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	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Health & Rehabilitation	1600 Murchison 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49854 Based on observation, interviews, and record review, the facility failed to ensure residents the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 2 residents (Resident #49 and #68) of 22 residents reviewed for call light placement. The facility failed to ensure call light was placed within reach for Resident #49 and Resident #68 This failure places residents at risk of having needs unmet when they are unable to contact staff. Findings included: Record review of Resident #49's Admission Record, dated 12/18/2024, reflected a [AGE] year-old female admitted on [DATE]. Record review of Resident # #49's Hospital History and Physical dated 11/14/23, revealed diagnoses of traumatic brain injury resulting in cognitive impairment, schizoaffective disorder, delusions, hypertension, and cognitive communication deficit. Record review of Resident #49's Annual MDS assessment dated [DATE], revealed a BIMS score of 3 demonstrating she was cognitively impaired. Record review of Resident # #49's care plan dated 1/8/24 revealed she had a communication problem related to not understanding things, being forgetful, and impaired in condition . It stated the call light should be with in reach at all times. In an intervie w and observation on 12/17/24 at 09:05 AM, Resident #49 was in bed facing the window. There was no call light connected to the wall to the right side of the residents' bed. She was alert and oriented to person only. Resident #49 stated she did not know what a call light was or what it was used for. Record review of Resident #68's Admission Record dated 12/19/24 reflected a [AGE] year-old male admitted on [DATE]. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident # 68's Hospital History and Physical dated 6/11/24 revealed the resident had a past medical history of Huntington's chorea (a hereditary disease marked by degeneration of the brain cells and causing progressive dementia), PEG tube placement (a procedure in which a tube is passed into a patient's stomach through the abdominal wall to provide means of feeding) and unknown right groin drain. Record review of Resident #68's quarterly MDS dated [DATE] revealed he had a BIMS of 3, indicating he was cognitively impaired. Record review of Resident # 68's care plan dated 1/17/24 revealed Resident #68 needed to always have a call light within reach. Resident #68 was impaired cognitively and functionally with dementia or impaired thought. He had a communication problem related to an impaired ability to make himself understood and to understand others, and had Huntington's disease. In an observation on 12/17/24 at 11:07 AM, Resident #68 was in bed and the call light was on the floor to his left side, out of reach. The resident was nonverbal. In an Interview and Observation on 12/17/24 at 11:15 AM with CNA J, the light turned on for the room and she explained Resident #68 tended to drop the call light from his bed to the floor, which caused the light to turn on. CNA J said that he used to have a call light that staff could clip on his bedsheet, but he was not able to press the button for that call light, so it was changed to the pad call light. CNA J stated that LVNs and CNAs made constant rounds to make sure the call light was within reach of the resident. She stated that the risk for a resident not having a call light within reach, was that the resident would not be able to call for help or assistance and if the call light was far from reach, they could try and reach for it and possibly fall from the bed causing injuries. In an Interview and Observation 12/18/24 at 03:00 PM with the DON in Resident #49's bedroom, she stated that the call light cord had been reinstalled. In an interview on 12/19/24 at 4:00 PM, The Administrator and the DON stated the facility did not have policies addressing call-light services for the residents.

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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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49854 Based on observation, interview, and record review, the facility failed to ensure residents had the right to have reasonable access to the use of a telephone and a place in the facility where calls can be made without being overheard for 2 of 22 (Resident #63 and #94) residents reviewed for telephone use. The facility failed to provide a place for Resident #63 and Resident #94 to make telephone calls without being overhead. This failure could place residents at risk of conversations being overheard and privacy rights not being respected. The findings included: Record review of Resident #63's Admission Record, dated 12/18/2024, reflected a [AGE] year-old female admitted on [DATE] and readmitted on [DATE]. Record review of Resident # 63's Hospital History and Physical dated 4/11/24, revealed diagnoses of Type 2 diabetes, hypertension, schizoaffective disorder. Record review of Resident # 63's Quarterly MDS assessment dated [DATE], revealed a BIMS score of 14 demonstrating she was cognitively intact. Record review of Resident #94's Admission Record, dated 12/18/2024, reflected a [AGE] year-old male admitted on [DATE]. Record review of Resident # 94's Hospital History and Physical dated 11/11/23, revealed diagnoses of Parkinson's disease, bipolar disorder, and sleep apnea. Record review of Resident # 94's Quarterly MDS dated [DATE], revealed a BIMS score of 13 demonstrating he was cognitively intact. In an observation on 12/17/24 at 09:01 AM: Resident #63 was observed at hallway 2200 on the second floor in the facility, making a private phone call with a relative talking about money. Another resident was at arm's length sitting on her wheelchair, 3 staff members were observed at about 6 and 8 feet away from the resident. In an observation on 12/17/24 at 10:30 AM: Resident #94 was standing by the front entrance of the facility at the nurses' station making a phone call to his relatives. There were 2 staff members sitting inside the nursing station three to four feet away from the resident. There were multiple residents sitting on their wheelchairs around the nursing station and all of them were in the near proximity of Resident #94 (continued on next page)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/17/24 at 10:01 AM with Resident #63, she said that she needed to have a phone call because she was dealing with issues with her pension check. Resident #63 said she did not like that there was no private place to make phone calls and that it had been that way almost since the time she was admitted . Resident #63 stated the facility used to have a private place to make phone calls, before, on the first floor, but since it was a cordless phone, it used to get lost all the time and residents were not able to make calls when needed. She said it bothered her to make phone calls when there were nurses or other residents around and that it could also be embarrassing, but that it was the only way for her to communicate outside the facility. In an interview with on 12/18/24 at 09:39 AM with LVN H, he stated that there was no designated private area in the facility for the residents to make a phone call. LVN H said that if a resident needed to make a call, they would usually use the nurses' station, or they could use the phones located in the hallways of the facility. LVN H stated that they could also request the Social Worker for assistance, and she would lend them a cell phone so they could talk in private in their rooms. LVN H said he believed all the residents who are alert and oriented knew they could request the phone from the Social Worker. LVN H said he considered the hallway a private area where the residents can have a conversation comfortably. In an interview on 12/18/24 at 9:43 AM with Resident #94, he stated he used the phone from the facility regularly, and he made phone calls in the nurses' station at the front lobby. Resident #94 said, for the most part, he was all right with using the phone in that area, but he would prefer if there was a place, he could do it more privately because sometimes he had a hard time hearing the conversations over the phone with so many people walking by in the lobby area. In an interview on 12/17/24 at 09:08 AM with CNA I, she said she had been trained last in Resident Rights about a month ago. CNA I stated that the residents had a right to make personal phone calls in the facility when they request it. CNA I said in the past there was a phone on the first floor that had privacy for the Residents, but the space was converted into a chapel and there was no phone there any longer. CNA I said that there was a possibility that other residents may hear their conversation and misinterpret what was being discussed over the phone. She also said that residents talked amongst each other, and they could start making rumors about what was overheard. She said the residents' right to privacy was not being respected for the residents at the facility if they did not have a place to make calls in private. In an interview and observation on 12/18/24 at 03:00 PM with the DON, she stated she believed that a private area with a cordless phone was designated for residents on 12/18/24 inside of the copying room . It was observed that there was a sign that stated the area, and the phone was for residents' use only. The DON said it was expected for a staff member to redirect a resident either to their room or to their designated private area to make the phone call if they saw a resident trying to make a call in a public area such as the nurses' station or in a hallway from the facility. The DON said if a staff did not redirect a resident to a private area, it could result in a resident being overheard by other residents or staff members on their personal affairs, possibly violating their right to privacy. The DON said the residents could also feel embarrassed discussing something with their relatives if there were people around, or if they needed to complain they could feel they can't discuss it with their family because staff or residents were present and around them. (continued on next page)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/18/24 at 03:44 PM with the Administrator and the Maintenance Director, they explained to the state surveyor the facility had been trying to find a private area for the residents to use so they could make calls in private. The Administrator stated the facility had tried to connect a phone by the chapel but a line that worked could not be found to connect a phone. The Maintenance Director stated the solution they found was to purchase a VOIP (voice over the internet) phone for the residents to use in private either in their room or in the copy machine office. They both stated that the phone had been operational since Monday 12/16/24. The Administrator said she did not believe the residents' privacy was violated because the staff working in the hallway of the second floor and at the nurses' station on the first floor, were busy and could not be paying attention to the residents' conversations. Record review of the facility's policy titled Resident Rights, Social Services Manual 2003 revised 11/28/16, revealed, the resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the president's own expense.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 49854 Resident #63 Privacy 12/18/24 09:55 AM Record Review of the facility's P&P 5. The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. Resident #94 Privacy

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871 Based on observations, interviews and record reviews, the facility failed to ensure they followed professional standards of practice in accordance with physician orders and facility policy for care of midline for 1 (Residents #27) of 4 residents reviewed for parenteral and intravenous care. The facility failed to change Resident #27's PICC line dressing as ordered. This failure placed the residents at risk of complications with their midlines needed for infusion therapy. Findings included: Record review of Resident #27's face sheet dated 12/17/24 revealed an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses of sepsis (an infection of the blood stream resulting in a cluster of symptoms such as drop in a blood pressure, increase in heart rate and fever), hemiplegia (paralysis that affects only one side of your body) muscle weakness, and cognitive communication deficit. Record review of Resident #27's admission MDS assessment dated [DATE] revealed BIMS of 12, his cognition was moderately impaired. Record review of Resident #27's care plan dated 11/20/24 revealed focus area for intravenous access with interventions of change dressing every 7 days and as needed. Record review of Resident #27's physician order dated 11/20/24 revealed PICC line dressing, change every 7 days one time a day every Wednesday infection control. During an observation and interview on 12/17/24 at 10:31 am, Resident #27 was alert and oriented to person, place, and event. Resident #27 had a PICC line on his right arm and the transparent dressing was dated 12/08/24. Resident #27 stated he had been waiting for the nurse to change his PICC line dressing because it had been bothering him. Resident #27 denied any pain or discomfort to the PICC line site. No redness, swelling, drainage was noted to the PICC line site. In an interview on 12/17/24 at 2:53 pm, RN C explained that PICC line dressings were required to be changed weekly, with charge nurses responsible for the task. RN C stated Resident #27's dressing was last dated 12/8/24 and had been due for a change on 12/15/24. RN C stated there was a risk of infection if the dressing was not changed as ordered, but stated there were no signs of infection, such as swelling, redness, or drainage at the site. RN C stated he had intended to change the dressing earlier that morning and confirmed they would do so shortly. RN C stated all nurses were responsible for changing PICC line dressings as ordered. In an interview on 12/18/24 at 11:41 am, Resident #27 stated the PICC line was removed yesterday. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/19/24 at 2:19 pm, ADON E explained that PICC line dressing changes were performed weekly and as needed, typically under the responsibility of the charge nurse on the floor. ADON E stated staff were expected to follow a physician's order, which included verifying the date of the last dressing change. ADON E stated when flushing the line, nurses assessed the site for cleanliness, redness, skin breakdown, and signs of infection. ADON E stated that failure to change the dressing as required could pose a potential risk of infection. In an interview on 12/19/24 at 3:18 pm, the DON stated PICC line dressings were changed every seven days or as needed (PRN) if the dressing became soiled or dislodged. The DON stated licensed nurses were responsible for completing that task. The DON stated the schedule was outlined in the TAR, with orders prompting nurses to sign off once completed. The DON stated documentation was auto populated, and the performing nurse was expected to check the dressing during rounds. The DON stated dressings were labeled with the date and the nurse's initials. The DON stated leadership and management were also involved, conducting checks to ensure compliance. The DON stated annual evaluations were completed to assess adherence to protocols. The DON stated the primary risk identified was infection if proper care and monitoring were not maintained. During an attempted interview on 12/19/24 at 3:46 pm, the Administrator referred the questions to the DON. Record review of the facility's Central Venous Catheters policy dated 2003 read in part CVC (central venous catheter) maintenance procedures: PICC lines dressing change 24 hours after insertion, then transparent dressing every 7 days and as needed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 8 residents (Resident #27) reviewed for pharmacy services. Resident #27 had an over the counter Selenium 200 mcg bottle and an over the counter Aspirin 81 mg bottle at his bedside. This failure could place residents at risk of inaccurate drug administration and not having appropriate therapeutic effects. Findings included: Record review of Resident #27's face sheet dated 12/17/24 revealed an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses of sepsis (an infection of the blood stream resulting in a cluster of symptoms such as drop in a blood pressure, increase in heart rate and fever), hemiplegia (paralysis that affects only one side of your body), muscle weakness, and cognitive communication deficit. Record review of Resident #27's admission MDS assessment dated [DATE] revealed BIMS of 12 indicating his cognition was moderately impaired. Record review of Resident #27's medical records revealed no assessment was completed for self-administration of medication. Record review of Resident #27's care plan dated 11/20/24 revealed no focus area addressing self-medication administration. Record review of Resident #27's December 2024 MARS revealed no orders for Aspirin 81 mg and Selenium 200 mcg. During an observation and interview on 12/17/24 at 10:31 am, Resident #27 had over the counter Selenium 200 mcg bottle and over the counter Aspirin 81 mg bottle at his bedside. Resident #27 was unable to verbalize the purpose of the medication used, and stated he would self-administer when he felt he needed them. Resident #27 was not able to recall when he last administered either of the mediations. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/18/24 at 2:23 pm, RN C stated that Resident #27 had a history of possessing unauthorized over-the-counter medications and supplements. RN C stated he provided previous redirection and education to Resident #27 on importance of not having unauthorized over the counter medication/supplement in his possession. RN C stated he did not inform upper management until the previous night. RN C stated that a self-medication administration assessment had not been completed for Resident #27 and expressed uncertainty about the resident's cognitive ability to adhere to prescribed medication schedules. RN C stated he monitored Resident #27's environment during rounds to ensure no unauthorized medications were present. RN C stated there was a risk of overmedication. In an interview on 12/19/24 at 2:19 pm, ADON E stated that residents were not permitted to keep OTC medication at their bedside unless an assessment had been conducted to determine their ability to self-administer safely. ADON E stated staff needed to report concerns related to residents having OTC at bedside to ensure proper monitoring was implemented. ADON E stated failure to report OTC medication at bedside posed risks, including potential overdose, misuse of medication, and lack of reporting due to insufficient monitoring. ADON E stated nurses were responsible to ensure no OTC medications were at bedside when conducting their rounds at least every 2 hours or as needed. In an interview on 12/19/24 at 3:18 pm, the DON stated that over-the-counter medications were not allowed at a resident's bedside without an assessment. The DON stated an assessment was required to evaluate the resident's cognitive ability to safely handle medications. The DON stated staff were expected to remove any unauthorized medications, conduct the necessary assessment, lock the medications away, and store them in the medication cart. The DON stated if issues or concerns arose with removing medications, staff were expected to report them, especially if the issue occurred more than once. The DON stated staff were trained to assist with proper assessment and storage to ensure medication safety. The DON stated risks identified included improper management of medication intake, and overall medication safety. The DON stated training was provided through Relias on an annual basis and every three months for different medications. The DON stated staff were required to check for medications left at the bedside during rounds, conducted every two hours, and during walking rounds at shift changes. The DON stated leadership was also responsible for conducting daily rounds to monitor compliance. The DON stated she had not received reports of Resident #27's noncompliance with OTC medication at bedside. In an interview on 12/19/24 at 3:46 pm, the Administrator stated an assessment was required before allowing over-the-counter medications at the bedside, which included ensuring the medications were locked, secured, and administered at appropriate times. The Administrator stated nurses were responsible for checking compliance during their rounds. The Administrator stated if there was a pattern of noncompliance, it was expected to be reported to the DON, followed by a meeting to address the issue, and provide education on compliance. Record review of the facility's Self Administration of Drugs policy dated 01/09/2006 read in part The facility acknowledges the right of each resident to self-administer medications unless the interdisciplinary team has evaluated the resident and judged that self-administration would present a danger to the resident or others. 1- Only medications permitted (ordered) for self-administration shall be left in the resident's room. 2- Failure of a resident to comply with these policies must be promptly reported to the DON/designee and the resident's attending physician.

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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. 30057 Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in locked compartments for 1 of 1 (treatment cart) reviewed for medication storage and security. The facility failed to ensure LVN A secured the facility's only treatment cart when it was left unattended. This failure could place residents at risk for drug diversion or accidental ingestion. Findings included: During an observation and an interview on 12/17/24 at 07:59 AM, the treatment cart was noted to be unlocked and unsupervised on hall 200. Inside the cart were several needles, dressings, and medicated ointments. Approximately 10 minutes later LVN A came out of a residents' room, and said she had stepped away and had forgotten to lock the cart. LVN A said she normally locked the cart whenever she stepped away, but that time, she had forgotten because she had to check on a resident with the doctor present. The LVN said leaving the cart open could pose a hazard to residents and leave access to other staff. During an interview on 12/19/24 at 02:24 PM, the DON was made aware of the observation of the unlocked and unattended treatment cart seen on hall 200. The DON said it was expected for any medication or treatment cart to be locked if left unattended. The DON said the nurse that was in charge of that cart stepped away to assist the doctor that was doing rounds at the facility, but forgot to lock her cart. The DON said she knew that was no excuse to leave the cart unlocked, and the nurse should have locked it. The DON said if the carts were left unlocked and unattended that could lead to staff, family members, or other residents having access to the items in the cart. During an interview on 12/19/24 at 02:44 PM, the Administrator was made aware of the observation of the unlocked and unattended treatment cart seen on hall 200. The Administrator said it was expected for the carts to be locked if the staff walked away from the carts. The Administrator said if the carts were left unlocked and unattended, then unauthorized staff, guests, or residents could have access to the stuff in the cart. The Administrator said she believed the failure occurred because the nurse left to assist the doctor and forgot to lock the cart when she walked away. Record review of the facility's policy Medication Carts dated 2003 indicated in part: The carts are to be locked when not in use or under the direct supervision of the designated nurse. Carts must be secured.

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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. 43871 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, in that: Dietary Aide G used a pitcher that had been placed in an uncleaned black cart and proceeded to refill it with tea by using the pitcher to scoop tea from the tea container before pouring it into cups. This failure could place residents who received drinks from the kitchen at risk for food borne illness. Findings included: Observation on 12/18/24 at 9:31 am revealed Dietary Aide G used a pitcher to serve tea by placing it inside the premade tea container to fill it with tea, and then poured the tea into cups. Dietary Aide G then placed the pitcher on the clean prepping table. Observation on 12/18/24 at am, Dietary Aide G placed the pitcher on a black cart next to the prepping table. Observation on 12/18/24 at 9:41 am, Dietary Aide G grabbed the pitcher from the black cart and proceeded to refill it with tea by using the pitcher to scoop tea from the tea container before pouring it into cups. In an interview on 12/18/24 at 9:51 am, the Kitchen Director stated the pitcher should not have been placed on the black cart as it had not been sanitized before use. The Kitchen Director stated there was a risk of cross-contamination. The Kitchen Director stated training had been provided on cross contamination during hire and annually. During an observation and interview on 12/18/24 at 9:54 am, Dietary Aide G stated the black cart had white sugar-like dirt particles and stains. Dietary Aide G stated she had received training on cross-contamination risks and stated failure to sanitize the cart could lead to cross-contamination and potential illness for residents. In an interview on 12/19/24 at 3:46 pm, the Administrator stated the Dietary Manager conducted annual competencies for staff, while the dietitian and dietary consultant monitored for cross-contamination practices alongside Infection Prevention (IP) measures. The Administrator stated staff were expected to avoid cross-contaminating clean and dirty items. The Administrator stated training in these practices was provided twice a year. The Administrator stated the primary risks identified included foodborne illnesses and bacterial infections, potentially stemming from improper handling or contamination, such as bacteria transferred from the cart. (continued on next page)

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Mountain View Health & Rehabilitation	1600 Murchison Rd El Paso, TX 79902

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Dietary Food Service Personnel Policy and Procedures dated 2012 read in part Sanitation and Food Handling: 8- work surfaces must be kept as neat and clean as possible during preparation and service.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871 Based on interview, and record review, the facility failed to ensure in accordance with professional standards of practices, the medical records on each resident were accurately documented for 1 of 8 (Resident #27) residents reviewed for accurate medical records. RN C documented he had changed Resident #27's PICC line when the task had not completed. This failure could place residents at risk for of having incomplete or inaccurate records and inadequate care. Findings included: Record review of Resident #27's face sheet dated 12/17/24 revealed an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses of sepsis (an infection of the blood stream resulting in a cluster of symptoms such as drop in a blood pressure, increase in heart rate and fever), hemiplegia (paralysis that affects only one side of your body), muscle weakness, and cognitive communication deficit. Record review of Resident #27's admission MDS assessment dated [DATE] revealed BIMS of 12, his cognition was moderately impaired and had a PICC line Record review of Resident #27's care plan dated 11/20/24 revealed a focus area for intravenous access with interventions of change dressing every 7 days and as needed. Record review of Resident #27's physician order dated 11/20/24 revealed PICC line dressing, change every 7 days one time a day every Wednesday infection control. Record review of Resident #27's December 2024 MAR revealed his PICC line dressing change was marked as completed on 12/11/24 by RN C. During an observation and interview on 12/17/24 at 10:31 am, Resident #27 was alert and oriented to person, place, and event. Resident #27 had a PICC line on his right arm, and the transparent dressing was dated 12/08/24. Resident #27 stated he had been waiting for the nurse to change his PICC line dressing because it had been bothering him. Resident #27 denied any pain or discomfort to the PICC line site. No redness, swelling, drainage was noted to the PICC line site. In an interview on 12/18/24 at 2:23 pm, RN C stated he had signed off that he had changed Resident #27's PICC line dressing on 12/11/2024, despite not performing the task. RN C stated he had received training on accurate documentation and stated he should not have signed off on a task he had not completed. RN C did not state a potential risk associated with documenting care that was not provided. RN C stated Resident #27's TAR documentation was not accurate. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/19/24 at 2:19 pm, ADON E explained that nurses were trained not to sign off on tasks they had not personally completed. ADON E stated training on this practice was provided through annual Relias (electronic training), and frequent checks were conducted on medication carts and during med passes. ADON E stated nurses also participated in in-service training and were observed to ensure compliance during annual competencies. ADON E stated a risk identified was that tasks could be mistakenly assumed completed based on documentation, leading to actions being taken-or not taken-under the false assumption the task had already been addressed. Interview on 12/19/24 at 3:18 pm, the DON that the TAR should not be signed off unless the task was fully completed. The DON stated there were concerns about discrepancies in documentation, as dates were not aligning, and one RN was unable to recall the date of the last PICC line dressing change. The DON stated nurses received frequent training due to the volume of assessments they performed and were expected to double-check their documentation for accuracy. The DON stated leadership conducted random spot checks weekly, reviewing orders, SBARs, event notes, and other documentation. The DON stated it was emphasized that if a PICC line required a PRN dressing change, a progress note and a sign-off on the TAR were mandatory. The DON stated the primary risk identified was infection, stemming from inadequate monitoring or lapses in IV management safety. Interview on 12/19/24 at 3:46 pm, the Administrator stated that staff should never document tasks that were not completed. The Administrator stated training on proper documentation practices was provided through Relias (electronic training). The Administrator stated the risk identified was the inconsistency in documentation, which could lead to increased errors. Record review of the facility's Documentation policy dated May 2015 read in part Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident. It includes observations, investigations, and communications of the resident involving care and treatments. Goal: The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets.

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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** 30057 FACILITY Infection Control Resident # 9 [NAME] TB 2 Step Mantoux Skin Test - Step 2 05/14/2021 Negative (0 mm) System. SARS-COV-2 (COVID-19) - Dose 1 208 06/01/2022 Complete System RSV 306 12/19/2023 Complete System PPSV23 33 12/05/2023 Complete System Fluzone High-Dose 135 Not Eligible System FLUAD QUADRIVALENT 205 09/30/2024 Complete System Covid-19 Spikevax (Historical Use Only) 207 01/10/2024 Complete System Resident # 22 [NAME]: PPSV23 Refused System COVID-19 Pfizer Booster (Historical Use Only) 208 10/30/2024 Historical System FLUAD QUADRIVALENT 205 09/30/2024 Complete System Other Vaccine 216 03/04/2024 Complete System SARS-COV-2 (COVID-19) - Dose 1 208 06/01/2022 Complete System Fluzone Quadrivalent 205 09/04/2021 Complete System Influenza 197 10/05/2019 Complete System TB 2 Step Mantoux Skin Test - Step 1 98 11/02/2018 Positive System Chest X-Ray 11/02/2018 Complete System Resident # 94 [NAME] PPSV23 33 Refused System (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	FLUAD QUADRIVALENT 205 Not Eligible System COVID-19 Pfizer Booster (Historical Use Only) 208 10/30/2024 Complete System Prevnar 20 216 06/12/2024 Complete System Resident # 72 [NAME] Covid-19 Spikevax (Historical Use Only) 207 Refused System FLUAD QUADRIVALENT 205 Not Eligible System TB 2 Step Mantoux Skin Test - Step 1 98 02/16/2022 Pending Results System PPSV23 33 01/20/2021 Historical System Resident # 13 [NAME] Covid-19 Spikevax (Historical Use Only) 207 Refused System Prevnar 20 216 Refused System TB 1 Step Mantoux (PPD) 98 Refused System Fluzone High-Dose 197 Refused System COVID-19 Pfizer Booster (Historical Use Only) 208 10/30/2024 Historical System FLUAD QUADRIVALENT 205 09/19/2023 Complete System During an observation on 12/17/24 at 11:20 AM CNA [NAME] performed incontinent care for Resident #19 Aiko [NAME]. CNA [NAME] entered the room sanitized her hands then put on some clean gloves. CNA [NAME] undid the residents soiled brief and wiped the vaginal and rectal area with some wet wipes. During the wiping the CNA's gloved hands came in contact with the resident's vaginal and rectal area. Resident #19 was noted to be wet with urine. While still wearing the same gloves, CNA [NAME] took a clean draw sheet and the clean brief and rolled it under the resident. While still wearing the same gloves, CNA [NAME] fastened the new brief and then covered the resident with with the bed sheets then finally removed the soiled gloves. During an interview on 12/19/24 at 08:37 AM CNA [NAME] said that usually when she believed her gloves were contaminated she would change them and sanitize her hands prior to putting a new pair of gloves on. CNA [NAME] was made aware that she had kept the same gloves with which she had used to wipe the resident's vaginal and rectal area and then to apply the new brief and cover the resident. CNA [NAME] said she understood that she had made a mistake and should have changed her gloves and sanitized her hands. CNA [NAME] said if she did not change her gloves and sanitize her hands that could lead to cross contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conducted record review of the facility's infection control binder/log: The book contained CDC certificates of Completion for nursing home infection preventionist training course-WB4448R which certified the DON [NAME] completed on 09/23/2024. Also contained CDC certificates of Completion for nursing home infection preventionist (IP) training course-WB4448R which certified the ADON Immeka [NAME] completed on 04/24/2024. The book also contained policy's/procedures for infection control in general, IP, Flu and pneumonia, EBP, Antibiotic stewardship, policy on legionella water management, COVID, list of reportable diseases also kept a tracking and trending infection logs for all months of this year from 01/2024 until present. 12/19/24 12:10 PM observation and inspection of the laundry was conducted, the laundry attendant was Edgard [NAME], there were 3 working commercial size dryers, [NAME] said he cleaned the lint traps every 2 hours at this time inspected the lint traps and they appeared fairly clean, there were 3 commercial size washers but only 2 of them were working, [NAME] said the non-working washer was needing a part or something but that he could keep up with the 2 washers, said whenever they had COVID or anybody in isolation the staff would deliver that linen/clothing in red bags so that he would know that clothing was from isolation room, said he would don PPE whenever he washed that clothing and he would wash it alone and 2 times, said facility provided sufficient PPE, inspected the chemicals for the washers which were self dispensing and the containers contained chemicals and not empty, at this time the attendant was washing some clothes, the linen appeared to be in good condition and not noticed any yellowish or stained linen, the laundry room was separated between clean and dirty. There was a small restroom for staff which contained a sink/faucet/soap and paper towel dispenser and trash can. There were no concerns noted during this observation. Resident #62 Tube Feeding During an observation on 12/18/24 at 04:12 PM LVN [NAME] Munoz (D) and ADON Immeka [NAME] (E) performed medication administration via PEG tube for Resident #62 [NAME]. LVN D and ADON E entered the resident's room sanitized their hands and put some gloves on the proceeded to perform the care for the resident. Neither of the nurses put on PPE prior to performing the medication administration on Resident #62. There was a plastic drawer container at the entrance of the room that contained several PPE items and also a sign posted that indicated Stop Enhanced Barrier Precautions, Everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following high contact resident care activities. Device care or use: Feeding tube. During an interview on 12/19/24 at 08:30 AM ADON Immeka [NAME] (E) said she had just plain forgotten to use EBP during the PEG tube medication administrator yesterday 12/18/24. The ADON said it was probably due to being nervous and caused her to forget to use the PPE. ADON E said is she did not use EBP during Resident #62's PEG care that could place the resident at risk of infections. During an interview on 12/19/24 at 12:03 PM LVN [NAME] Munoz (D) said she was aware that she had messed up yesterday 12/18/24 when she had assisted Resident #62 with the PEG medication administration. LVN D said she was not normally Resident #62's nurse so she was not used to the EBP procedures plus she was nervous. LVN D said she felt very bad that she had forgotten to wear PPE because she placed t he resident at risk for infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	43871 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 2 (Resident #19 and Resident #62) of 16 residents reviewed for infection prevention and control. 1. CNA B failed to change her gloves when going from dirty to clean during Resident #19's incontinent care. 2. LVN D and ADON E failed to use PPE (special equipment that protect the wearer's body from infection) during PEG (tube passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding) medication administration performed for Resident #62 as the resident was on EBP precautions These failures could place residents at risk of infections, secondary infections, tissue breakdown, and communicable diseases. Finding include: Record review of Resident #19's admission record dated 12/18/24 indicated she was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease, muscle weakness, and dementia. She was [AGE] years of age. Record review of Resident #19's quarterly MDS assessment dated [DATE] indicated: the resident's Cognitive Skills for Daily Decision-Making Skills was severely impaired and she never/rarely made decisions. She was always incontinent of bowel and bladder . Record review of Resident #19's care plan dated 09/27/2024 indicated in part: Focus: Resident has bowel & bladder incontinence Dementia. Requires limited assistance with toileting needs. Goal: Resident will remain free from skin breakdown due to incontinence and brief use through the review date. Interventions/Tasks: Provide incontinent care as needed and apply moisture barrier after each episode as needed. During an observation on 12/17/24 at 11:20 AM, CNA B performed incontinent care for Resident #19. CNA B entered the room, sanitized her hands, then put on some clean gloves. CNA B undid the resident's soiled brief and wiped the vaginal and rectal area with some wet wipes. During the wiping, the CNA's gloved hands came in contact with the resident's vaginal and rectal area. Resident #19 was noted to be wet with urine. While still wearing the same gloves, CNA B took a clean draw sheet and the clean brief and rolled it under the resident. While still wearing the same gloves, CNA B fastened the new brief and then covered the resident with the bed sheets, then finally removed the soiled gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/19/24 at 08:37 AM, CNA B said that when she believed her gloves were contaminated, she would change them and sanitize her hands prior to putting a new pair of gloves on. CNA B was made aware that she kept the same gloves with which she had used to wipe the resident's vaginal and rectal area and then to apply the new brief and cover the resident. CNA B said she understood that she had made a mistake, and should have changed her gloves and sanitized her hands. CNA B said if she did not change her gloves and sanitize her hands, that could lead to cross contamination. During an interview on 12/19/24 at 02:20 PM, the DON was made aware of the observation of the incontinent care performed by CNA B on Resident #19. The DON said it was expected for the CNA to change her gloves and sanitize her hands before touching the clean items. The DON said if the staff did not change their gloves or sanitize their hands, that could lead to cross contamination and infections. The DON said she believed the failure occurred because the CNA got nervous and forgot her steps because she knew the CNA did know the correct steps. The DON said the CNAs received in-services and computer training on proper infection control and when to change gloves and wash or sanitize their hands. During an interview on 12/19/24 at 02:40 PM, the Administrator was made aware of the observation of the incontinent care performed by CNA B on Resident #19. The Administrator said the CNA should have changed her gloves and washed her hands prior to applying the new brief and covering the resident with the blankets. The Administrator said if the CNA did not do that, it could possibly lead to the spread of infections. The Administrator said the failure probably occurred because the CNA got nervous and forgot her steps. The Administrator said the DON was responsible for training the nursing staff on infection control and the staff also received in-services and computer training on proper glove changing and hand sanitizing. Record review of Resident #62's admission record dated 12/18/24 indicated he was admitted to the facility on [DATE] with diagnoses of dementia and dysphagia (difficulty swallowing). He was [AGE] years of age. Record review of Resident #62's quarterly MDS assessment dated [DATE] indicated the resident's Cognitive Skills for Daily Decision-Making Skills was moderately impaired. Resident received nutrition via a feeding tube (e.g., nasogastric or abdominal (PEG). Record review of Resident #62's care plan dated 10/27/2024 indicated in part: Focus : Resident has a swallowing problem related to Dysphagia. Resident requires tube Feeding. Goal: The resident will maintain weight and nutritional balance through the review date. Resident insertion site will be free of signs and symptoms of infection through the review date. Tasks/Interventions: Diet to be followed as prescribed. Clean insertion site daily as ordered, monitoring for signs and symptoms of infection or breakdown such as redness, pain, drainage, swelling, and/or ulceration and report to MD if symptoms arise. Record review of Resident #62's order summary report dated 12/18/24 indicated in part: Order summary - Enteral Feed Order every shift Check residual before medications and feedings; return contents after each check. Order date 04/17/2024. Start date - 04/17/2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/18/24 at 04:12 PM, LVN D and ADON E performed medication administration via the PEG tube for Resident #62. LVN D and ADON E entered the resident's room, sanitized their hands, put gloves on, and proceeded to perform the care for the resident. Neither of the nurses put on a gown and face mask prior to performing the medication administration on Resident #62. There was a plastic drawer container at the entrance of the room that contained several PPE items such as gowns, gloves, face masks and also a sign posted that indicated Stop Enhanced Barrier Precautions, Everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following high contact resident care activities. Device care or use: Feeding tube. During an interview on 12/19/24 at 08:30 AM, ADON E said she had just plain forgotten to use EBP during the PEG tube medication administration yesterday 12/18/24. The ADON said it was probably due to being nervous, and it caused her to forget to use the PPE such as the gowns and face masks. ADON E said if she did not use EBP during Resident #62's PEG care that could place the resident at risk of infections. During an interview on 12/19/24 at 12:03 PM, LVN D said she was aware that she had messed up yesterday 12/18/24 when she had assisted Resident #62 with the PEG medication administration. LVN D said she was not normally Resident #62's nurse, so she was not used to the EBP procedures, plus she was nervous. LVN D said she felt very bad that she had forgotten to wear PPE such as the gown because she placed the resident at risk for infections. During an interview on 12/19/24 at 02:22 PM, the DON was made aware of the observation of the PEG medication administered by LVN D and ADON E to Resident #62. The DON said both nurses should have put on PPE as Resident #62 was in EBP precautions. The DON said she was not sure why the failure occurred other than that the nurses forgot to put on the PPE. The DON said due to the nurses not using PPE on a resident with EBP precautions, that could lead to the spread of infections. During an interview on 12/19/24 at 02:42 PM, the Administrator was made aware of the PEG medication administered by LVN D and ADON E to Resident #62. The Administrator said the nurses should have used PPE when they assisted Resident #62 due to him being on EBP precautions. The Administrator thought that the failure occurred because the nurses simply failed to use PPE. The Administrator said the risk of the nurses not using PPE could lead to the spread of infections. The Administrator said the nurses received training regarding EBP and when to use the PPE plus all the rooms had postings by the entrance to the resident's room to remind staff that the resident in that room were under EBP precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled Fundamentals of infection control precautions and dated 03/2024 indicated in part: A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control precautions. Hand hygiene continues to be the primary mean of preventing the transmission of infection. The following is a list of some situations that require hand hygiene. Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice). Before and after assisting a resident with personal care(e.g. bathing). After removing gloves and aprons and after completing duty. Gloves are worn for three important reasons. To provide protective barrier and prevent cross contamination of the hands when touching blood body fluids secretions excretions mucous membranes and non-intact skin the wearing of in specified circumstances were reduced the risk of exposure to blood borne pathogens and is mandatory for all employees. Wearing gloves does not replace the need for hand washing because gloves may have small and apparent defects or be torn during use and hands can become contaminated during removal of gloves failure to change gloves between Residents and contacts is an infection control hazard. Record review of the facility's policy titled Enhanced Barrier Precautions and dated 04/01/2024 indicated in part: Multi-drug resistant organisms (MDROs) transmission is common in long term care (LTC) facilities. Many residents in nursing homes are at increased risk of becoming colonized and developing infections with MDROs. Enhanced Barrier Precautions (EBPs) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP are sued in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Donning PPE for residents on EBP based on activity provided/assistance while in resident room - resident activity/assistance don gown and gloves when device care or use: . feeding tube