him back. The Autonomous Person stated the local police officer and her had called the Administrator and placed him on speaker and let him know there was no other place for Resident #1 to go and he had already been accepted back into the facility. The Autonomous Person stated the Administrator commented that they did not have the security and were not equipped to take care of Resident #1. During an interview on 09/03/25 at 1:30 PM with the Family Member, she stated Resident #1 was only at the facility for one day. The Family Member stated he was referred to the facility for therapy as he had an accident. The Family Member stated Resident #1 was having behaviors according to what the facility told her. The Family Member stated Resident #1 went out of the facility window, was hitting staff, wanted to kill himself, and talking about his gun that she had sold. The Family Member stated the local police were called to the facility and later sent to the hospital. The Family Member stated the hospital cleared Resident #1 and was later accepted back to the facility. The Family Member stated later she received a call from the facility informing her she needed to go to the facility to pick up Resident #1 and take him with her. The Family Member stated the Administrator blamed her for not staying with Resident #1. The Family Member stated she was not given an incident report, and the facility refused to tell her what was going on. During an interview on 09/03/25 at 2:15 PM with LVN D, she stated Resident #1 was being very aggressive on 08/09/25 by kicking staff. LVN D stated Resident #1 was being re-directed but it was not always easy to do. LVN D stated other residents were scared of Resident #1 due to him lying underneath their beds. LVN D stated they were re-directing Resident

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Health & Rehabilitation	1600 Muchison Rd El Paso, TX 79902

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	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 10 residents (Resident #4) reviewed for infection prevention and control. 1. The facility failed to implement precautions and interventions after Resident #4 was sent out to the hospital for isolation due to a positive AFB (a type of bacteria causing tuberculosis) to ensure there was no spread of infection or disease. These failures could place residents at risk for infections, secondary infections, communicable diseases due to improper care practices.Findings include: Record review of Resident #4's face sheet, dated 09/03/25, revealed an admission date of 07/15/24 and re-admission on [DATE] to the facility. Record review of Resident #4's hospital history and physical. dated 08/18/25, revealed a [AGE] year-old female. Resident #4 had diagnoses which included cavitation PNA (a severe, destructive lung infection where the infection destroys lung tissue, leading to the formation of one or more air-filled cavities), End Stage Renewal Disease (the final stage of chronic kidney disease (CKD), where the kidneys have severely deteriorated and can no longer function adequately to filter waste products and excess fluid from the blood), and Diabetes Mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired). Lung abscess/hospital acquired pneumonia/chest tuberculosis. Concern for TB/lung abscess and also possible HA pneumonia (a lung infection that develops in hospitalized patients at least 48 hours after admission). The resident was in and out of healthcare facilities. Tuberculosis PCR (a rapid molecular test that detects DNA from the Mycobacterium tuberculosis complex, which causes TB) not detected. Sputum AFB negative x3, no indication for airborne precautions or concerns for TB at this time. Record review of Resident #4's annual MDS, dated [DATE], revealed an intact cognition with a BIMS score of 14. Resident #4 was able to recall information or make daily decisions. Coded for Dialysis. Record review of Resident #4's Care Plan, dated 12/02/24, revealed dialysis to be done three times a week. Monitor labs and report to doctor as needed. Obtain vital signs and weights per protocol. Resident #4 had Diabetes Mellitus and identify areas of non-compliance or other difficulties in resident diabetic management. Diagnosed with pneumonia. Assess rhythm, rate, and depth of respiration. Maintain universal precautions when providing resident care. Record review of Resident #4's Hospital Microbiology, dated 08/28/25, revealed on 08/13/25, there was no AFB noted. On 08/28/25, Preliminary: it was noted AFB - isolated on liquid media only. Record review of Resident #4's Progress Notes, dated 08/29/25, revealed [Resident #4] was transferred to a hospital on [DATE] at 5:00 PM. Related to receiving fax from hospital for microbiology preliminary AFB. This was intended to serve as notice of an emergency transfer. Record review of Resident #4's Vitals for Temperature, dated 08/20/25 to 08/29/25, revealed temperature to be between 97-98 degrees Fahrenheit. There was no fever noted. Record review of NP K's text messages to physician, dated 08/19/25 at 11:30 AM, revealed NP K - Hi, Are isolation precautions needed for MSSA infections. Physician - No. There was no mention of isolation for any other infection disease asked in the text message as Resident #4 was still at the facility. Record review of Resident #4's Orders dated 08/26/25, revealed, Follow up with physician in 14 days follow up on 09/30/25 at 1:00 PM. Every shift related to MSSR infection as the cause of disease. Observation on 09/03/25-09/09/05/25 ranging from 8:00 AM to 5:00 PM on 2 floors, revealed, there were no residents noted to be coughing, sneezing, sweaty, pale, or having trouble with breathing. No facility were observed wearing N95 masks. During an interview on 09/03/25 at 11:15 AM with NP J, she stated there were no issues with any of her residents regarding signs or symptoms of TB. NP J stated any resident who had a positive TB needed to be isolated for droplet precautions. NP J stated the facility was not equipped with a negative pressure room (a specially designed room, also known as an airborne infection isolation room) and would have to be sent out to a facility or hospital that had one. During an interview on 09/03/25 at 1:41 AM with LVN M, she stated Resident #4 was sent to the hospital and was not at the facility. LVN M stated she was unsure if Resident #4 had a positive TB. LVN M stated all staff were trained on infection prevention control. LVN M stated she worked that Monday (09/01/25) and noticed there was PPE placed outside of Resident #4's room. LVN M stated seeing the PPE outside of her room gave her the indication there might have been something with an infection. LVN M stated since Resident #4 returned to the facility from the hospital, she had been at activities and in the dining room for mealtimes with other residents. During an interview on 09/03/25 at 1:48 PM with