STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455569	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage at Longview Healthcare Center	112 Ruthlynn Dr Longview, TX 75605

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019 Based on interview, and record review, the facility failed to ensure assessments accurately reflected the status for 1 of 16 residents reviewed for assessments. (Resident #26). The facility failed to complete an accurate resident assessment for Resident #26 indicating the resident had an inaccurate diagnosis of bipolar. This failure could place residents at risk of not having individual needs met and a decreased quality of life. Findings included: Record review of the face sheet dated 04/16/24 indicated Resident #26 was [AGE] year-old female and was admitted [DATE] with diagnoses including Huntington's disease (an inherited condition in which nerve cells in the brain break down over time), mood disorder (a mental health condition that primarily affects emotional state) , and cognitive communication disorder (difficulty communicating due to injury of the brain that control ability to think). Record review of the most recent MDS dated [DATE] indicated Resident #26 was understood and understood others. Resident #26 did not have a BIMS score which indicated severely cognitively impairment. The MDS indicated Resident #26 was bipolar. Record review of PASRR Level 1 screening dated 4/3/2020, indicated Resident #26 did not have a mental illness. Record review of care plan revised on 2/1/2024 indicated Resident #26 had potential for mood, behaviors and impaired social interaction, severe anxiety, and disorganized thinking and was referred to psychiatry services within the facility and Resident #26 refused. Record review of Visit note dated 4/27/2024 indicated Resident #26 had Huntington's, mood disorder, depressive episodes, cognitive communication deficit, agitation, aggressive behaviors, verbal behaviors and resistance to ADL's and medications. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455569	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2024
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/2024 at 2:11 p.m., the MDS nurse said she was responsible for ensuring the MDS was accurate. The MDS nurse said it would be important to have an accurate assessment for Resident #26 to have proper treatment and care. The MDS nurse said she was responsible for the diagnoseis on the MDS. The MDS nurse said she did not see a diagnosis on Resident #26's chart for bipolar and she would get with the Rregional Nurse to modify the assessment and the Regional Nurse would ensure corrections. The MDS nurse said she was expected to make corrections and modifications when a data error was identified. During an interview on 6/5/2024 at 2:21 p.m., the ADON said the MDS should be corrected when an error is identified. The ADON said it was important to have an accurate assessment on the residents, so the staff know how to care for the residents. The ADON said the staff could have the wrong interventions and goals in place. She said if the wrong diagnosis was added, a resident would have incorrect orders in place and the plan of care would not be addressed properly. During an interview on 6/5/2024 at 2:36 p.m., the ADM said the MDS nurse, and the DON was responsible for ensuring the MDS and assessments were completed with accuracy. The ADM said the MDS should be corrected when an error was identified. The ADM said an inaccurate assessment may or may not affect the resident's care depending on what was inaccurate. The ADM said the facility would want to make sure the staff provide the residents with the correct diagnosis. Review of the facility's policy titled Minimum Data Set (MDS) Policy for MDS assessment data accuracy, dated 2/2021, indicated, .the purpose of the MDS policy was to ensure each resident receives an accurate assessment by qualified staff to address the needs of the resident who were familiar with his/her physical, mental, and psychological well-being . according to CMS's RAI Version 3.0 Manual . the MDS was a core set of screening, clinical and functional status elements, including common definitions and coding categories, which form a foundation of a comprehensive assessment for all residents of nursing home .Federal regulations at 42 CFR 483.20 (b) (1) (xviii), (g) and (h) require that .the assessment accurately reflects the resident's status .the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shift . Procedure .8. Each individual participating in the completions of the MDS . In addition, each individual responsible for a portion of the MDS must sign and certify that their portion of the assessment if accurate and complete .9. Once the assessment is completed, the RN signs certifying the assessment is completed .By signing the assessment, the RN is certifying each section was completed by the appropriate person and the individual is qualified to determine the accuracy of the portion of the resident's assessment he/she completed .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019 Based on interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical, nursing, mental and psychosocial needs for 1 of 16 residents reviewed for care plans. (Resident #12) The facility failed to develop a person-centered PASRR care plan for Resident #12 to meet medical, nursing, mental and psychosocial needs. The failures could place residents at risk of not having individual needs met, a decreased quality of life, and cause residents not to receive needed services. Findings include: Record review of Resident #12's Admission Record indicated Resident #12 was [AGE] year-old male who was readmitted on [DATE] with diagnosis of Traumatic Hemorrhage of cerebrum (a type of bleeding inside the skull or brain), Cognitive communication deficit (difficulty with any aspect of communication that is affected by disruption of cognition), Vascular Dementia (decline in thinking skills caused by conditions that block or reduce blood flow to various regions of the brain) and severe protein-calorie malnutrition (inadequate intake of food such as protein, calories and other essential nutrients). Record review of Resident #12's MDS dated [DATE] revealed that the resident was rarely or never understood, which indicated cognition was severely impaired. The MDS also revealed, Resident #12 was dependent on 2 or more staff to complete ADL's. Record review of Resident #12's PASRR evaluation dated 9/8/2021 revealed recommended services provided and coordinated by the facility were specialized occupational therapy, physical therapy, and durable medical equipment. Record review of Resident #12's Care Plan revised on 2/01/2024, revealed Resident #12 was receiving hospice services and there was no care plan that indicated the resident was PASRR positive. During an interview on 6/5/2024 at 2:01 PM, the Social Worker said she completed some of the PASRR's at the facility and the PASRR positive resident should have it care planned. The Social Worker said the MDS nurse was responsible for adding the care plan. During an interview on 6/5/2024 at 1:42 p.m., the LVN G said the MDS nurse was responsible for the MDS and care plan. The Treatment Nurse said it was important for the MDS and care plan to be accurate to let the staff view what the resident needs and provides insight into their care. During an interview on 6/5/2024 at 2:11 p.m., the MDS nurse said she was responsible for completing the PASRR and a resident who was PASRR positive should be on the care plan which would be completed by the IDT. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/2024 at 2:21 p.m., the ADON said if a resident was PASRR positive, it would be on the care plan. The ADON said the MDS nurse is responsible for ensuring the PASRR positive residents were care planned. During an interview on 6/5/2024 at 2:36 p.m., the ADM said the MDS nurse and DON are responsible for ensuring the MDS and assessments were completed with accuracy and PASRR positive residents should be care planned. Record review of a facility policy undated titled 'Comprehensive Care Planning revealed, The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . The facility will establish, document, and implement the care and services to be provided for each resident to assist in attaining or maintaining his or her highest practical quality of life. Resident's preferences and goals may change throughout their stay, so facilities should have ongoing discussions with resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128 Based on observation, interview, and record review, the facility failed to ensure a resident who is unable to carry out activities of daily living the necessary services to maintain personal hygiene for 2 of 16 residents reviewed for ADLs. (Resident #25 and Resident #43) The facility failed to provide scheduled baths/showers to Resident #25 and Resident #43. This failure could place residents who required assistance from staff for ADL's at risk of not receiving care and services to meet their needs which could result in poor care, risk for skin breakdown, feelings of poor self-esteem, lack of dignity and health. Findings included: 1. Record review of a face sheet dated 06/05/24 revealed Resident #25 was [AGE] years old and was admitted on [DATE] with diagnoses including brain damage, reduced mobility, and depression. Record review of the most recent MDS dated [DATE] indicated Resident #25 was understood and understood others. The MDS indicated a BIMS score of 12 which indicated moderate impaired cognition. The MDS indicated Resident #25 required substantial/maximal assistance with bathing/showering. Record review of a care plan last revised on 03/26/24 indicated Resident #25 had a history of depression and was at risk for impairment to skin integrity. There was an intervention to keep skin clean and dry. The care plan indicated the resident had an ADL self-care performance deficit and required 1 staff member assistance with bathing. There was an intervention to provide the resident with a sponge bath when a full bath or shower could not be tolerated. The care plan did not indicate the resident refused or resisted care. Record review of the nurse's notes from 05/01/24 to 06/05/24 did not indicate Resident #25 had refused baths/showers. Record review of a Bath Schedule indicated Resident #25 was to receive baths on Tuesdays, Thursdays, and Saturdays. There was a note at the bottom of the schedule that indicated, Please adjust bath schedule to the needs of the resident. If resident desires bath/shower on another shift accommodate that resident. NO EXCEPTIONS!!!. Record review of bathing documentation dated 05/2024 for Resident #25 indicated no documented evidence the resident received a bath/shower on Tuesday - 05/02/24, Thursday - 05/09/24, Saturday - 05/11/24, Tuesday - 05/14/24, Thursday 05/16/24, Saturday - 05/18/24, Tuesday - 05/21/24, Thursday - 04/23/24, and Thursday - 05/30/24. There were only 3 baths/showers documented for 05/2024. Record review of bathing documentation for Resident #25 from 06/01/24 - 06/05/24 indicated no documented evidence the resident received a scheduled bath/shower on Saturday - 06/01/24 or Tuesday - 06/04/24. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/03/24 at 9:25 a.m., Resident #25 said she was only showered every once in a while. She said she only had one bath in May 2024. She said CNA D gave it to her. She said CNA D was the only aide that would give her a shower. During an interview and observation on 06/05/24 at 12:10 p.m., Resident #25 said bed baths were okay, but she preferred to go to the shower. She said she had never refused a bath or shower. She said sometimes her hair itched from not being bathed. She said she did not feel clean. She said she had not had a shower in June 2024. She said she marked a S on her calendar on the days she was showered. There was a June 2024 calendar hanging on the wall beside her bed. There were no days marked with an S. 2. Record review of a face sheet dated 06/05/24 revealed Resident #43 was [AGE] years old and was admitted on [DATE] with diagnoses including heart failure, depression, reduced mobility and need for assistance with personal care. Record review of the most recent MDS dated [DATE] indicated Resident #43 was understood and understood others. The MDS indicated a BIMS score of 15 which indicated intact cognition. The MDS indicated Resident #43 required partial/moderate assistance with bathing. Record review of a care plan last revised on 04/19/24 indicated Resident #43 had an ADL self-care performance deficit due to decrease mobility, morbid obesity, and limited range of motion. The care plan indicated the resident was bedfast most of the time. There was an intervention to provide the resident with a sponge bath when a full bath or shower could not be tolerated. The care plan indicated Resident #43 required extensive staff participation with bathing. The care plan did not indicate the resident refused or resisted care. Record review of the nurse's notes from 05/01/24 to 06/05/24 did not indicate Resident #43 had refused baths/showers. Record review of a Bath Schedule indicated Resident #43 was to receive baths on Monday, Wednesday, and Friday. There was a note at the bottom of the schedule that indicated, Please adjust bath schedule to the needs of the resident. If resident desires bath/shower on another shift accommodate that resident. NO EXCEPTIONS!!!. Record review of bathing documentation dated 05/2024 for Resident #43 indicated no documented evidence the resident received a bath/shower on Wednesday - 05/01/24, Friday - 05/03/24, Monday - 05/06/24, Wednesday - 05/08/24, Monday - 05/13/24, Friday - 05/17/24, Monday - 05/20/24, Wednesday - 05/22/24, Friday - 05/24/25, Monday - 05/27/24, Wednesday - 05/29/24, and Friday - 05/31/24. There were only 2 baths/showers documented for 05/2024. Record review of bathing documentation for Resident #43 from 06/01/24 - 06/05/24 indicated no documented evidence the resident received a scheduled bath/shower on Monday - 06/03/24. During an interview on 06/03/24 at 9:42 a.m., Resident #43 said she did not receive her scheduled baths. She said she was only being bathed once a week. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/05/24 at 1:36 p.m., Resident #43 said she did not like to be showered because it hurt her to sit on the shower chair. She said she preferred bed baths. She said she was scheduled for baths on Mondays, Wednesdays, and Fridays. She said it bothered her to not get her baths. She said she felt dirty. She said it upset her . During an interview on 06/05/24 at 1:40 p.m., CNA D said she had never provided care to Resident #43. She said she had provided care to Resident #25. She said the 2:00 p.m. to 10:00 p.m. shift was responsible for bathing Resident #25. She said she would bathe Resident #25 any time she asked to be bathed. She said Resident #25 had told her that she was the only aide that would give her a bath. She said residents should be bathed three times a week and whenever they asked to be bathed. She said Resident #25 never refused to be showered and would always go when asked. CNA D said, She loves her showers. During an interview on 06/05/24 at 2:04 p.m., CNA H said Resident #43 had never asked her to give her a bath. She said the 2:00 p.m. to 10:00 p.m. shift was responsible was responsible for giving her baths. She said if she had asked she did not mind bathing her. She said she never told her she had missed her baths. She said she did not know if she had refused her baths. CNA H said if a resident refused a bath the CNAs were supposed to tell the charge nurse and they were supposed to chart it. She said she had known Resident #43 to have refused baths. During an interview on 06/05/24 at 2:10 p.m., CNA E said residents were bathed three times a week. She said she had worked with Resident #25, and she did get her baths. She said she did not know where it was documented. She said Resident #43 had told her she was not getting her baths. She said she did not know why Resident #43 had missed her baths . She said she documented any refusals from any resident and told the charge nurse. She said the charge nurse was supposed to document the refusal. During an interview on 06/05/24 at 2:16 p.m., LVN A said Resident #43 received bed baths if she got anything . He said she did not like getting out of bed. She said Resident #25 had not complained of not getting her baths. He said Resident #25 did not like getting out of bed. He said he did not know why the residents had missed their scheduled baths. He said if a resident refused it was supposed to be reported to the charge nurses and they were supposed to chart the refusal in the progress notes. He said not being bathed could cause skin issues and dignity issues. During an interview on 06/05/24 at 2:35 p.m., the ADON said the DON was out of the facility on vacation. She said all residents were scheduled to be bathed or showered three times a week. She said any time a resident wanted a bath staff should give them a bath. She said she would have expected for the residents to have at least received their scheduled bath. She said she did not know why the residents had not been bathed. She said she felt they had been bathed. She said she felt it was a documentation issue. She said Resident #43 had refused baths at times. She said charge nurses were supposed to document any refusals in the progress notes. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/05/24 at 2:58 p.m., the Administrator said he had encouraged Resident #43 to get out of bed. He said she cried and had refused baths. He said he did visit with all the residents and Resident #25 had never told him she was not getting her baths. He said he understood how the documentation looked. He said both residents were offered baths, and both refused baths. He said he would have expected any refusals to have been documented. He said there had been a problem with their electronic charting system. He said neither resident had any skin issues and he felt if they went that long without a bath, they would. He said a resident not getting their scheduled baths could cause a dignity issue, skin breakdown, and/or cause an odor. Record review of a Refusal of Showers by Resident, In-Service Training Attendance Roster for CNA's and Nurses Only dated 02/13/24 indicated, .All showers must be given on the days and shifts that they are assigned. If the Resident refuses, please report to the Charge Nurse, the Charge Nurse is to follow-up and chart accordingly . Record review on a Giving Showers, In Service Training Attendance Roster dated 04/05/24 indicated, Please remember to give showers to residents as they are scheduled .we must offer them a shower on scheduled days, if they refuse, please report refusal to the charge nurse. Sometimes it takes someone else to speak to them and they will accept, this isn't always the case, but it can then be charted concerning showers . Review of a Bedbath, Complete facility policy dated 2003 indicated, .The complete bedbath is performed for those residents on bedrest who need total or partial assistive care. It is done to cleanse the skin to remove soil, dead epithelial cell, microorganisms, and promote comfort, exercise, and relaxation. The aging skin becomes thinner, drier, and more fragile and requires special consideration in regards to soaps, oils, and frequency of bathing .Goals .The resident will maintain skin integrity .The resident will be clean and free of dryness, irritation, or pruritus (itching) .The resident will verbalize a feeling of comfort and well-being .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062 Based on observation, interview, and record review, the facility failed to ensure that respiratory care was provided consistent with professional standards of practice for 1 of 8 residents (Resident #11) reviewed for respiratory care. The facility failed to ensure Resident #11's oxygen concentrator filter was free of gray fuzz and dust-like particles. These failures could place residents requiring respiratory care at risk for respiratory infections or complications. Findings included: Record review of Resident #11's face sheet dated 6/04/24 revealed she was [AGE] years old and admitted to the facility on [DATE]. Resident #11 had diagnoses including COPD (chronic obstructive pulmonary disease -constriction of the airways and difficulty or discomfort in breathing), heart failure, heart disease, and weakness. Record review of Resident #11's quarterly MDS dated [DATE] revealed she was understood and usually understood others. Resident #11 had a BIMS of 11, which indicated she had moderate cognitive impairment. Resident #11 was dependent to required substantial assistance with most ADLs . The MDS did not reveal the resident was on oxygen. Record review of Resident #11's undated care plan revealed she had COPD and was at risk for respiratory problems, she used oxygen therapy as needed at 2.5 LPM per nasal cannula (tubing used to deliver oxygen into the nose) and she was receiving hospice services. Record review of Resident #11's Order Summary Report dated 6/04/24 revealed an order to check oxygen filter for placement and cleanliness every week on Sunday and as needed related to COPD with a start date of 12/14/23 and may use oxygen at 2-5 LPM as needed for comfort measures related to COPD with a start date of 1/26/24. Record review of Resident #11's TAR dated 6/01/24-6/30/24 revealed the check oxygen filter for placement and cleanliness was to be completed every week on Sunday and as needed and was scheduled on the night shift. There was documentation indicating the oxygen filter had been checked for placement and cleanliness on 6/01/24, 6/02/24, and 6/03/24 by LVN K. During an observation and interview on 6/03/24 at 9:09 AM, Resident #11 was lying in bed wearing her oxygen and said her only concern was she needed softer food. There was gray fuzz like particles on the oxygen concentrator filter. During an observation on 6/04/24 at 4:28 PM, Resident #11 was lying in bed asleep, wearing her oxygen. The oxygen concentrator filter continued to be dirty and covered in gray fuzz and dust like substances. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Attempted to call LVN K on 6/05/24 at 10:34 AM and again at 2:10 PM, but there was no answer and voice mails were left. LVN K did not return call prior to exit of facility. During an interview on 6/05/24 at 2:26 PM, RN F said she had worked at the facility for about a year as needed. RN F said the nurses on the weekend night shift were responsible for cleaning the oxygen filters. RN F said a dirty oxygen concentrator filter could cause allergens for the resident. RN F said it could also cause the oxygen concentrator to not work as well and reduce the oxygen intake for the resident. During an interview on 6/05/24 at 2:43 PM, LVN B said she had worked at the facility since September 2023 and normally worked the day shift. LVN B said the nurses were responsible for ensuring the oxygen concentrator filters were cleaned and in place. LVN B said any nurse could clean or change the oxygen concentrator filter when the filter needed it. LVN B said she had changed or cleaned dirty oxygen concentrator filters herself when she found them. LVN B said a dirty oxygen concentrator filter could spread infection and the oxygen concentrator machine may not work as well with a dirty filter. LVN B said the resident could inhale the fuzz/dust particles from a dirty filter. LVN B said a dirty oxygen concentrator filter could cause problems breathing for a resident. During an interview on 6/05/24 at 3:19 PM, the ADON said the nurses were responsible for ensuring the oxygen concentrator filters were in place and cleaned on Sundays. The ADON said the resident's oxygen concentrator machine may not function as well if the filter was dirty. The ADON said whatever was on the oxygen concentrator filter could be inhaled by the resident through the oxygen tubing. The ADON said a dirty oxygen concentrator filter could cause the oxygen concentrator machine to not give the amount of oxygen needed and it could cause the resident's oxygen level to drop. During an interview on 6/05/24 at 3:41 PM, the ADM said he would expect the oxygen concentrator filters to be kept clean. The ADM said the oxygen concentrator filters should be kept clean to prevent issues for the oxygen concentrator. The ADM said he did not think the resident would be affected by a dirty oxygen concentrator filter, but the oxygen concentrator could turn off if the oxygen concentrator filter became to clogged up. Record review of the facility's policy titled Breathing Therapy Devices dated February 13, 2007, revealed . breathing therapy devices were used to provide inhalation treatments that encourage and sustain inspirations, or deliver moisture or medications to the airways and environment . goals . the resident would maintain optimal breathing pattern . the resident would be free from infection .

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NAME OF PROVIDER OR SUPPLIER: Heritage at Longview Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 112 Ruthlynn Dr Longview, TX 75605	

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062 Based on observation, interview, and record review the facility failed to ensure pain management was provided to residents who require such services, consistent with professional standards of practice, pain management services for 1 of 16 residents reviewed for pain. (Resident #203) 1.The facility failed to effectively manage Resident #203's pain. 2.The facility failed to ensure Resident #203's low air loss mattress was plugged in, functioning, and fully inflated to prevent pain. 3.The facility failed to ensure LVN B notified Resident #203's physician after a family member requested a medication change to manage his pain related to muscle spasms. These failures could result in residents experiencing unnecessary pain and a decreased quality of life. Findings included: Record review of Resident #203's face sheet dated 6/04/24 indicated he was [AGE] years old and admitted to the facility on [DATE]. Resident #203 had diagnoses which included stage 4 pressure ulcer to sacrum (most severe pressure ulcer to bottom of spine, full thickness skin loss, may be muscle, bone tendon, or joint involvement), incomplete C5-C7 quadriplegia (paralysis or weakness in all four limbs, but with some ability to move, feel sensations, or control automatic body processes), reflex neuropathic bladder (nerves and muscles that control the bladder do not work properly and causes difficulty urinating), benign prostatic hyperplasia with lower urinary tract symptoms (prostate enlarges and results in difficulty urinating), resistance to multiple antimicrobial drugs, depression (persistent sadness), insomnia (hard to fall asleep, stay asleep, or get quality sleep), cystostomy (opening into gallbladder to drain fluid), and pain. Record review of Resident #203's hospital history and physical dated 4/30/24 revealed he had incomplete Quadriplegia with a history of muscle spasms and pain, and he should continue as needed medications for spasms and pain control. Record review of Resident #203's admission MDS revealed it had not been completed prior to survey exit. Record review of Resident #203's care plan initiated on 5/28/24 indicated: Resident #203 had a potential for uncontrolled pain with interventions which included anticipate the resident's need for pain relief and respond immediately to any complaint of pain; evaluate the effectiveness of pain interventions with alleviating symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition; and notify physician if interventions were unsuccessful or if the current complaint was a significant change from resident's past experience of pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Resident #203 had peripheral vascular disease (narrowed blood vessels reduce blood flow to the limbs causing leg pain) with interventions which included to monitor/document/report to physician as needed for any signs or symptoms of complications of extremities such as pain. Resident #203 had a pressure ulcer or potential for pressure ulcer development with interventions which included to treat pain as per orders prior to treatment/turning to ensure the resident's comfort. Resident #203 required antidepressant medication with interventions which included to monitor/document/report to physician as needed of depression unaltered by antidepressant meds with behaviors of sad, irritable, anger, never satisfied, crying, negative mood/comments, and agitation. Record review of Resident #203's Order Summary Report dated 6/04/24 revealed orders for Gabapentin 300 mg one capsule by mouth two times daily for neuropathy (nerve pain) with a start date of 5/28/24, Methocarbamol 500 mg one tablet by mouth four times a day for muscle relaxer related to Quadriplegia with a start date of 5/28/24, Tylenol 325 mg two tablets by mouth every four hours as needed for pain or fever with a start date of 5/28/24, May have pressure relieving mattress every shift for wound with a start date of 5/28/24, and Norco 10/325 mg one by mouth every six hours for pain routinely with a start date of 5/29/24. Record review of Resident #203's MAR dated 5/01/24-5/31/24 and MAR dated 6/01/24-6/30/24 revealed the above medications were administered as ordered. Record review of Resident #203's Pain-MDS dated [DATE] revealed he experienced pain almost constantly and the pain frequently affected his sleep and almost constantly interfered with his activities of daily living. Record review of Resident #203's pain level summary dated 5/28/24-6/05/24 revealed he had pain values from 0 to 7 on a 1-10 scale (1 being the least pain to 10 being the worst pain). Resident #203's pain level on 6/03/24 was a 4 at 11:59 AM, a 7 at 2:05 PM, a 7 at 5:04 PM, and a 5 at 8:56 PM. Record review of Resident #203's NP visit note dated 5/29/24 revealed the resident stated he could move both lower extremities but chose not to because with movement muscle spasms would follow. There was a new order to change Resident #203's Norco to 10/325 mg by mouth every six hours scheduled. Record review of Resident #203's progress notes dated 5/28/24-6/03/24 revealed on 5/29/24, LVN M received new orders to change his Norco 10/325 mg every six hours to routinely. On 5/30/24, LVN B documented he continued to complain of pain upon turning and repositioning and getting weight. On 5/31/24, LVN B documented Resident #203 was known to holler for a while when treatments were done. On 6/02/24, RN N documented Resident #203 had a low air loss mattress in place and the resident was receiving routine pain medication and reported it was effective. There was no documentation of Resident #203's continued complaints of pain being reported to the physician. There was no documentation related to Resident #203's family member requesting a different medication for his pain related to leg spasms from LVN B. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an observation on 6/03/24 beginning at 11:16 AM, the surveyor entered Resident #203's room while LVN G and CNA E were still in the resident's room after performing wound care. CNA E repositioned Resident #203's pillow. Resident #203 was hollering out that he was having severe pain and he felt like he was lying on a board. LVN G told Resident #203 it was just the wound vac (wound dressing and tubing attached to a machine that pulls a vacuum to assist in the closure and drainage of wounds), but the resident continued to holler out saying it had never felt like that before and to please look back there (his bottom). LVN G asked CNA E to roll the resident over so she could look under Resident #203. CNA E rolled the resident toward her while LVN G looked under the resident and again told him it was just the wound vac. Resident #203 was then propped up his on right side with pillows under his left back. LVN G said she would tell Resident #203's nurse and see if he could have a pain pill. During an observation and interview on 6/03/24 beginning at 11:21 AM, Resident #203 said he was having severe pain on his bottom, and he felt like he was lying on a board. Resident #203 said he had never had it feel like that before. Resident #203 said with tears in his eyes, he was not crazy, and something was wrong. Resident #203 continued to holler out in pain and asked the surveyor to please do something, because it had never felt like that before. Resident #203 said he had been in the facility for about a week. Resident #203 had a low air loss mattress (prevents and treats pressure wounds) and it was not operating and there were no lights on the control box to indicate it was on. The power the cord of the low air loss mattress was unplugged from the wall and was lying across the top of the bed frame at the head of the bed . During an observation and interview on 6/03/24 beginning at 11:52 AM, with surveyor intervention, RN F accompanied the surveyor to Resident #203's room and she said LVN G had told her Resident #203 was having pain and she was going to get him a pain pill. While entering Resident #203's room, he continued to holler out that it was killing him, and he felt like he was lying on a board on his back. RN F put on gloves and rolled Resident #203 over to his right side and ran her gloved hand under him and looked under him. RN F told Resident #203 there was nothing under him except the wound vac to his bottom. RN F then repositioned Resident #203 with pillows and told him she would get him a pain pill. With surveyor intervention, RN F was asked if the low air loss mattress was functioning. RN F looked at the low air loss mattress control box and she said it was not on and she found the cord/plug that was lying at the head of the bed on the bed frame. RN F had to unwrap the cord from under the bed and plugged it in to the electrical plug and turned it on at the control box. RN F said it would take a few minutes for the low air loss mattress to re-inflate. RN F told Resident #203 she was going to get his pain medication. During an observation and interview on 6/04/24 at 5:01 PM, Resident #203 said after the air mattress re-inflated yesterday, it helped his pain level tremendously. Resident #203 said he felt like he was lying on a board, and he said the therapist told him the mattress was not inflated and he was lying on the steel frame. Resident #203 thanked the surveyor for bringing it to the facility's attention and getting it turned back on. Resident #203 said he had only had that feeling of lying on a board after the nurse did his wound care yesterday (6/03/24). Resident #203 continued to have right leg spasms and would holler out and would speak to his leg when it would start to spasm and said please, please, don't do it, don't do it as he rubbed his right leg. Resident #203 said he has had leg spasms and chronic pain for a long time. Resident #203 said he wished they could find something to help the pain with his muscle spasms or if they could just cut his right leg off, but they would not do it. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/03/24 at 12:02 PM, RN F brought Resident #203 a pain pill and said if the treatment nurse had let her know she was going to change his wound vac, she could have gotten him pain meds before the wound care to help prevent pain. RN F said the purpose of the low air loss mattress was to relieve pressure and if it was not plugged in, it could cause increased pressure to Resident #203's wounds. RN F said Resident #203 usually hollered out and complained of pain, but she felt his pain had gotten better. RN F said she thought they probably accidently unplugged his low air loss mattress when they were doing his wound care earlier and did not realize it. During an interview 6/05/24 at 1:50 PM, CNA H said she had worked at the facility for fourteen years. CNA H said it was just her second day to take care of Resident #203. CNA H said Resident #203 was in pain all the time and he had muscle spasms and hollered while she provided care. CNA H said she had not told the nurse anything about Resident #203's pain because she felt the nurse should already know. CNA H said Resident #203 mainly hurts when they moved him. CNA H said she would let Resident #203 do most of the positioning himself as much as he could, and it seemed easier on him. During an interview on 6/05/24 at 2:04 PM, LVN G said she had worked at the facility for eleven years and had been the treatment nurse for two years. LVN G said Resident #203 came into the facility hollering and complaining of pain and legs spams. LVN G said Resident #203 took routine pain medications. LVN G said she was positioning Resident #203 when the surveyor came into Resident #203's room on 6/03/24 and Resident #203 was complaining about being on a board. LVN G said she had already checked under him for anything that could cause him pain and she did not find anything other than the wound vac dressing on the wound to his sacrum she had just changed. LVN G said they did not do anything to unplug the low air loss mattress while performing Resident #203's wound care. LVN G said she did not know how the low air loss mattress became unplugged. LVN G said she knew there was air in the mattress because she put her hand on it when she checked under Resident #203. LVN G said the low air loss mattress had air in it and she did not hear a hiss like it was losing air. LVN G said if the air deflation level was very low, it could have made Resident #203 feel like he was lying on a rail, but she did not think it was that deflated. LVN G said everything they did for Resident #203 hurt him. LVN G said when she could not determine why Resident #203 was hurting, she reported to RN F and told her Resident #203 needed something for pain. LVN G said not addressing pain could make the resident feel hopeless, lose trust, have anger, depression, and a multitude of negative thought processes. During an interview on 6/05/24 at 2:26 PM, RN F said she had worked at the facility for approximately a year as needed. RN F said Resident #203 had a pressure wound on his sacrum with a wound vac dressing. RN F said Resident #203 was awake, alert, and oriented. RN F said Resident #203 could follow a verbal pain scale and he had a low pain tolerance. RN F said if residents complained of pain, she would look for the cause of pain, check to see what medications they had for pain, and use alterative pain management methods such as redirection. RN F said if the resident was awake, alert, and oriented, the resident would know what they wanted. RN F said she would notify the physician for new or changed orders if what they were doing was not working or managing the resident's pain. RN F said Resident #203's low air loss mattress not being plugged in on 6/03/24 could have contributed to his pain level, but she did not feel it was completely deflated and it still had air in it when she checked under him. RN F said pain management was important to keep the resident as comfortable as possible. RN F said if pain was not controlled, the resident could start losing functions. RN F said if the resident's pain was not managed effectively, the resident could have extreme pain and irritably and it could cause psychological issues such as not eating, decline in functions, and they could become depressed. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/05/24 at 2:43 PM, LVN B said she had worked at the facility since September 2023 and normally worked the day shift. LVN B said Resident #203 was receiving round the clock pain medications. LVN B said Resident #203 complained of pain all the time and hollered out even when just touching the bed and he seemed to do it worse when his family was in the room. LVN B said they tried to reposition him, got him a longer bed, and gave pain medications routinely to manage Resident #203's pain and thought he had not complained as much since. LVN B said Resident #203 usually just complained when they provided care. LVN B said Resident #203 said he had spasms to his legs. LVN B said Resident #203's family member wanted him to have a different medication for his leg spasms. LVN B said the family member told her the name of the medication they wanted to change to, but LVN B did not remember the name of the medication. LVN B said she told the family member she (LVN B) would have to talk to the physician about it to obtain an order for the medication. LVN B said the family member asked her about wanting the medication for his pain from the muscle spasms changed about 3-4 days ago. LVN B said she had not talked to the physician and had forgotten all about it . LVN B said if the low air mattress was not plugged in, it could make a difference in the how the resident felt. LVN B said pain management was important to manage. LVN B said if pain was not managed effectively, then it could affect the resident's behavior, they could become more irritable and complain. During an interview on 6/05/24 at 3:01 PM, CNA E said she had worked at the facility full-time for approximately three months, but she had worked at the facility for about ten years as needed. CNA E said Resident #203 hollers out in pain a lot. CNA E said if she did anything to Resident #203, he would holler out in pain. During an interview on 6/05/24 at 3:19 PM, the ADON said when a resident reported pain, they could give medications, provide alternative measures, and then go back in 45 minutes to evaluate if the resident had relief from pain. The ADON said if there was no relief, then they should notify the physician for new or changed orders. The ADON said pain management could cause a lot of problems in the resident such as they could stop eating, change in behaviors, and unable to sleep. The ADON said she did not know why the physician had not been notified related to Resident #203's continued pain and muscle spasms, but the ADON said the physician would be notified as soon as she was done with the surveyor. During an interview on 6/05/24 at 3:41 PM, the ADM said he would expect residents' pain to be managed. The ADM said Resident #203 was a new resident and he felt Resident #203's pain was being managed. The ADM said he had visited with Resident #203 a lot and the ADM said he would not say his pain was out of control. The ADM said he had talked to RN F, and she had told him Resident #203 was not on the bed frame and the low air loss mattress was not deflated when it was not plugged in. The ADM said he did not feel Resident #203 had a negative effect because they were managing his pain with routine pain medications. Record review of the facility's In-service Attendance Record dated 6/01/24 with the subject of Monitoring for pain/pain management revealed . pain assessments should be ongoing . individualized and documented so that all involved in the patient's care understand the pain problem . asking patient's to describe their pain using words would guide staff to the appropriate interventions for specific pain types . patients may have more than one type of pain . and it said to see attached sheets and the Pain Management, Assessment Scale policy was attached to the in-service. The Inservice Attendance Record was signed by LVN G, RN F, and CNA E. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Record review of the facility's policy titled Pain Management, Assessment Scale with a revised date of May 25, 2016 revealed . pain was a subjective sensation of discomfort derived from multiple sensory nerve interactions generated by physical, chemical, biological, or psychological stimuli . complaints of pain would be assessed accordingly by the nurse and effectively managed through prescribed medications, and comfort measures, and all available resources of the facility . talk with the resident about pain and assess for pain relief after interventions . monitor for effectiveness of pain interventions .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019 Based on observation, interview, and record review the facility failed to ensure drugs and biologicals were stored in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 1 of 16 residents. (Resident #27) The facility failed to ensure Lantiseptic skin protectant 50% cream was properly stored and locked in accordance with currently accepted professional standards. This failure could place residents at risk for adverse effects and reduced therapeutic effects of medication and supplies. Findings included: Record review of Resident #27's Admission Record indicated Resident #27 was [AGE] year-old female admitted on [DATE] indicating diagnosis including Dementia (general term for memory loss), Atherosclerosis of native arteries of extremities with gangrene right leg (disease causing chronic limb-threatening restriction of blood flow to tissue, muscle group or organs), hypertensive heart disease without heart failure (chronic elevated blood pressure), and non-pressure chronic ulcer of buttock (a chronic ulcer caused by poor circulation). Record review of Resident #27s Quarterly MDS dated [DATE] revealed that the resident had a BIMS score of 10 indicating she was moderately impaired cognitively and made self-understood and was understood others. The MDS also revealed, Resident #27 was dependent on 2 or more helper with most ADL's. Record review of Resident #12's Care Plan revised on 3/13/2024 indicated Resident #27 had a Stage III pressure ulcer with an initiation of enhanced barrier precautions on 5/24/2024 and on 5/31/2024 initiated incontinent care after each episode and apply moisture barrier. Record review of the facility's order summary report dated 6/5/2024 for Resident #27 revealed to apply Lantiseptic to her buttock after incontinence episode ordered on 5/12/2024. Record review of the facility's medication record dated 5/1/2024-5/31/2024 revealed Resident #27 did not have an order to apply Lantiseptic as needed. Record review of the facility's treatment administration record dated 6/1/2024-6/30/2024 did not indicate orders for Lantiseptic skin protectant 50% cream. During an observation on 6/3/2024 at 8:43 a.m., revealed Resident # 27 had a white container labeled Lantiseptic skin protectant 50% cream on her bedside table and was dispensed on 3/22/2024. During an observation on 6/3/2024 at 8:50 a.m., revealed Resident # 27 had a white container labeled Lantiseptic skin protectant 50% cream on her bedside table and was dispensed on 3/22/2024. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/4/2024 at 2:45 p.m., revealed Resident # 27 had a white container labeled Lantiseptic skin protectant 50% cream on her bedside table and was dispensed on 3/22/2024. During an interview on 6/5/2024 at 8:57 a.m., CNA C said she cared for Resident # 27. CNA C said she had never used the Lantiseptic from the residents beside table. CNA C said Resident #27 brought the cream back from when she was in the hospital. CNA C said medications were not to be stored in resident room or at bedside. During an interview on 6/5/2024 at 11:50 a.m., Resident #27 said the staff applied multiple products to her bottom and was not sure if the staff were using the Lantiseptic cream at the bedside. Resident #27 said she could not recall where she received the Lantiseptic. During an interview on 6/5/2024 at 11:55 a.m., LVN B said when a resident was prescribed Lantiseptic, it would be on the medication administration record. LVN B said Resident #27 currently did not have an order for Lantiseptic. LVN B said she considered Lantiseptic a medication. LVN B said normally the ointment was stored in her drawer. During an interview on 6/5/2024 at 1:42 p.m., the LVN G said the charge nurse was responsible for placing medications on the medication cart. The treatment nurse said she does not consider Lantiseptic a medication. She said Lantiseptic should not be kept at residents beside due to risk for misuse, ingestion or the resident could apply it incorrectly that could cause harm. The treatment nurse said some residents have cognitive deficits and they may not know what it was for or how to administer. The treatment nurse said if another resident obtained the Lantiseptic, they could ingest or apply it incorrectly. During an interview on 6/5/2024 at 2:21 p.m., the ADON said no medications would be stored at beside. The ADON said barrier cream does not require an order. The ADON said Lantiseptic would be on the medication record and the treatment record. The ADON said the facility does not have a resident with Lantiseptic and said the facility had barrier cream if ordered. The ADON said it depended on the resident if they got ahold of cream, it could get in their eyes. The ADON said everyone is responsible to ensure all medications coming into the facility, hospital, or other facilities. During an interview on 6/5/2024 at 2:36 p.m., the ADM said residents could have medications in their room if it was determined by the interdisciplinary team meeting and it was not a controlled substance. The ADON said he did not know if Lantiseptic was considered a medication. The ADM said the charge nurse, the ADON and nurse management were responsible for ensuring medications are locked up when a resident returned from another facility. The ADM said he expected the nurses to make sure the medications were stored properly. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility Bedside Storage of Medication policy dated 2003 revealed Bedside medication storage was permitted for sublingual and inhaled emergency medications and for resident who were able to self-administer medication upon the written order of the prescriber and when it was deemed appropriate in the judgement of the facilities interdisciplinary resident assessment team . Procedure .1.A written order for the bedside storage of medication is placed in the residents medical record. 2. The facility interdisciplinary team must assess that the resident was capable of safely administering the medication .Beside storage of medication was indicated on the resident medication administration record for the appropriate medications . 3. For residents with bedside emergency medications, the beside medications were stored in a drawer or cabinet that was locked for security, at the residents bedside 6. For residents who self-administer all medications, the following conditions were met for bedside storage to occur: the manner of storage prevents access by other residents .The bedside medication record is reviewed on each nursing shift, and the administration information was transferred to the medication administration record kept at the nurse's station . 7. The resident is instructed in the proper uses of the bedside medication .12. Candy, cough drops, mouthwashes, after-shave lotions, colognes and perfumes, hair sprays, dentifrice, deodorants, lotions, and dry skin creams not considered medications may be stored at the bedside in small quantities in accordance with the facility's policy and procedures for personal items .

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NAME OF PROVIDER OR SUPPLIER Heritage at Longview Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 112 Ruthlynn Dr Longview, TX 75605	

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128 Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards in 1 of 1 kitchen reviewed for food service safety. The facility failed to repair a leaking roof that caused rainwater to drip from the range hood and nearby ceiling tiles. This failure could place residents at risk of foodborne illness and food contamination. Findings include: During an observation and interview on 06/03/24 at 8:31 a.m., revealed water was dripping down the front of the range hood approximately 3 inches from the right corner. The water was dripping into a small green bucket. There was a large puddle of water on the floor behind the bucket. The deep fryer sat under the right-hand side of the range hood. Dietary Aide J said the water was coming from the roof. He said anytime it rained a lot the roof leaked. He said he had worked at the facility for [AGE] years and the roof had been leaking the entire time. During an observation and interview on 06/03/24 at 2:24 p.m., revealed water was dripping down the front of the range hood approximately 3 inches from the right corner. The water was dripping into a small green bucket on the floor. There was no visible damage to the ceiling. The Dietary Manager said it had been leaking forever. She said the roof had been patched in the past. She said they had even had a roofer out. During an observation on 06/04/24 at 10:23 a.m., revealed water was dripping down the front of the range hood approximately 3 inches from the right corner. There was a drip every 6 seconds into a bucket sitting on the floor next to the deep fryer. During an observation on 06/04/24 at 10:50 a.m., [NAME] L had chicken and flour near the deep fry and the drip. [NAME] L was dipping the chicken in the flour and dropping it in the deep fryer. During an observation on 06/04/24 at 11:58 a.m., revealed water was dripping down the front of the range hood approximately 3 inches from the right corner. There was a drip every 3 seconds into a bucket sitting on the floor next to the deep fryer. During an interview on 06/05/24 at 8:44 a.m., the Maintenance Supervisor said there had been a leak around the range hood in the kitchen for a couple of months. He said they recently had 3 roofing companies out to give them estimated repair cost and those had been sent to corporate for approval. He said he had not attempted any repairs himself. He said the water was coming from a roof leak. Record review of roofing repair estimates indicated the facility obtained 3 estimates for repair from 3 different companies on 11/01/23, 11/06/23, and 11/08/23. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 06/05/24 at 9:23 a.m., revealed water was steadily dripping down the front right side of the range hood approximately 3 inches from the corner. The deep fryer was sitting just under the right side of the range hood. There were two other areas dripping from nearby ceiling tiles that were not dripping during previous observations. Two of the drips were dripping into buckets on the floor near the deep fryer. One drip was dripping onto the floor and not into a bucket. During an interview on 06/05/24 at 9:24 a.m., the Dietary Manager said the area around the range hood had been leaking a good while. She said she could not say how long. She said she did know it had been leaking over a year. She said if the water was going to drip into anything it would be the deep fryer. She said the water was dripping from the roof. She said the water could possibly drip into the residents' food . During an interview and observation on 06/05/24 at 10:00 a.m., the Dietary Manager said maintenance requests were sent electronically. She said she used her phone to scan in a QR code (a two-dimensional code that can be scanned with a smart phone) to submit a request. She said she could not remember the last time she reported the leak through this system. She said every time it rained she did show it to the Maintenance Supervisor. The QR code for maintenance requests was hanging in the hall near the nurse's station. During an interview on 06/05/24 at 2:58 p.m., the Administrator said the leak in the kitchen was brought to his attention in November 2023. He said he set into motion for companies to give bids on roof repairs. He said they did receive bids. He said corporate decided they would send out someone to repair the roof. He said they were placed on the list to have the leak repaired. He said they had not had much of an issue with the leak until the recent heavy rains. He said since the leak was not over the stove it did not have the potential to contaminate food. He said he did not think it could negatively affect a resident. During an interview on 06/05/24 at 3:31 p.m., the Administrator said the facility had a Resident Rights policy, but did not have a specific maintenance policy. Review of a Dietary Food Service Personnel Policy and Procedures facility policy dated 2012 indicated, . Spills are to be mopped up immediately . Review of a Cleaning Vent Hood facility policy dated 2012 indicated, .Venting equipment will be clean and free of grease, to ensure a clean and safe food production area . Review of a Resident Rights facility policy dated 11/28/16 indicated, .Safe environment - The resident has a right to a safe, clean, comfortable and homelike environment .

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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** 46062 Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 16 residents reviewed for infection control. (Resident #34 and Resident #203). 1. The facility failed to ensure a sign was posted on Resident #34 and Resident #203's doors to indicate they were on Enhanced Barrier Precautions (interventions to prevent spread of infection in high-risk residents) and what personal protective equipment was required to enter the residents' rooms. 2. The facility failed to ensure CNA E, LVN G , and RN F followed the Enhanced Barrier Precautions to wear a gown while providing care for Resident #203 who had a urinary catheter, gallbladder drain (tube inserted through right abdominal wall into the gallbladder to drain fluid) and a stage 4 pressure ulcer (most severe pressure ulcer, full thickness skin loss, may be muscle, bone tendon, or joint involvement). These failures could place residents at risk for cross-contamination, increased risk of infection and the spread of infection. Findings included: 1. Record review of Resident #34's face sheet dated 6/05/24 indicated she was [AGE] years old and admitted to the facility on [DATE]. Resident #34 had diagnoses which included diabetes (high blood sugar), history of cerebral infarction (stroke-disruption of blood flow to the brain causing brain tissue to die), and reflex neuropathic bladder (nerves and muscles that control the bladder do not work properly and causes difficulty urinating). Record review of Resident #34's admission MDS assessment dated [DATE] indicated she was understood and understood others. The MDS indicated Resident #34 had a BIMS score of 15 which indicated she did not have cognitive impairment. Resident #34 required supervision to partial assistance for most ADL's. The MDS indicated Resident #34 had an indwelling catheter (urinary catheter-tube inserted into bladder to drain urine) and was always continent of bowel. Record review of Resident #34's undated care plan indicated she had an indwelling catheter with interventions which included Enhanced Barrier Precautions. Record review of Resident #34's Order Summary Report dated 6/05/24 revealed an order for a urinary catheter with a start date of 4/24/24. During an observation on 6/03/24 at 11:33 AM, Resident #34 had an isolation cart outside of her room, but there was no isolation sign on her door to indicate what type of isolation Resident #34 was on and what personal protective equipment was required to enter her room. (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 and interview on 6/03/24 at 4:00 PM, Resident #34 said she was able to walk, and the staff did not provide care for her except to give her medications. Resident #34 said her family member was an RN and he assisted her with bathing. Resident #34 said she had a urinary catheter with a leg bag because she had a neurogenic bladder (nerves and muscles that control the bladder do not work properly and caused difficulty urinating). Resident #34 raised her pant leg to show the surveyor her urinary catheter leg bag attached to her leg with a strap. During an interview on 6/03/24 at 4:30 PM, the ADON, who was also the Infection Preventionist, said Resident #34 was on Enhanced Barrier Precautions because she had a urinary catheter. The ADON said she did not know why there was not a sign on Resident #34's door and it should have been on the door. The ADON said she would have a sign placed on Resident 34's door . 2. Record review of Resident #203's face sheet dated 6/04/24 indicated he was [AGE] years old and admitted to the facility on [DATE]. Resident #203 had diagnoses which included stage 4 pressure ulcer to sacrum (most severe pressure ulcer to bottom of spine, full thickness skin loss, may be muscle, bone tendon, or joint involvement), incomplete C5-C7 quadriplegia (paralysis or weakness in all four limbs, but with some ability to move, feel sensations, or control automatic body processes), and reflex neuropathic bladder (nerves and muscles that control the bladder do not work properly and causes difficulty urinating), benign prostatic hyperplasia with lower urinary tract symptoms (prostate grow and results in difficulty urinating), resistance to multiple antimicrobial drugs, and has a cystostomy (opening into bladder to drain fluid). Record review of Resident #203's admission MDS revealed it had not been completed prior to survey exit. Record review of Resident #203's undated care plan indicated he had a pressure ulcer or potential for pressure ulcer development), had a catheter (condom/intermittent/indwelling suprapubic), had a surgical site, and had ADL self-care performance deficit. Record review of Resident #203's Order Summary Report dated 6/04/24 revealed orders to empty cholecystostomy (drain tube placed in gallbladder to drain fluid from gallbladder), monitor/provide urinary catheter care, and wound care to stage 4 pressure ulcer to sacrum and right ischium (lower back part of hip bones). During an observation and interview on 6/03/24 at 11:10 AM, Resident #203 had an isolation cart outside his door, but there was not an isolation sign on his door. The ADON, who was also the Infection Preventionist, said Resident #203 was on Enhanced Barrier Precautions and the sign had been on his door and she did not know why the sign was not on there at that time. The ADON said she would get it replaced. The ADON said they used the Enhanced Barrier Precautions for residents with urinary catheters and wounds to prevent the spread of infection. (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 6/03/24 beginning at 11:16 AM, the surveyor entered Resident #203's room while LVN G and CNA E were still in the resident's room. LVN G had performed wound care to Resident #203's sacrum area. LVN G and CNA E were not wearing gowns upon surveyor entering Resident #203's room . CNA E leaned over Resident #203 to reposition his pillow. Resident #203 was hollering out that he was having severe pain and felt like he was laying on a board and he asked LVN G to take a look back there (his bottom). LVN G asked CNA E to roll resident over so LVN G could look at Resident #203's bottom. CNA E rolled resident toward her to his right side and held him over against side rail allowing the front of her clothes to contact the front of the resident's bedding, while LVN G looked under resident and ran her gloved hand under the resident while leaning against his bed allowing the front of her clothing to contact his bedding. LVN G then placed pillows under his left back and Resident #203 was propped up on his right side. CNA E attached Resident #203's urine catheter bag to his bed frame and placed Resident 203's gallbladder drain tube and pouch under the resident's cover and gown. During an observation and interview on 6/03/24 at 11:21 AM, Resident #203 said he had been in the facility for about a week and had a gallbladder drain, a urinary catheter, and a wound on his bottom. Resident #203 had a urinary catheter hanging from his bed frame. During an observation and interview on 6/03/24 at 11:52 AM, RN F accompanied the surveyor to Resident #203's room and she said LVN G had told her Resident #203 was having pain and she was going to get him a pain pill. While entering Resident #203's room, he continued to holler out he felt like he was lying on a board on his back. RN F put on gloves, pulled back his bedding, rolled Resident #203 over to his right side, held him over, and ran her gloved hand under him and then repositioned him with pillows pushed under his back. RN F did not put on gown. During an interview on 6/05/24 at 1:50 PM, CNA H said she had worked at the facility for fourteen years. CNA H said the isolation carts outside the residents' doors were for the residents who had wounds or tubes such as a feeding tube or urinary catheter. CNA H said staff would need to put on a gown and gloves when caring for those residents. CNA H said during any type of resident care or treatment the y would need to wear the required personal protective equipment. CNA H said the sign on door told staff what personal protective equipment was required to enter the isolation rooms. CNA H said she did not know what Enhanced Barrier Precautions were. CNA H said the purpose of wearing a gown and gloves during resident care was so she would not spread infection. CNA H said she could spread infection to the resident if she did not wear a gown and gloves during resident care. CNA H said she had just come out of Resident #203's room when the surveyor stopped her. CNA H said she did not wear a gown just to empty Resident #203's urinary catheter bag. CNA H said Resident #203 refused to be repositioned at the time. CNA H said she did not know what Enhanced Barrier Precautions were, but she was told she had to put on a gown and wear gloves when providing care to Resident #203. (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 6/05/24 at 2:04 PM, LVN G said she had worked at the facility for eleven years and had been the treatment nurse for two years. LVN G said she had just completed Resident #203's wound care and had just removed her gown and gloves and discarded in the trash bag prior to the surveyor entering his room. LVN G said she did not remember if CNA E was wearing a gown when she was assisting her with positioning of Resident #203 during his wound care. LVN G said she did not put a gown on to reposition and check under him for anything that could have been hurting Resident #203 because she did not realize she needed a gown and gloves to just reposition him. LVN G said the Enhanced Barrier Precautions were to protect the resident or staff from getting any fluids from out of the body on them. LVN G said if she did not wear the appropriate personal protective equipment for Enhanced Barrier Precautions, she could be placing the resident at risk for infection. LVN G said she knew residents were on isolation when there was a sign on the door and an isolation cart outside the resident's room. LVN G said there were no signs for Enhanced Barrier Precautions, but they did have signs for other isolations such as for C-Diff (inflammation of the colon caused by bacteria Clostridium difficile). LVN G said the Enhanced Barrier Precautions protected the resident and the staff from transmission of disease. During an interview on 6/05/24 at 2:26 PM, RN F said she had worked at the facility for approximately a year as needed. RN F said she would know a resident was on Enhanced Barrier Precautions by the resident having a sign on their door and an isolation cart outside their door. RN F said they also discussed residents on isolation in their daily nursing report. RN F said the Enhanced Barrier Precautions were set up to protect residents from staff bringing anything into the resident that could compromise the resident or from passing bacteria to other residents/staff. RN F said if the appropriate personal protective equipment was not worn for Enhanced Barrier Precautions, it placed the resident at risk for complications in their healing process. During an interview on 6/05/24 at 2:43 PM, LVN B said she had worked at the facility since September 2023 and normally worked the day shift. LVN B said the Enhanced Barrier Precautions were precautions to prevent transferring bacteria from a patient to another person. LVN B said if staff do not wear the appropriate personal protective equipment for Enhanced Barrier Precautions, they could spread germs and lead to secondary infections for residents. LVN B said Enhanced Barrier Precautions were important to prevent spreading of germs between residents. (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 6/05/24 at 3:01 PM, CNA E said she had worked at the facility full-time for approximately three months, but she had worked at the facility for about ten years as needed. CNA E said she had gone into Resident #203's room to help LVN G while she performed his would care. CNA E said she washed her hands and put on gloves and said she did not put a gown on while LVN G was performing Resident #203's wound care. CNA E said LVN G was wearing a gown during the wound care. CNA E said she would know a resident was on isolation when there was a sign on the door and an isolation cart by their door. CNA E said she would read the sign to see what personal protective equipment she needed to wear to enter the resident's room. CNA E said if there was not a sign on the door and an isolation cart was outside a resident's door, she would go ask the nurse what isolation the resident was on before entering the resident's room. CNA E said she did not know what Enhanced Barrier Precautions were, but she would go find out before she entered the resident's room. CNA E said she would need to put on gloves and a gown for a resident on Enhanced Barrier Precautions. CNA E said she was just LVN G's assistant to help turn Resident #203, so she did not put a gown on. CNA E said she did not allow her clothing to touch Resident #203 when she turned him and held him over while LVN G was doing Resident #203's wound care. CNA E said she realized now that both people in close contact of the resident during care should be wearing gloves and a gown. CNA E said the Enhanced Barrier Precautions were to protect the resident from the spread of infection or bacteria. CNA E said by not wearing the appropriate personal protective equipment, she could spread infection or bacteria to the resident. During an interview on 6/05/24 at 3:19 PM, the ADON, who was also the Infection Preventionist, said the purpose of the Enhanced Barrier Precautions was for the protection of the residents and staff by preventing cross-contamination between residents and staff. The ADON said she did not know what had happened to the Enhanced Barrier Precautions signs for Resident #34 and Resident #203's doors, she said they had been on the doors previously. The ADON said the Enhanced Barrier Precautions sign and the isolation cart outside the residents' rooms would indicate to staff that the resident was on isolation and what personal protective equipment would be required to enter the resident's room. The ADON said if the Enhanced Barrier Precautions were not followed, it could place residents and staff at risk for spread of infection. During an interview on 6/05/24 at 3:41 PM, the ADM said he would expect staff to follow the Enhanced Barrier Precautions policy. The ADM said the residents would be at risk of getting infections if the Enhanced Barrier Precautions were not followed. Record review of the facility's form titled C.N.A. Proficiency Audit dated 2/13/24, revealed CNA E was marked with an N, indicating she needed improvement with Infection Control Awareness, and it reflected she was in-serviced Record review of the facility's form titled Licensed Nurse Proficiency Audit dated 7/21/23 by the reviewer, revealed LVN G was marked with an S, indicating she had satisfactory performed the Infection Control skills of proper handwashing technique, prevented cross contamination, and universal 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 Infection control Plan: Overview with an updated date of March 2022 revealed . the facility would establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection . when the Infection Control Program determines a resident needed isolation to prevent the spread of infection, the facility would isolate the resident . facility would require staff to Donn and doff PPE before and after contact with resident who needs isolation to prevent the spread of infection to others in the facility . Record review of the facility's undated policy titled Enhanced Barrier Precautions revealed . Multidrug-resistant organism (MDRO) transmission was common in long term care facilities . many residents in nursing homes were at increased risk of becoming colonized and developing infections with MDROs . Enhanced Barrier Precautions (EBP) referred to an infection control intervention designed to reduce transmission of MDROs that employ targeted gown and glove use during high contact resident care activities . EBP were used in conjunction with standard precautions and expand the use of PPE (personal protective equipment) to donning (putting on) of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing . EBP were indicated for residents with any of the following . wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO . indwelling medical device examples include . urinary catheters . facility would utilize postings outside the room and Point Click Care to communicate to staff if a resident required EBP .