STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455627	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society-Denton Village	2500 Hinkle Dr Denton, TX 76201

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for one (Resident #19) of thirteen residents reviewed for dignity. The facility failed to treat Resident #19 with dignity and promote enhancement of her quality of life when the resident was not provided a privacy bag for her catheter bag. This failure placed residents at risk of not having their right to a dignified existence maintained. Findings included: Review of Resident #19's Face Sheet, dated 08/21/2024, reflected that the resident was an [AGE] year-old female admitted on [DATE]. Resident #19 was diagnosed with neuromuscular dysfunction of bladder (the muscles and nerves that control the bladder do not work properly due to illness). Review of Resident #19's Quarterly MDS Assessment, dated 07/13/2024, reflected Resident #19 was cognitively intact with a BIMS score of 13. The Quarterly MDS Assessment indicated that the resident had an indwelling catheter. Review of Resident #19's Comprehensive Care Plan, dated 06/28/2024, reflected Resident #19 had an indwelling catheter related to neurogenic bladder (the normal bladder function is disrupted due to nerve damage) and one of the interventions was catheter care every shift. Review of Resident #19's Physician Order, dated 11/07/2023, reflected CATHETER: Foley 18fr (French: unit used to indicate the size of the catheter) with 10 cc balloon to dependent drainage. Change catheter and drainage bag monthly on the 3rd, and prn one time a day every 1 month(s) starting on the 3rd for 1 day(s) related to NEUROMUSCULAR DYSFUNCTION OF BLADDER, UNSPECIFIED AND as needed for patency. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with Resident #19 on 08/21/2024 at 6:30 AM revealed Resident #19 was in her bed, awake. Resident #19 had a catheter bag hanging at the railings below her bed. The urine inside catheter bag was observed visible from the hallway and upon entrance to the room. The catheter bag did not have a privacy bag. Resident #19 stated she had the catheter for the longest time because there was something wrong with her bladder. Resident #19 said she was not aware her catheter bag was exposed. Resident #19 said she did not know how long it had been exposed. Observation on 08/21/2024 at 7:13 AM revealed Resident #19's catheter bag was still hanging on the railings below her bed. It still did not have a privacy bag. The content of the catheter bag was still visible from the hallway and upon entrance to the room. In an interview with CNA C on 08/21/2024 at 7:15 AM, CNA C confirmed that Resident #19's catheter bag did not have a privacy bag. CNA C stated he saw it when he made his rounds, and he should have gotten a privacy bag as soon as he saw it. CNA C said the privacy bag was used so that the content of catheter bag wiould not be seen by other people. CNA C added that the privacy bag was used to prevent embarrassment. CNA C said he would get a privacy bag and put it on the railing below the bed. CNA C said the resident had a privacy bag on the wheelchair but then said there should also be a privacy bag when the resident was inside the room. In an interview with LPN A on 08/22/2024 at 8:32 AM, LPN A stated the staff needed to make sure Foley bags were inside a privacy bag. LPN A said there should be a privacy bag for the catheter bag so that it will not be visible to other residents or visitors. She said without the privacy bag, the resident might be embarrassed, humiliated, or uncomfortable going out of the room. She said she did not notice the urine drainage bag was exposed the day before. She said she would make a round and check if the residents with catheter had their privacy bags. She said she was responsible in making sure the catheter bag had a privacy bag. In an interview with the ADON on 08/22/2024 at 7:15 AM, the ADON stated all the residents should be treated with dignity. She said dignity could be in the form of pulling the privacy curtain while providing care or making sure nothing was exposed when transporting the residents. She said, for a resident with catheter, there should be privacy bag to maintain dignity. She said the expectation was for the staff to be mindful of the feelings of the residents with catheter. She said they would do an in-service pertaining to maintaining the residents' dignity. In an interview with the DON on 08/22/2024 at 7:35 AM, the DON stated the catheter bag should have been placed inside a privacy bag to avoid embarrassment and humiliation. The DON said all the residents had the right for a dignified existence and not having a privacy bag was not one of them. She said all the staff, including her, were responsible in providing dignity to the residents with catheter. The DON said the expectation was for the staff to make sure the catheter bag had a privacy bag when the resident was inside or outside the room. She concluded that she would continually remind the staff the importance of dignity and privacy for residents with catheter through an in-service. In an interview with the Administrator on 08/22/2024 at 7:53 AM, the Administrator stated her expectation was for all the staff to provide dignity to all the residents. She said a catheter bag without a privacy bag was a dignity issue because if the urine bag was visible from the hallway, it could cause embarrassment. She said he would coordinate with the DON concerning the privacy bag. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy, Resident Dignity - Rehab/Skilled Rehab/Skilled & Long Term Care: Therapy & Rehab revised 11/16/2023 revealed Purpose: To maintain dignity . Policy: The location will promote care . enhances each resident's dignity and respect in full recognition of his or her individuality . Procedure . l. Refraining from practices demeaning to residents such as keeping urinary catheter bags uncovered.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for two (Resident #4 and Resident #23) of thirteen residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #4 and Resident #23's rooms were in a position that was accessible to the residents. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. Findings included: Resident #4 Review of Resident #4's Face Sheet, dated 08/20/2024, reflected that resident was a [AGE] year-old female admitted on [DATE]. Resident #4 was diagnosed with generalized muscle weakness and chronic pain. Review of Resident #4's Quarterly MDS Assessment, dated 08/15/2024, reflected that Resident #4 had a moderate impairment in cognition with a BIMS score of 12. Resident #4 required limited assistance for transfer and toileting. Review of Resident #4's Comprehensive Care Plan, dated 05/16/2024, reflected that Resident #4 was at risk for falls and one of the interventions was to call for assistance. Observation on 08/20/2024 at 9:32 AM revealed Resident #4 was in her wheelchair, awake. It was observed that the resident's call light was on the floor between the bed and the wall. Observation and interview with Resident #4 on 08/20/2024 at 10:38 AM revealed Resident #4 was in her wheelchair, awake. Resident #4's call light was still on the floor between the bed and the wall of the room. Resident #4 stated she would use her call light if she needed assistance from the staff. She said she wanted her call light near her especially at night in case she could not stand up or move around. Resident #4 checked the side of her bed and said she could not find her call light. Resident #4 saw the cord of the call light behind her bed and said she could not reach it. She said she needed her call light to call the staff. Resident #23 Review of Resident #23's Face Sheet, dated 08/20/2024, reflected the resident was an [AGE] year-old female admitted on [DATE]. Resident #23 had history of falling. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #23's Quarterly MDS Assessment, dated 07/14/2024, reflected Resident #23 had a severe cognitive impairment with a BIMS score of 00. Resident #23 needed moderate assistance for transfers. Review of Resident #23's Comprehensive Care Plan, dated 07/29/2024, reflected Resident #23 was at risk for falls related to gait balance problems and one of the interventions was to ensure/provide a safe environment. Observation on 08/20/2024 at 9:43 AM revealed Resident #23 was on her wheelchair inside the room. It was observed that the resident's call light was on the floor at the end of the bed. The resident was asked about the call light, the resident only smiled back. In an interview and observation with LPN A on 08/20/2024 at 10:42 AM, LPN A stated the call lights should be with the residents all the time because they used the call lights to call for assistance if needed. She said the residents used the call lights to communicate to the staff that they needed something. She added that if the call lights were not with the residents, the residents might fall. Some of the residents would be mad and frustrated because they could not call the staff. She said all the staff were responsible in making sure the call lights were within reach of the residents. LPN A went inside Resident #4's room and confirmed the call light was on the floor in between the bed and wall. LPN A pulled the call light and put it on top of the bed where Resident #4 could reach it. Then LPN A went to Resident #23's room and also confirmed that the call light was on the floor. LPN A picked up the call light and put it on top of the bed where Resident #23 could access it. In an interview with the ADON on 08/22/2024 at 7:15 AM, the ADON stated the call lights should not be on the floor or in a place not accessible to the residents. The ADON said the call light must be within reach of the residents at all times because they use the call light to call the staff if they needed refill of their pitcher or if they needed to be changed. The ADON said if the call lights were far from the residents, the residents would not be able to call the staff and their needs would not be met. The ADON said the resident might even have a fall if they try to do things by themselves because they could not call the staff. The ADON said the expectation was for all the staff to make sure the call lights were within the reach of all the residents. The ADON said they would do an in-service about call lights being accessible to the residents. In an interview with the DON on 08/22/2024 at 7:35 AM, the DON stated call lights were very essential for the residents and they should be placed where the residents could easily reach it. The DON said, for some residents, the call lights were the only way of communication between the residents and the staff. The DON said the call lights were used by the resident if they needed something, like pain medication, refill of water, or to turn the lights off. The DON said without the call lights, the needs of the residents would not be known and would not be met. The DON said the expectation was for the staff would be mindful that every time they leave the resident's room, the call lights were with the residents. The DON said he would conduct an in-service about the call lights. He said the in-service would be for the nurses, CNAs, housekeeping, therapists, and management. He said he would personally monitor that all the residents' call lights were within reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Administrator on 08/22/2024 at 7:53 AM, the Administrator stated the call lights should not be far from the residents because they were used by the residents to call the staff. The Administrator said the residents might be having an emergency and staff would not know. The Administrator said the staff should be sensible about call light placement. The Administrator said she would coordinate with the DON regarding call lights and would constantly remind them that before leaving the room, make sure the call lights were with the resident. Record review of facility's policy Call Light - R/S, LTC, Therapy & Rehab /Skilled & Long Term Care: Therapy & Rehab revised 07/29/2024 revealed Purpose: To ensure resident always had a method of calling for assistance . Procedure . 4. When leaving the room, place call light within easy reach of the residents.

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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. 50444 Based on observation, interview and record review, the facility failed to ensure the residents' rights to privacy for 15 (#4, #44, #8, #11, #49, #10, #157, #16, #43, #13, #15, #40, #21, #22, #27) of 15 residents reviewed for personal privacy. The facility failed to ensure LPN D locked the computer screen, displaying the names of 15 residents, while LPN D was in a resident's room administering a treatment. This failure could allow residents' protected HIPAA information to be shared with individuals who did not have a need or right to know. The findings included: An observation 08/21/24 at 09:58 AM revealed an open laptop on the nurse's cart on hall 300. The screen displayed the full name and room number of 15 residents on hall 300. The nurse was in a resident's room providing a treatment at the time. The cart was outside the door of the room the nurse was in. No visitors or other residents were near the laptop when the observation was made. During an interview 08/22/24 at 07:13 AM, LPN D stated she was supposed to lock the screen when away from the computer. She stated it was a HIPAA violation to leave the screen open, unattended, with resident information displayed. During an interview with the DON 08/22/24 at 08:18 AM, he stated LPN D should close the computer when not using it, because resident information could be seen. He stated this was a privacy issue. During an interview with the QAPI Nurse Manager 08/22/24 at 08:57 AM, she stated when a staff member was not using a computer, they should lock the screen or close the computer. She stated anyone who walked by the open screen could look at residents' information and information should be kept private. Review of the facility policy, revised 11/16/23 and titled Resident Dignity, stated maintaining an environment . able to be seen by visitors and/or other residents that includes confidential clinical or personal information.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observations, interviews, and record review the facility failed to provide a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for 6 (room [ROOM NUMBER], #1111, #1113, #1114, #1115, and #1116) of 12 resident rooms and the facility's high traffic areas reviewed for cleanliness and sanitization. The facility failed to ensure that Resident Rooms #1109, #1111, #1113, #1114, #1115, and #1116 were thoroughly cleaned and sanitized. This failure could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life. Findings included: An observation on 08/20/24 at 10:44 AM of Resident room [ROOM NUMBER] reflected the corners of the floor in the resident bathroom had dirt particles and built-up dust. The widow blinds had a film of this dust on them. The trashcan in the bathroom had no trash bag in it, and it had two unused adult diapers in it. The backside of the entry door had black dirt stains near the door handle and the door frame. An observation on 08/20/24 at 10:49 AM of Resident room [ROOM NUMBER] reflected the corners of the floor in the resident bathroom and behind the toilet, had dirt particles and built-up dust. The sink drain hole had rust on the metal ring circling the drain hole. An observation on 08/20/24 at 10:53 AM of Resident room [ROOM NUMBER] reflected the corners of the floor in the resident bathroom and behind the toilet, had dirt particles and built-up dust. An observation on 08/20/24 at 10:57 AM of Resident room [ROOM NUMBER] reflected the corners of the floor in the resident bathroom and behind the toilet, had dirt particles and built-up dust. The sink drain hole had rust on the metal ring circling the drain hole. The light greenish bedside table in the resident's room had dried up brownish stains and black dirt stains along the bottom of the table. An observation on 08/20/24 at 11:18 AM of Resident room [ROOM NUMBER] reflected the corners of the floor in the resident bathroom and behind the toilet, had dirt particles and built-up dust. The trashcan in the resident room had reddish and brownish stains all over the outside of the trashcan. An observation on 08/20/24 at 11:23 AM of Resident room [ROOM NUMBER] reflected the corners of the floor in the resident bathroom and behind the toilet, had dirt particles and built-up dust. There was a dead cricket near the trashcan in the bathroom. The floor in front of the toilet had yellowish stains. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/22/24 at 10:13 AM, Housekeeper A stated she had been cleaning for [AGE] years. She stated she cleaned the 100 and 400 halls, but they sometime switched up. She stated they were supposed to clean everything in the room, such as the bathroom, floors, and wipe things down. She stated the residents liked her because she got things done. She was shown pictures of the concerns observed in resident room [ROOM NUMBER], #1111, #1113, #1114, #1115, and #1116, and she stated she was concerned that her peers were not consistent when cleaning rooms and she had received feedback from residents with the same concerns. She stated she worked to ensure the residents room were thoroughly cleaned but her peers skipped over areas and then the dirt would build up. She stated she had pointed this out to housekeeping supervisor, but she had not seen any changes in their behaviors. In an interview on 08/22/24 at 10:26 AM, the Environmental services supervisor stated he had been at the facility for [AGE] years. He stated housekeeping were supposed to clean everything in the room, but sometimes they were unable to clean everything every day. He was shown pictures of the concerns observed in resident room [ROOM NUMBER], #1111, #1113, #1114, #1115, and #1116, and he stated he had inspected the rooms to ensure they were cleaned but needed to look a little closer. He stated deep cleaning was done as needed, but it was primarily done once a month. He stated the concerns observed were an infection control concern, and it could also impact their morale. In an interview on 08/22/24 at 10:50 AM, the Administrator stated she had not been made fully aware of the concerns observed in the resident rooms. She was shown pictures of the concerns observed in resident rooms #1109, #1111, #1113, #1114, #1115, and #1116. She stated that she would follow-up with the Environmental services supervisor to ensure these concerns were addressed. She stated her expectation was for housekeeping to ensure they were thoroughly cleaning rooms. She stated the risk of not thoroughly cleaning resident rooms could result in infections and it was not good for their dignity. Review of the facility's policy on Housekeeping (undated) reflected Rehabilitation/skilled care settings provide care and services to residents who are often vulnerable to infections and effects of infections due to weakened immune systems. As such, thorough, routine, and high-quality cleaning procedures are necessary to minimize the prevalence of infection.

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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** 47743 Based on observations, interviews, and record review, the facility failed to ensure assessments accurately reflected the resident's status for one (Resident #27) of six residents reviewed for Accuracy of Assessments. The facility failed to ensure Resident #27's Quarterly MDS Assessment accurately reflected that Resident #27 was on oxygen therapy. This failure could place residents at risk for not receiving care and services to meet their needs, diminished function of health, and regressions in their overall health. Findings included: Review of Resident #27's Face Sheet, dated 08/21/2024, reflected that resident was an [AGE] year-old female admitted on [DATE]. Resident #27 was diagnosed with chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and pleural effusion (collection of fluid around the lungs). Review of Resident #27's Quarterly MDS Assessment, dated 04/13/2024, reflected Resident #27 was cognitively intact with a BIMS score of 15. Resident #27's Quarterly MDS Assessment did not indicate that the resident was on oxygen therapy. Review of Resident #27's Comprehensive Care Plan, dated 08/02/2024, reflected Resident #27 had oxygen therapy related to COPD and one of the interventions was oxygen therapy continuous. Review of Resident #27's Physician Order, dated 07/27/2022, reflected O2 via nasal cannula 1-3L every shift. Observation and interview with Resident #27 on 08/21/2024 at 9:37 AM revealed the resident was on her wheelchair, awake. She was on oxygen administration via nasal cannula at 2 to 3 liters per minute. According to Resident #27, she was on oxygen for years because sometimes she had a hard time breathing. In an interview with the ADON on 08/22/2024 at 7:15 AM, the ADON stated if a resident was using oxygen, it should be reflected on the system to make sure all the needed respiratory care was given to the resident. She added there should be an accurate assessment to know how to care for the residents. The ADON said if there was no accurate assessment, there could be a misunderstanding about the care needed by the resident and the resident might not be able to get the treatment needed. She said she would coordinate with the DON and the MDS Nurse to address the issues. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 08/22/2024 at 7:35 AM, the DON stated an accurate assessment was important so that the staff would know how to take care of the residents. He said the care plan of the residents would be based on the assessment. He said if a resident was using oxygen, it should be reflected on the medical diagnosis, physician orders, the MDS, and the care plan. He said if the residents were not properly assessed, the proper care and needs would not be met. The DON said the expectation was that the residents were properly assessed not only during admission but every day to see if there were changes in condition, any refusal of care, or a resident acting different than usual. He said he would collaborate with the MDS Nurse and the ADON to audit the MDS Assessments and make proper changes. In an interview with the Administrator on 08/22/2024 at 7:53 AM, the Administrator stated the MDS should reflect the current condition of the resident. She said, by doing so, the needs of the residents would be addressed. She said she would coordinate with the DON to evaluate the situation, discuss it during quality assurance, and conduct in-services. Observation and interview with MDS Nurse on 08/22/2024 at 8:16 AM, the MDS Nurse stated she was responsible in doing the MDS Assessment and the care plan. She said once the staff put in the initial order, it would take seven days before the MDS was triggered. She said the medical diagnosis, physician order, the MDS, and the care plan should be all in-line and should match to provide a clear overview of the resident's current condition. She turned on the computer and went to Resident #27's profile. The MDS nurse reviewed the date of the resident's order for oxygen. The resident's Physician order reflected that the order for oxygen was placed on the system last 07/27/2022. She then checked the resident's MDS and confirmed that the resident was not triggered for oxygen use. The MDS nurse said the MDS was used to make the care plan. She said if the MDS was not triggered, the care might be missed. She said she would make an audit to make sure the MDS would reflect the current condition of the residents. Record review of facility policy, Resident Assessment (Comprehensive Assessment), LTC Rehab/Skilled & Long-Term Care: Therapy & Rehab revised 07/20/2023 revealed Purpose: To identify the resident's care needs . Procedure . during examination . any shortness of breath.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society-Denton Village	2500 Hinkle Dr Denton, TX 76201

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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 - Some	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** 47743 Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for a resident for three (Resident #9, Resident #15, and Resident #106) of eight residents reviewed for Care Plans. 1. The facility failed to ensure Resident #9 was care planned for indwelling Foley catheter. 2. The facility failed to ensure Resident #15 were care planned for oxygen administration. 3. The facility failed to ensure Resident #106 were care planned for oxygen administration. These failures could place the residents at risk of not receiving the necessary care and services. Findings included: 1. Review of Resident #9's Face Sheet, dated 08/21/2024, revealed Resident #9 was a [AGE] year-old male who was admitted to the facility 07/22/2024. Relevant diagnoses included benign prostatic hyperplasia (a condition in men in which the prostate gland is enlarged and not cancerous) with lower urinary tract symptoms and chronic kidney disease. Review of Resident #9 Quarterly MDS Assessment, dated 07/28/24, revealed Resident #9 was cognitively intact with a BIMS score of 15, an indwelling foley catheter, and was dependent on staff for toileting hygiene. Review of Resident #9's Physician Order, dated 07/22/2024, revealed Catheter: 18 f (French: unit used to indicate the size of the catheter) with cc balloon to dependent drainage. Review of Resident #9's Comprehensive Care Plan on 08/21/2024 reflected no care plan for indwelling catheter. Observation on 08/21/2024 at 12:46 PM revealed Resident #9 had a foley catheter hanging on his wheelchair. It was in a privacy bag and not touching the floor. 2. Review of Resident #15's Face Sheet, dated 08/20/2024, reflected that the resident was an [AGE] year-old male admitted on [DATE]. Resident #15 was diagnosed with chronic respiratory failure (condition where there is not enough oxygen in the body or too much carbon dioxide in the body) with hypoxia (insufficient amount of oxygen in the body). Review of Resident #15's Quarterly MDS Assessment, dated 07/23/2024, reflected that Resident #15 was cognitively intact with a BIMS score of 15. Resident #15's Quarterly MDS Assessment indicated that the resident had oxygen therapy while a resident of the facility. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #15's Physician Order, dated 07/27/2022, reflected Oxygen via nasal cannula 1-4 liters per minute continuously and as needed for dyspnea (difficulty in breathing), hypoxia (low level of oxygen in the blood) or acute angina (chest pain). As needed for dyspnea, hypoxia, acute angina, AND every shift. Review of Resident #15's Comprehensive Care Plan on 08/20/2024 reflected no care plan for oxygen therapy. Observation on 08/20/2024 at 9:09 AM revealed Resident #15 was on his bed, asleep. It was observed that Resident #15 had oxygen administration via nasal cannula at 3 liters per minute. The nasal cannula was connected to an oxygen concentrator. In an interview with Resident #15 on 08/20/2024 at 11:27 AM, Resident #15 stated he had been using oxygen for almost two years. He said he used the oxygen day and night. 3. Review of Resident #106's Face Sheet, dated 08/21/2024, reflected that resident was an [AGE] year-old female admitted on [DATE]. Resident #106 was diagnosed with pneumonia (inflammation and fluid in the lungs caused by a bacterial, viral, or fungal infection) and anxiety disorder. Review of Resident #106's Quarterly MDS Assessment, dated 04/30/2024, reflected Resident #106 was cognitively intact with a BIMS score of 15. Resident #106's Quarterly MDS Assessment did not indicate that the resident was on oxygen therapy. Review of Resident #106's Physician Order, dated 08/16/2024, reflected Oxygen at 2 LPM (per nasal cannula, face mask, facial tent) via O2 concentrator and/or tank at bedtime every night shift for SOB. Review of Resident #106's Comprehensive Care Plan on 08/21/2024 reflected no care plan for oxygen therapy. Observation and interview with Resident #106 on 08/20/2024 at 9:09 AM revealed that Resident #106 was on her bed, awake. It was observed that she had a nasal cannula connected to an oxygen concentrator. According to Resident #106, she would use the oxygen at night. In an interview with the ADON on 08/22/2024 at 7:15 AM, the ADON stated it was important that residents had a care plan to fully provide the care and services the residents needed. The ADON said that for this case, there should be a care plan for the indwelling catheter and oxygen administration. She said without the care plan, there could be confusion on the care of the residents and their needs would not be addressed. She said she was responsible in making the care plan. She said the expectation was all the issue of the residents were care planned. In an interview with the DON on 08/22/2024 at 7:35 AM, the DON stated every resident needed a comprehensive care plan to make sure the residents received the applicable and appropriate care needed. The DON said the care plan should be in place so that the staff providing care would be on the same page. The DON stated the care plan was important because it reflected the resident's needs. He said the care plan should be resident-centered and should show what specific care the resident needed. He said the expectation was for all residents to have a complete and detailed care plan. He said he would coordinate with the ADON and the MDS Nurse to audit the care plans of the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Administrator on 08/22/2024 at 7:53 AM, the Administrator stated all the residents should have a care plan appropriate to their needs. She said without the care plan, the staff would not know the goals and the interventions needed by the residents. The Administrator concluded that the expectation was for the staff to ensure that the residents were care planned accordingly. She said she would coordinate with the DON and the MDS Nurse to make sure all the residents were care planned. Observation and interview with MDS Nurse on 08/22/2024 at 8:16 AM, the MDS Nurse confirmed that Resident #9 did not have a care plan for the indwelling catheter. She also confirmed that Resident #15 and Resident #106 did not have a care plan for oxygen therapy. She stated she missed it and would add the care plan for the indwelling catheter and oxygen therapy. The MDS Nurse stated care plans were important to ensure the residents were getting the care needed. She said care plans served as guides on how the staff would take care of the residents. The MDS Nurse added that without the care plans, the staff could miss significant interventions needed by the residents. Record review of facility's policy, Comprehension Care Plan and Care Conferences - Rehab/Skilled Rehab/Skilled & Long-Term Care: Therapy & Rehab revised 12/04/2023 revealed Purpose: to develop a person-centered care plan for each resident . Procedure . 5. Formulating the care Plan . a. The care plan is driven by identified resident issues/conditions.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45055 Based on observation, interviews, and record reviews the facility failed to ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 (Residents #37) of 6 residents reviewed for (ADLs) care provided to dependent residents. 1.The facility failed to ensure Resident #37 received scheduled showers for his days scheduled, nor had had the resident received any unscheduled showers reviewed since the resident was admitted to the facility on [DATE]. 2. The facility failed to ensure Resident #37's toes were trimmed since admitting to the facility on [DATE]. These failures placed the resident at risk of not receiving necessary services to maintain good personal hygiene and decreased self- esteem. Findings included: Record review of Resident #37's Face Sheet, dated 08/21/2024, revealed he was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included Kidney Failure and required ADL assistance. Record review of Resident #37's Quarterly MDS dated [DATE] revealed, he had a BIMS score of 12 (cognitively intact) and for ADL care it stated, for transfers, toileting, and bathing, the resident required total assistance. In an observation and interview on 08/20/24 at 11:05 AM, Resident #37 was observed sitting in his wheelchair in his room. His clothing appeared dingy and stained. His feet were observed, and his toenails were at least a 1/2 long. He was asked if he was receiving his showers and he shook his head no. He was asked if he wanted a shower, and he shook his head yes. He was asked if he wanted his toenails trimmed and he shook his head yes. Record review of the facility's shower sheet for Resident #37 from 07/21/24 to 08/21/24 reflected refused showers for the resident on 07/24/24, 08/01/24, 08/23/24, 08/08/24, 08/13//24, and 08/15/24. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/22/24 at 08:55 AM, CNA A stated she had been at the facility for nearly 6 years. She stated that Resident #37 normally showered in the evenings. She stated they completed shower sheets, and she was scheduled to provide the resident a shower today. She stated if a resident refused a shower, the CNA attempted to convince the resident to take a shower and if the resident refused, they had to get a nurse to go in the room with them to hear them attempt to provide the resident a shower and if the resident refused, they would chart it as a refusal. She stated that they were supposed to document the refusal in the progress notes and then the nurses and DON would receive an alert. She stated she had observed the resident's toe nails today and they were horrible. She stated she had not told a nurse because today was her first day working with the resident in quite a while. She stated she normally tells a nurse when she observed toenails that needed to be trimmed and they would say that they were scheduling a podiatrist to come to the facility to trim resident toes nails. She stated that if the resident was not receiving his scheduled showers, he could have an infection and his toes could get cuts. She stated the resident was a sweet guy and she had not known him for refusing showers, maybe from certain CNAs he might not like, but she had not had any problems. She stated he was scheduled to receive his showers on Tuesday, Thursday, and Saturday. In an interview on 08/22/24 at 09:13 AM, RN D stated she had been at the facility for 6 years and she was the 06:00 AM - 02:00 PM nurse for the 100 hall. She was advised that Resident #37 shower information was reviewed from 07/21/24 to 08/21/24 and it indicated that he had refused all of his showers. She stated that if a resident refused a shower, the CNA must alert the nurse and if the resident still refused, they must alert the DON. She stated the DON would attempt to encourage him into taking a shower. She stated she was not sure if the resident refused showers, because he was scheduled to receive his showers in the evenings. She stated if the resident continued to refuse a shower, they must also document it in the progress notes. She stated she had noticed the length of the resident's toenails and stated that he was on the podiatrist list, and they came every three months. She stated that the resident arrived at the facility with the long toenails, but no action was taken. She stated the resident was not a diabetic, so she was able to trim the resident's toenails. She stated the resident could get an infection or the resident could have skin problems if he did not receive showers or have his feet manicured. In an interview on 08/22/24 at 09:50 AM, the DON stated he was made aware of the concerns for Resident #37 by RN D, and he stated he was unaware that the resident was refusing showers. He stated that if a resident refused a shower, it must be documented, and the nurse must inform him. He stated that he was unaware of the resident ever refusing showers and he had never observed the resident's feet. He stated that the nurses were able to trim resident toenails, but a lot of them were uncomfortable trimming toenails. He confirmed that the resident was not a diabetic, so the nurses were able to trim his toes. He stated that he was told by his staff that the resident had arrived at the facility on 06/25/24 with his toenails in bad condition but no one had made him aware of the need for his feet to be addressed at that time. He stated that if the resident refused showers, it should have been care planned. He stated the risk of the residents, feet not being addressed could result in him getting an infection, and the resident not getting showers could result in skin problems. Record review of facility policy on Bathing, dated 08/29/2023, Purpose: Promote cleanliness and general hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	To stimulate circulation of the skin To promote comfort, relaxation, and wellbeing. To observe resident's condition. To assist resident with personal care. To promote safety for the resident in the bath.

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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 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** 47743 Based on observations, interviews, and record review, the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for two (Residents #27 and Resident #106) of eight residents reviewed for Respiratory Care. 1. The facility failed to ensure Resident #27's breathing mask used for nebulization was properly stored. 2. The facility failed to ensure Resident #106's nasal cannula (flexible tube used to deliver oxygen to the nose through two prongs) was properly stored. These failures could place the residents at risk for respiratory infection and not having their respiratory needs met. Findings included: 1. Review of Resident #27's Face Sheet, dated 08/21/2024, reflected that the resident was an [AGE] year-old female admitted on [DATE]. Resident #27 was diagnosed with chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and pleural effusion (collection of fluid around the lungs). Review of Resident #27's Quarterly MDS Assessment, dated 04/13/2024, reflected Resident #27 was cognitively intact with a BIMS score of 15. Resident #27's Quarterly MDS Assessment indicated that the resident had COPD. Review of Resident #27's Comprehensive Care Plan, dated 08/02/2024, reflected Resident #27 had oxygen therapy related to COPD and one of the interventions was oxygen therapy continuous. Review of Resident #27's Physician Order, dated 03/01/2024, reflected Arformoterol Tartrate Inhalation Nebulization Solution (Arformoterol Tartrate) 2 ml inhale orally via nebulizer two times a day related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE. Observation and interview with Resident #27 on 08/21/2024 at 9:37 AM revealed the resident was on her wheelchair, awake. It was noted that Resident #27's nebulizer machine was observed sitting on top of the resident's side table. A breathing mask was connected to the nebulizer machine. The breathing mask was observed on the table. The breathing mask was not bagged. The part of the nebulizer mask that touched the face when in use was in contact with the table. Resident #27 said she had a breathing treatment twice a day because of her breathing problem. Resident #27 said the nurse would put a solution on the container connected to the mask, would turn it on, and would put the mask on her face. Resident #27 said she was not sure if the nurse was putting it in a bag, but she never saw a bag for her nebulizer mask. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with LPN D on 08/20/2024 at 11:57 AM, LPN D stated the breathing mask should not be exposed nor touching anything because it could cause cross contamination and infection. LPN D said the breathing mask should be bagged when not in use. LPN D went inside Resident #27's room and confirmed the breathing mask was on top of the table. LPN D said she did administer the resident's breathing treatment but was not able to put the mask in the plastic bag when the treatment was done. LPN D disconnected the breathing mask and said she would obtain a new one and would put it in a plastic bag. LPN D went to her cart, opened the last drawer, took a new breathing mask and a plastic bag out. LPN D went back to Resident #27's room, connected the new breathing mask and then placed it inside a plastic bag. 2. Review of Resident #106's Face Sheet, dated 08/21/2024, reflected that resident was an [AGE] year-old female admitted on [DATE]. Resident #106 was diagnosed with pneumonia (inflammation and fluid in the lungs caused by a bacterial, viral, or fungal infection) and anxiety disorder. Review of Resident #106's Quarterly MDS Assessment, dated 04/30/2024, reflected Resident #106 was cognitively intact with a BIMS score of 15. Resident #106's Quarterly MDS Assessment did not indicate that the resident was on oxygen therapy. Review of Resident #106's Comprehensive Care Plan on 08/21/2024 reflected no care plan for oxygen therapy. Review of Resident #106's Physician Order, dated 08/16/2024, reflected Oxygen at 2 LPM) (per nasal cannula, face mask, facial tent) via O2 concentrator and/or tank at bedtime every night shift for SOB. Observation and interview with Resident #106 on 08/20/2024 at 9:09 AM revealed that Resident #106 was on her bed, awake. It was observed that she had a nasal cannula that was coiled on the railings of the resident's bed. The nasal cannula was not bagged. She said she would use the nasal cannula once in a while. She said sometimes the nurse would put it on and off. She said she never saw a plastic bag for her nasal cannula. Interview with RN E on 08/21/2024 at 10:41 AM, RN E stated the nasal cannula should not be coiled in the railing of bed because the railing of the bed was not clean. She said this could cause cross contamination and probable infection. She said coiling the tubing of the nasal cannula could also compromise the passage of oxygen on the tubing. She said she did not notice that the nasal cannula was not bagged. She said she would check on Resident 106's nasal cannula. She said she would also change it and put it in a bag. In an interview with the ADON on 08/22/2024 at 7:15 AM, the ADON stated the breathing mask, and the nasal cannula should be bagged when the resident was not using it to prevent cross contamination and infection. She said the staff who took off the mask and the nasal cannula should put it in a bag. She said if the resident was the one taking it off, there should be a bag ready for them to put the mask in. She also said that the resident should be educated why the mask should be bagged. She said the expectation was for the staff to bag the breathing mask and the nasal cannula when not in use. She said she would coordinate with the DON to conduct an in-service pertaining to bagging the nasal cannula and the breathing mask when the residents were not using them. She said she would also make a round to check if the breathing masks and nasal cannula not in used were bagged. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 08/22/2024 at 7:35 AM, the DON stated the breathing mask, and the nasal cannula should be bagged when not in use to keep it clean. The DON said the proper way of storing the breathing mask and the nasal cannula was to place them inside the plastic bag when the resident was done with the breathing treatment or when the resident was not using the nasal cannula. He said if those breathing apparatus were not bagged, were exposed, or touching surfaces that were not clean, then oxygen administration could be compromised. The DON said the staff, including him, were responsible in monitoring that the breathing mask and the nasal cannula were bagged when not in use. He said the expectation was the breathing mask and the nasal cannula would be stored properly. The DON said she would continually remind the staff to be diligent in making sure the procedures for respiratory care were followed. He said he would re-educate the staff providing respiratory care. In an interview with the Administrator on 08/22/2024 at 7:53 AM, the Administrator stated everything used by the residents should be kept clean. She said the nasal cannula and the breathing mask should be stored properly to prevent respiratory infections. The Administrator said the expectation was for the staff to do their due diligence in order to provide the highest level of respiratory care. The Administrator said he would coordinate with the DON to address the issue. Review of facility policy Oxygen Administration, Safety, Mask Types - R/S, LTC, Therapy & Rehab Rehab/Skilled & Long -Term Care: Therapy & Rehab revised 07/08/2024 revealed Purpose: To keep oxygen equipment clean and maintained in good condition . Procedure . Oxygen cylinder . 14. When oxygen is not in use, store cannula, face mask . plastic bag.

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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** 47743 Based on observations, interviews, and record review, the facility failed to ensure that two (Resident #19 and Resident #48) of five residents were provided medications and/or biologicals and pharmaceutical services to meet their needs. The facility failed to ensure MA re-ordered medications in a timely manner for Resident #19 (Torsemide 20 mg) and Resident #48 (Solifenacin 5 mg). This failure could place the residents at risk of not receiving medications as ordered by the physician. Findings included: Resident # 19 Review of Resident #19's Face Sheet, dated 08/21/2024, reflected that resident was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included cystitis (inflammation of the bladder) and acute kidney failure. Review of Resident #19's Quarterly MDS Assessment, dated 06/13/2024, reflected resident was cognitively intact with a BIMS score of 13. The Quarterly MDS Assessment also indicated Resident #19 had an acute kidney failure. Review of Resident #19's Comprehensive Care Plan, dated 06/28/2024, reflected resident was on diuretic therapy the intervention was monitor resident's condition related to use of torsemide. Review of Resident #19's Physician Order for torsemide, dated 07/27/2023, reflected Torsemide Oral Tablet 20 MG (Torsemide) Give 0.5 tablet by mouth one time a day for edema. Resident #48 Review of Resident #48's Face Sheet, dated 08/21/2024, reflected that resident was a [AGE] year-old male admitted on [DATE]. Resident #48 was diagnosed with chronic kidney disease. Review of Resident #48's Quarterly MDS Assessment, dated 07/26/2024, reflected resident had a severe impairment in cognition with a BIMS score of 06. The Quarterly MDS Assessment indicated Resident #48 was diagnosed with renal (pertaining to the kidney) failure. Review of Resident #48's Care Plan on 08/21/2024 revealed no care plan for renal failure. Review of Resident #48's Physician's Order for Solifenacin 5 mg reflected Solifenacin Succinate Oral Tablet 5 MG (Solifenacin Succinate). Give 5 mg by mouth one time a day for antispasmodic. (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 observation and interview with MA on 08/21/2024 at 6:30 AM revealed MA was preparing Resident #19's medication. MA said Resident #19 did not have a blister pack for torsemide. She said she would ask the nurse to get it from the e-kit. MA looked for the nurse and told her that she needed torsemide for Resident #19. MA continued to prepare Resident #19's medication and then gave it to Resident #19. MA then prepared Resident #48's medication. MA placed the last pill of Resident #48's Solifenacin. MA finished preparing the medications and gave it to Resident #48. She said she did not have another blister pack for Resident #48's Solifenacin. She said she would check her cart because it might be with the other resident's medication. While still looking for the medication, the nurse came and gave her Resident #19's torsemide that was placed in a small plastic cup. MA checked the name and milligrams of the medication, opened it, placed it in a small cup, and gave it to Resident #19. MA said the medication should be re-ordered as soon as the medications reach the last line. MA explained they could re-order medications through the system, through faxing, or by calling the pharmacy. MA said she would go ahead and re-order the medications. MA said she was responsible for re-ordering medication that were running low. MA stated she did notice that the medications were running low but was not able to re-order them. MA said if medications were not re-ordered on a timely manner, the residents might run out of medications and their present medical situations might worsen. MA stated she would check her medication carts and re-order the medications that were running low. In an interview with LPN A on 08/21/2024 at 1:50 PM, LPN A confirmed that MA asked her to get Resident #19's torsemide from the e-kit. She said the e-kit would be for emergencies and new admissions and not for the medications that were not re-ordered in a timely manner. She said the medications should have been re-ordered when there were only four or five medications left in the blister card. She said things could happen and the pharmacy would not be able to deliver or refill the e-kit. She continued that if that happened, the residents would not have medications to take. She said adverse outcome could happen. She stated sometimes the computer would let you know that it was time to re-order certain medications so there would be no reason for not re-ordering on a timely manner. In an interview with the ADON on 08/22/2024 at 7:15 AM, the ADON stated the staff should re-order the medications once the medications hit the last dark line of the blister pack. The ADON said the nurses and the MA were responsible in re-ordering medications once they were running low. The ADON said if the MA was busy, the nurses could re-order the medications. The ADON said if the medications were not re-ordered on a timely manner, there could be a possibility the residents would not have their medications. The ADON added without the medications the medical issues of the residents could worsen. The ADON said the expectation was for the staff to be diligent in re-ordering the medications to prevent missed medications. The ADON said the facility had an e-kit but said the e-kit should not be used because the medications were not re-ordered in a timely manner. The ADON said she would do an in-service for ordering and re-ordering the medications. (continued on next page)

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	455627	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society-Denton Village	2500 Hinkle Dr Denton, TX 76201

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 08/22/2024 at 7:35 AM, the DON stated medications should be re-ordered in a timely manner. The DON said anything could happen that could affect the delivery of the medications from the pharmacy. The DON said the staff must make sure they re-order the medications in a timely manner so the residents would have their needed medications all the time. The DON said the staff should not wait for the last minute to re-order the medications. The DON said if the residents did not get their medications, their medical issues may worsen. The DON said they would in-service the staff about re-ordering medications. The DON said whichever staff observed the medication was running low should have re-ordered it. The DON continued the staff only needed to click the re-supply button on the residents' profile, fax it to the pharmacy, or call the pharmacy. The DON concluded the expectation was for the staff to be diligent in re-ordering medications and said they would audit all the carts, MA's and nurses', to check which medications needed re-ordering. In an interview with the Administrator on 08/22/2024 at 7:53 AM, the Administrator stated the medications should be re-ordered on time to prevent missed medications. The Administrator said it was not good for the residents if they missed their medications. The Administrator said she would coordinate with the DON about the issue to address it. Record review of facility policy, Local Pharmacy Medication ordering - R/S, LTC [NAME] Policy ENTERPRISE Rehab/Skilled & Long-Term Care: Therapy & Rehab revised 08/29/2023 revealed Procedure . 2. If a new medication or STAT medication . use emergency kit . medications are out . communicate to the pharmacy.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observation, interviews, and record reviews the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food storage, labeling, dating, and kitchen sanitation. 1. The facility failed to ensure the ice machine and the ice scoop holder in the kitchen area, was thoroughly cleaned. 2. The facility failed to ensure expired foods in the facility's refrigerator and freezer were discarded according to guidelines. 3. The facility failed to ensure foods in the refrigerator and freezer were properly sealed from air-borne contaminations. 4. The Dietary Manager failed to properly wear a beard covering while breakfast was being prepared and served, in the kitchen area. 5. The facility failed to place a cover on top of the tea dispenser. These failures could place residents at risk for cross contamination and other air-borne illnesses. Findings included: Observations on [DATE] from 09:03 AM to 09:14 AM in the facility's only kitchen reflected: The Dietary Manager was observed in the kitchen area during breakfast service, wearing his beard covering dangling from one ear, and not worn correctly covering his beard (approximately ,d+[DATE] inch in length). One large tea dispenser, located in the Assisted living dining area (also used by skilled nursing), was sitting uncovered and full of tea. The tea was exposed to air-borne contaminants. One bag of seedless red grapes in the refrigerator was open and not sealed. One large piece of cooked ham in a pan in the refrigerator, had use by date of [DATE]. One bag of [NAME] in the refrigerator was open and not sealed. One large ziplocked bag of bread rolls in the refrigerator, had use by date of [DATE]. The ice machine had dust and dirt particles along the outside of the unit. The inside of the unit had rust like substance near the door hinges of the lid, which trickled down to the ice. The metal ice scoop holder had rust along the bottom of the holder. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 10:37 AM, the Dietary Manager stated he had been at the facility for 3 years. He was advised of the findings in the kitchen and dining area, and he stated he had made a lot of the corrections that were initially observed, especially cleaning the ice machine. He stated all kitchen staff were responsible for throwing away expired foods, ensuring the foods were sealed, and making sure the lid was placed back on top of the tea dispenser; however, it was overall his responsibility to ensure that all of it was being completed. He stated the tea was prepared at 07:00 AM and the dietary aide who prepared the tea often forget to place the lid back on the top of the dispenser and he often had to remind them. He stated the tea was shared by both skilled nursing and assisted living. He stated he knew he should have worn his beard covering correctly but had gotten hot and it was hard for him to breath with it on. He stated the risk of these issues not being addressed could result in residents getting sick. In an interview on [DATE] at 10:50 AM, the Administrator stated she had not been made aware of some the concerns observed in the kitchen area. She was advised of the concerns that were observed in the kitchen and she stated that she expected the kitchen area to meet all guidelines and comply with state and federal regulations. She stated the risk of the concerns not being addressed could result in infection control. Record Review of the Facility's policy on Food Storage dated [DATE], revealed To ensure that food is stored properly. USE By/USE or Freeze By* (expiration date) - This is used on Time/temperature Control for Safety Foods (TCS). Safety phrasing will inform customers that these products should be consumed on or before the date listed on the package. The product should not be consumed after the date on the package due to the product's perishable nature and the product should be disposed of. This date label is for perishable products with potential safety implications or material degradation of critical performance, such as nutrition. Record Review of the Facility's policy on General Kitchen Sanitation, dated [DATE], reflected To provide guidelines that limit the chance of foodborne illness at locations that prepare and/or serve food. The location stores, prepares, distributes and serves food under sanitary conditions at all times. The location's food preparation, kitchen, serving areas and dry storage are cleaned and sanitized on a regular basis to limit contamination and prevent foodborne illness. Review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S ,d+[DATE].18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts ,d+[DATE] - ,d+[DATE].

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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** 47743 Based observations, interviews, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for four (Resident #7, Resident #29, Resident #39, and Resident #40) of fifteen residents observed for Infection Control. 1. The facility failed to ensure that CNA C performed hand hygiene while providing incontinent care to Resident #7 and Resident #39. 2. The facility failed to ensure that CNA B would not lower the catheter bag to the floor before transferring Resident #29. 3. The facility failed to ensure that LPN D perform hand hygiene during Resident #40's wound care. These failures could place the residents at risk of cross-contamination and development of infections. Findings included: 1. Review of Resident #7's Face Sheet, dated 08/21/2024, reflected that resident was a [AGE] year-old female admitted on [DATE]. Resident #7 was diagnosed with spastic hemiplegia (muscles on one side of the body being in constant state of contraction) affecting left side. Review of Resident #7's Comprehensive MDS Assessment reflected that the resident was not able to complete the interview to determine the BIMS score. The Comprehensive MDS Assessment indicated Resident #7 was frequently incontinent for bladder and bowel and dependent on staff for self-care needs. Review of Resident #7's Comprehensive Care Plan, dated 07/02/2024, reflected that the resident had bowel and bladder incontinence and one of the interventions was to provide skin care after each incontinent care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/21/24 at 10:52 AM revealed CNA C and CNA F washed their hands in resident's room prior to providing incontinence care. CNA C explained to Resident #7 what the staff was going to do. CNA F stood on the opposite side of the bed. CNA F assisted CNA C to pull Resident #7's pants down and unfasten tabs on the brief. CNA C cleaned one side of the labia, from the top down, repeated on the other side, and then the vaginal area from the top down. A clean wipe was used with each pass. CNA C removed the soiled gloves and put on clean gloves. CNA C did not sanitize her hands before putting on the new gloves. CNA F assisted CNA C to roll Resident #7 on her right side and CNA F held Resident #7 while CNA C cleaned Resident #7s bottom. CNA C cleaned each side of Resident #7's bottom, then the rectal area, wiping away from the vagina. A clean wipe was used with each pass. CNA C removed the soiled gloves and applied clean gloves. CNA C did not sanitize her hands before putting on the new gloves. CNA C placed a clean brief under Resident #7 and Resident #7 was turned to lie flat on the bed. CNA F and CNA C secured the tabs on the front of the brief and pulled up Resident #7's pants. CNA C and CNA F removed their gloves washed their hands in the sink before leaving Resident #7's room. Review of Resident #39's Face Sheet, dated 08/21/2024, reflected that resident was a [AGE] year-old female admitted on [DATE]. Resident #39 was diagnosed with need for assistance with personal care. Review of Resident #39's Comprehensive MDS Assessment, dated 05/17/2024, reflected that the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated Resident #39 was frequently incontinent for bladder and bowel. Review of Resident #39's Comprehensive Care Plan, dated 05/17/2024, reflected that the resident had an ADL selfcare performance deficit and one of the interventions was to assist to bathroom every 2 hours while awake. Observation on 08/21/2024 at 7:11 AM revealed CNA C was about to transfer Resident #39 to her wheelchair because the resident wanted to go to the bathroom. CNA C put on a pair of gloves. He did not do hand hygiene before putting on the gloves. CNA C then transferred Resident #39 from bed to wheelchair and ushered the resident to the bathroom. When inside the bathroom, CNA C transferred the resident from the wheelchair to the toilet. While the resident was sitting on the toilet, CNA C took off the resident's hospital gown and put a new blouse on. CNA C then took the waste can and pulled a plastic bag from beneath the waste can. He did not change his gloves nor did hand hygiene after touching the waste can. When the resident said she was done, CNA C ripped the soiled brief on both sides and threw it in the waste can. CNA C then requested the resident to stoop forward and cleaned the resident's bottom. After cleaning the resident's bottom, CNA C took the new brief from the sink and put it on the resident. After putting the new brief, CNA C put on the resident's pants. He did not change his gloves nor performed hand hygiene after cleaning the resident's bottom. CNA C then transferred the resident to her wheelchair. CNA C washed his hands after incontinent care. An interview with CNA C on 08/21/2024 at 11:00 AM, CNA C stated hands should be washed or sanitized before and after doing incontinent care. He said the hands should also be sanitized before putting on clean gloves. CNA C said hand hygiene was important to prevent the spread of germs and that staff had an in-service on incontinence care about a month ago. He said he should have done hand hygiene and changed his gloves after touching the waste can, after touching the soiled brief, after cleaning the resident's bottom, and before touching the new brief. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with LPN A 08/22/2024 at 08:32 AM, LPN A stated hand sanitizer and handwashing was part of the staff's uniform, especially those that were providing direct care. She said staff should use sanitizer before going inside a room and when they come out of the room. She said, during incontinent care, the staff should do hand hygiene before and after. She continued that the gloves should be changed after touching anything that was dirty or soiled and before touching the clean items. She said hands should also be sanitized in between changing of gloves. She said sanitizers were available in the halls and sanitizers in a container were provided by the facility. LPN A said if hand hygiene and changing of gloves were not done, cross contamination and infection could happen. An interview with the QAPI Nurse Manager on 08/22/24 at 08:57 AM revealed when she made her rounds and staff observation, she reminded them to sanitize before going inside the room of the residents and before touching the residents. She said staff should wash hands or sanitize before putting on new gloves. She said staff should wash their hands or use hand sanitizer before and after providing care. She said by doing so, cross contamination could be prevented. 2. Review of Resident #29's Face Sheet, dated 08/21/2024, reflected that resident was a [AGE] year-old female admitted on [DATE]. Resident #29 was diagnosed with neuromuscular dysfunction of the bladder (the muscles and nerves that control the bladder do not work properly due to illness). Review of Resident #29's Quarterly MDS Assessment, dated 07/14/2024, reflected Resident #29 had a moderate impairment in cognition with a BIMS score of 08. The Quarterly MDS Assessment indicated that the resident had an indwelling catheter. Review of Resident #29's Comprehensive Care Plan, dated 08/13/2024, reflected Resident #29 had an indwelling catheter related to neurogenic bladder (the normal bladder function is disrupted due to nerve damage) and one of the interventions was catheter care every shift. Review of Resident #29's Physician Order, dated 11/07/2023, reflected CATHETER: 16fr (French: unit used to indicate the size of the catheter) with 10 cc balloon to dependent drainage. Change catheter and drainage bag monthly on the 13th, and PRN if dislodged or plugged and unable to clear with irrigation. One time a day starting on the 13th and ending on the 13th every month related to NEUROMUSCULAR DYSFUNCTION OF BLADDER, UNSPECIFIED AND as needed for patency. Observation on 08/20/2024 at 9:47 AM revealed CNA B was about to transfer Resident #29 from wheelchair to the recliner. It was observed that the resident had catheter bag hanging at the bottom of the wheelchair. The catheter bag was inside a privacy bag. Before transferring the resident to the recliner, CNA B took the catheter bag from the privacy bag and put it on the floor. CNA B proceeded with the transfer. When the resident was already in the recliner, CNA B took the catheter bag from the floor and hung it on the side of the recliner. CNA B put the catheter bag inside the privacy bag. The privacy bag was touching the floor. In an interview with CNA B on 08/21/2024 at 2:07 PM, CNA B stated the catheter bag or the privacy bag should not be touching the floor because germs could get inside. She said she should have transferred the resident first and then hook the catheter bag at the side of the recliner or hook first the catheter bag on the recliner then transfer the resident. She said instead of transferring the catheter bag to the recliner, she should have just placed it at the side of the wheelchair to make sure the privacy bag was not touching the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with LPN A on 08/22/2024 at 8:32 AM, LPN A stated the Foley bag should not touch the floor because it would pick up germs and could cause infection such as urinary tract infection. She said even though the catheter bag was inside privacy bag, the privacy bag should not touch the floor. She said she would check to ensure Resident's 29's bag was not touching the floor. 3. Review of Resident #40's Face Sheet, dated 08/21/2024, reflected that resident was an [AGE] year-old female admitted on [DATE]. Resident #40 was diagnosed with venous thrombosis (blood clot forms in the veins) and venous embolism (clot travels through the vein). Review of Resident #40's Comprehensive MDS Assessment, dated 05/21/2024, reflected that the resident had a severe impairment in cognition with a BIMS score of 01. The Comprehensive MDS Assessment indicated Resident #40 was at risk of developing pressure ulcer (injury to skin due to prolonged pressure). Review of Resident #40's Comprehensive Care Plan, dated 06/30/2024, reflected that the resident had an actual impairment to skin integrity R/T immobility to right lateral ankle and one of the interventions was to monitor location, size, and treatment of skin injury. Review of Resident #40's Physician Order, dated 08/09/2024, reflected Apply skin prep to peri (around) wound, apply Alginate Calcium cover with island dressing daily, x 30-day one time a day for right lateral ankle. Observation and interview on 08/21/2024 at 9:57 AM revealed LPN D was about to do wound care. She sanitized her hands and put on a gown and a pair of gloves. LPN D prepared the things needed for wound care. She said the treatment for the resident's wound to the right ankle was cleaned with normal saline, apply calcium alginate, and then cover with a border dressing. Before doing the wound care, she took off her gloves, went to the other side of the bed, grabbed the waste basket with her bare hands, and placed it on her side. After touching the waste basket, LPN D proceeded to put on a pair of gloves. After placing the waste basket on her side, LPN D proceeded with wound care. She did not perform hand hygiene before putting on a new pair of gloves. She said she should have worn a pair of gloves before touching the waste basket because apparently the waste basket was dirty. She also said that she should have washed her hands after touching the waste basket. She said not changing the gloves and doing hand hygiene could cause infection. In an interview with the ADON on 08/22/2024 at 7:15 AM, the ADON stated hand hygiene was included in all the procedures of any care. She said the staff should be mindful that they were to take care of the residents and not give them additional medical issues. She said the staff should do hand hygiene before and after any care. She said gloves should be changed when transitioning from dirty to clean. She said for these instances, after touching the waste can, after touching the soiled brief, and after cleaning the residents' bottom. She said the hands should be washed or sanitized before putting on a new pair of gloves. She also said that the catheter bag should always be off the floor, even though the catheter bag was inside a privacy bag. She said all the issues discussed were causes of cross contamination and probable development of infections. She said the expectation was for the staff to do hand hygiene before and after every care, after changing their gloves, when transitioning from a dirty area to a clean area, sanitizing their hands when changing their gloves, and not to put the catheter bag on the floor. The ADON said she would coordinate with the DON on how to go forward. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON on 08/22/2024 at 7:35 AM, the DON stated all the staff should know that hand hygiene was the most effective way to prevent cross contamination and infection. He said, first, the gloves should be changed after touching any soiled items. He said for this case, the gloves should have been changed after removing the soiled brief, after cleaning the resident's bottom, and after touching the waste basket. He continued that secondly, every time staff change their gloves, they should do hand hygiene before putting on a new pair of gloves. He said there could be instances that while they were providing care, the staff did not notice the gloves were torn, and the germs could enter the gloves and soil the hands. He said that was why it was important to do hand hygiene when changing the gloves. He said this should have been done during incontinent care and wound care. He also said, the catheter bag should not be placed on the floor during transfer. He said the staff could have just left it on the side of the wheelchair to be sure it was off the floor. He said the expectation was for the staff to do hand hygiene before and after any care, to change their gloves from dirty to clean, to do hand hygiene when changing the gloves, and not to put the catheter bag on the floor. He said he would do an in-service about infection control immediately after the interview and he would monitor the staff. In an interview with the Administrator on 08/22/2024 at 7:53 AM, the Administrator stated not doing hand hygiene before and after any care, not changing the gloves after touching soiled items, not sanitizing the hands in between changing of gloves, and placing the catheter bag on the floor could contribute to cross contamination and probable infection. She said the expectation was for the staff to follow the policy and procedures pertaining to infection control. She said he would collaborate with the DON to in-service the staff about infection control. Review of facility policy, Hand Hygiene Policy Infection Prevention revised 03/29/2022 revealed Purpose . to establish hand hygiene as the single most important factor in preventing the spread of disease-causing organisms . Policy . All employee in patient care areas will adhere . hand hygiene . 1. Entering room . 2. Before clean task . 3. After bodily fluid/Glove removal . 4. Exiting room . When moving from contaminated body site to clean body site. Review of facility policy, Catheter: Care, Insertion, & Removal, Drainage bags, Irrigation, Specimen - AL, R/S & LTC Policy Assisted Living: Rehab/Skilled & Long-term Care revised 07/30/2024 revealed Policy . Catheter tubing/drainage bags . should never be allowed to touch the floor.