STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455690	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parks Health Center	111 Parks Village Dr Odessa, TX 79765

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 30057 Based on observation, interview, and record review the facility failed to provide pharmaceutical services, including procedures that ensure the accurate administering of all drugs to meet the needs of the residents and failed to ensure medications were disposed of when expired for 1 of 3 nurses carts inspected for medication storage. The nurse cart for used for halls one and three had four insulin pens and one insulin vial that had expired as indicated by the manufacturer's recommendations. This failure could place residents at risk of receiving medications that were expired and not produce the desired effect. The findings were: During an observation and interview on [DATE] at 11:32 AM the nurse medication cart for halls 1 and 3 was inspected with LVN E. On the top drawer of the cart were several insulin pens and one insulin vial. Five of the insulins observed had open dates of [DATE], [DATE], [DATE], [DATE] and [DATE] written on them. The insulin pens indicated Use within 28 days after initial dosage on their label. The insulin vial indicated Discard unused portion 28 days after first opening on the vial's box. LVN E said she had the nurse cart assigned to her today but had not noticed the insulins had expired. LVN E said she probably had not noticed that because she had not had to administer any of them recently. LVN E said it was each nurse's responsibility to date the insulin pens or vials whenever they opened them. LVN E said she did not recall being the one that had opened any of the insulin pens or vial. LVN E said if that insulin was administered to a resident, then it could possibly lead to the insulin not being as effective due to it being expired. LVN E said she would remove those insulins from the cart. During an interview on [DATE] at 03:18 PM the DON was said it was expected for the nurses to date the insulin pens and insulin vials as soon as they opened them. The DON said if an expired insulin was administered it could possibly lead to it not being as effective. The DON said she expected for the nurses to remove the expired insulins and have them replaced with a new one. The DON said she monitored the nurse carts and medication room as needed to check for expired or undated medications. The DON said that from now on they would have someone assigned to check the carts and medication rooms. The DON believed the failure occurred because the nurses failed to remove the insulins from the cart once they were expired. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 04:25 PM the Administrator said it was expected for the nurses to date the insulins as soon as they opened them. The Administrator said the failure probably occurred because the nurses had not removed the expired insulins. The Administrator said if the nurses used the expired insulin it could lead to ineffective results. Record review of the facility policy titled Medication labeling and storage and dated ,d+[DATE] indicated in part: . The nursing staff is responsible for maintaining medication storage . If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning of destroying these items. Medication labeling - The medication label includes at a minimum: Expiration date when applicable. Multi-dose vials that have been opened or accessed (e.g., needle puncture) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. Record review of the facility policy titled Insulin Administration and dated ,d+[DATE] indicated in part: Purpose. To provide guidelines for the safe administration of insulin to residents with diabetes. Check expiration date if drawing from an opened multi-dose vial. If opening a new vial, record expiration date and time on vial (follow manufacturer recommendations for expiration after opening).

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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 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** 30057 Based on observation, interview, and record review the facility failed to ensure that medications were secure and inaccessible to unauthorized staff and residents and ensure medications were dated when opened for 1 of 3 nurses' carts (cart for hall 100), 1 of 4 medication carts (cart used for hall 100) and for 1 of 2 medication rooms (Medication room on hall 100) and disposed of when expired and for 1 of 7 residents reviewed Residents (Residents #13) of three residents observed for drug storage in that: The nurses' and medication carts were left unlocked and unsupervised. The medication room had an opened and undated vial of Tuberculin (TB) medication in the refrigerator. The facility failed to ensure Resident #13's 3 vials of breathing treatments were secured. These failures could cause access, loss, diversion, or accidental ingestion of medications and place residents at risk of receiving medications that were expired and not produce the desired effect. The findings included: During an observation and interview on [DATE] at 07:00 AM the nurse cart and medication cart on hall 100 were observed to be unlocked and unattended. Inside the cart were several medications that included over the counter bottles and several blister packs of prescribed medications. The CNAs that were passing by said they did not know who had left the carts unlocked and continued to walk by. After about 15 minutes LVN A was seen walking towards the carts and locking them. During an interview on [DATE] at 07:30 AM LVN A said she was supposed to lock the medication carts whenever she stepped away. LVN A said she had counted the medications with the night nurse, so she was in charge of both the nursing and medication carts, and it was her that had left the carts unlocked and unsupervised. LVN A said she had gotten distracted when one of the CNAs' called for her and she left the carts unlocked to go check what the CNA needed. LVN A said the carts were supposed to be kept locked so that no unauthorized people could get into it. LVN A said if the carts were left unlocked and unsupervised that could lead to drug diversions or someone could take the medications that they shouldn't and get the insulin pens. During an interview on [DATE] at 03:27 PM the DON said it was expected for the nursing staff to lock their carts when they were away from them. The DON said if the carts were left unlocked and unattended a resident could get the medications from the cart and accidentally ingest them or unauthorized staff could take some of the medications which lead to a drug diversion. The DON said the failure probably occurred because the nurse stepped away and forgot to lock the carts. The DON said they monitored the carts to make sure they were locked by conducting rounds. (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 interview on [DATE] at 04:34 PM the Administrator said the nursing staff was supposed to lock the carts when they were not being used. The Administrator said if the carts were left unlocked then there were possibilities of drug diversions. The Administrator said the failure probably occurred because the nurse had walked away from the carts and had forgotten to lock them. Record review of the facility policy titled Medication labeling and storage and dated ,d+[DATE] indicated in part: Only authorized personnel have access to keys. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner. Compartments containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. Resident #13 Review of Resident #13's Admission Record, dated [DATE], revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including congestive heart failure (the heart does not pump blood as well as it should). Review of Resident #13's Initial MDS Assessment, dated [DATE], revealed: He scored a 15 of 15 on his mental status exam (indicating he was cognitively intact). Active Diagnosis included Heart Failure and hypertension. Respiratory treatments = Oxygen therapy. Review of Resident #13's Care Plan revealed the following care area: *Revised on [DATE] Resident #13 had Congestive Combined Heart failure. The goal was the resident will be free of peripheral edema (swelling to the legs and hands) through the review date. Identified goals included: Give cardiac medications as ordered. Monitor Vital Signs, notify Medical Doctor of significant abnormalities, *Initiated [DATE] The Resident had hypertension related to Congestive Heart Failure. The identified goal was the resident will remain free of complications related to hypertension through the review date. Identified interventions included: Give anti-hypertensive medications as ordered, monitor for side effects such as orthostatic hypotension and increased heart rate (Tachycardia) and effectiveness. Review of Resident #13's Order Summary Report, dated [DATE], revealed orders: Ipratropium-Albuterol Solution 0XXX,d+[DATE].5 (mg/mL)3 ML inhale every 4 hours every 4 hours as needed for shortness of breath or wheezing via nebulizer. Start date[DATE] Observation and interview on [DATE] at 10:00 a.m. revealed Resident #13 was out of his room. A Small Volume Nebulizer (breathing treatment) machine on Resident #13's bedside table. On top of it were three vials of a liquid in a tube with do not inject and for inhalation only on the tube. Surveyor asked the charge nurse to identify the tubes. LVN A looked at them and stated, those aren't supposed to be there. LVN A identified the tubes as breathing treatments and quickly added I didn't leave those there. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 3:11 p.m. the DON stated her expectation for storage of medication was they be secured at all times. The DON stated breathing treatments should be stored in the nurse's medication cart. The DON stated the Charge Nurses were responsible for ensuring medications were put up in the medication carts. The DON said the chances of three vials of breathing treatments being left on the bedside table were that someone could easily ingest it, or it could be given to someone else. The DON looked up the side effects and stated allergic reactions by drinking the breathing treatment included increased blood pressure, muscle cramps or difficulty breathing. The DON said she was not aware of any residents who had orders to be able to self-administer medications. The DON stated Resident #13 would probably be able to physically and mentally, but his breathing treatments were as needed. The DON looked at Resident #13's Treatment Administration Record and stated Resident #13 got a breathing treatment the morning of [DATE] at 1:28 a.m. The DON stated the facility had 4 wanderers, none who lived on Resident #13's hallway. The DON said each room had a manager who did rounds. The DON looked and stated the Administrator was assigned to Resident #13's room. In an interview on [DATE] at 3:38 p.m. the Administrator stated he was manager who did rounds. He stated he was in Resident #13's room on [DATE] and totally missed it, the breathing treatment left in the room. EXPIRED TB VIAL During an observation and interview on [DATE] at 04:58 PM the medication room was inspected with the ADON present. Inside the refrigerator was a TB vial that had been opened but no open date was found on the vial or the box container. The ADON said the nurses were supposed to date the TB vial whenever they opened it. The ADON said they did periodically inspections of the medication room for expired and undated medications. The ADON said there was not a specific person assigned to do the inspection of the medication room. The ADON said if a nurse used the undated TB vial solution, the test could result in a false negative or a false positive result as the solution could be expired but the nurse would be unable to know if the solution was still good or not due to no open date. The TB box container indicated Once entered, vial should be discarded after 30 days. During an interview on [DATE] at 03:18 PM the DON was said it was expected for the nurses to date TB vials as soon as they opened them. The DON said if a nurse performed a TB test on someone and the TB solution might had been expired it could lead to false readings. The DON said she expected for the nurses to remove the undated opened TB vials and have them replaced with a new one. The DON said she monitored the medication room as needed to check for expired or undated medications. The DON said that from now on they would have someone assigned to check the carts and medication rooms. The DON believed the failure occurred because the nurses failed to date the TB vial when they opened it. During an interview on [DATE] at 04:25 PM the Administrator said it was expected for the nurses to date the TB vials as soon as they opened them. The Administrator said the failure probably occurred because the nurse failed to date the TB vial when they opened it. The Administrator said if the nurses used the undated TB it could lead to ineffective results. (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 the facility policy titled Medication labeling and storage and dated ,d+[DATE] indicated in part: . The nursing staff is responsible for maintaining medication storage . If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning of destroying these items. Medication labeling - The medication label includes at a minimum: Expiration date when applicable. Multi-dose vials that have been opened or accessed (e.g., needle puncture) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. Record review of the facility policy titled Insulin Administration and dated ,d+[DATE] indicated in part: Purpose. To provide guidelines for the safe administration of insulin to residents with diabetes. Check expiration date if drawing from an opened multi-dose vial. If opening a new vial, record expiration date and time on vial (follow manufacturer recommendations for expiration after opening). Record review of the facility policy titled Storage of medications and dated ,d+[DATE] indicated in part: The facility stores all drugs and biologicals in a safe, secure and orderly manner. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications. Compartments containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Based on observation, interviews, and record reviews, the facility failed to ensure food was prepared in a form designed to meet individual needs for three of three residents (Residents #1, #37, #42) reviewed for food meeting residents' needs, in that: The DM did not puree eggs and ham to a puree consistency as required for Residents #1, #37, #42 who were ordered a pureed diet. This deficient practice could affect residents who received pureed meals from the kitchen by contributing to choking, poor intake, and/or weight loss. The findings included: Resident #1 Record review of Resident #1's admission record revealed Resident #1 was a [AGE] year-old female with an admitted [DATE]. Resident #1 had medical diagnosis of Dysphagia (Difficulty in swallowing). Record review of Resident #1's Annual Minimum Data Set (MDS) dated [DATE] revealed Resident #1's Brief Interview for Mental Status (BIMs) score of 03 indicating she was severely impaired cognitively. In Section GG - Functional Abilities and Goals Resident #1 was indicated as dependent in eating. Record review of Resident #1's order summary revealed an order for a regular diet Pureed texture, thin consistency, large protein portions with breakfast and lunch related to dysphagia, and Nurse to supervise that aids are assisting resident with feeding before meals for weight loss. Record review of Resident #1's Care plan dated 10/17/24 revealed The resident is on a pureed regular diet with goals and interventions of The resident will have adequate nutrition and fluid intake through the next review date. Dietary Manager to monitor and discuss for food preferences. Resident #37 Record review of Resident #37's admission record revealed Resident #37was a [AGE] year-old female with an admitted [DATE]. Resident #37 had medical diagnosis of Dysphagia (Difficulty in swallowing),. Record review of Resident #37's Annual Minimum Data Set (MDS) dated 9.18.2024 revealed Resident #37's Brief Interview for Mental Status (BIMs) score of 12 indicating she is cognitively intact. In Section GG - Functional Abilities and Goals Resident #37 is indicated as needing supervision or touching assistance in eating. Record review of Resident #37's order summary revealed an order for a Regular diet Pureed texture, Thin consistency. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #37's Care plan dated 10/17/24 revealed The resident has an ADL self-care performance deficit r/t Musculoskeletal impairment with goals and interventions of The resident will improve current level of function in ADLs through the review date. EATING: The resident requires set up and clean up from staff for meals. Resident #42 Record review of Resident #42's admission record revealed Resident #42 is a [AGE] year-old female with an admitted [DATE]. Resident #42 had medical diagnosis of Dysphagia (Difficulty in swallowing. Record review of Resident #42's Annual Minimum Data Set (MDS) dated 9.12.2024 revealed Resident #1's Brief Interview for Mental Status (BIMs) was not scored because the resident is rarely or never understood. In Section GG - Functional Abilities and Goals Resident #42 is indicated as needing supervision or touching assistance in eating. Record review of Resident #42's order summary revealed an order for a Regular diet Pureed texture, Thin consistency ordered on 09/26/24. Record review of Resident #42's Care plan dated 06/11/24 revealed The resident is on a regular diet with goals and interventions of The resident will have adequate nutrition and fluid intake through the next review date. Dietary Manager to monitor and discuss for food preferences. Observation on 10/15/24 at 8:26 a.m. the three resident's were eating meal trays that were severed labeled as puree. The puree trays revealed the ham had the consistency of a mechanical soft diet with gravy on top and served with regular consistency eggs. Further observation revealed the only difference from the puree trays and the regular and mechanical tray was the puree food was served with gravy. In an interview on 10/15/24 at 8:34 a.m. LVN A stated the mechanical soft tray, and the puree tray did look the same. LVN A stated no one on the puree diets had problems swallowing the mechanical soft breakfast meat. LVN A stated there were three residents with a puree diet. In an interview on 10/16/24 at 3:10 pm the Dietary Manager (DM) was shown a picture of the puree tray that was served and stated she did not think the food appeared to be puree texture and appeared closer to mechanical soft. The DM stated she was unsure why the tray was approved by nursing staff who was supposed to check trays. The DM stated she will ensure there was a training on proper meal textures and checking trays. In an interview on 10/16/24 at 3:24 pm [NAME] F stated she thought the blender was not working this morning, so she attempted to puree the meat by smashing the meat down to a smoother consistency and added milk to the eggs to make them softer in consistency. [NAME] F stated she had the lid to the blender misaligned and it was working properly. [NAME] F stated that she thought the puree was soft enough to be safe. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/16/24 at 3:40 pm DON was shown a picture puree breakfast tray and stated she did not think the food appeared to be mechanical soft in texture. DON stated the nursing staff and the staff who are assisting in feeding the residents should all know the difference in diet textures. DON stated she was unsure why the kitchen served this as puree. DON stated often times the resident family members will bring food to these residents that are on puree, and they will cut them into small pieces and the residents are able to eat them. DON stated this may be why the staff felt comfortable feeding that tray to the puree resident. DON stated the staff still should follow diet orders. DON stated she was not aware of any of the residents choking or aspirating due to food texture. DON stated she will ensure there was an in-service done on appropriate diet consistencies. Review of In-service with the topic being Hall trays and dining room dated 10/02/2024 reveals objective that states in part The nurse at all meals should verify tickets. The diet orders should match the meal is served. Review of the facilities policy titled Food and Nutritional Services dated October 2017 the policy statement is Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Under policy interpretation and implementation sections 7 states food and nutritional services staff will inspect food trays to ensure that the correct mail is provided to each resident, the food appears palatable and attractive, and is served at a safe and appetizing temperature. (Subsection a) If an incorrect meal is provided to a resident, or a meal does not appear palatable, nursing staff with report it to the Food Service Manager so that a new food tray can be issued.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48593 Based on observation, interview, and record review, the facility failed to provide daily meals at regular times for 2 of 2 meals (breakfast and lunch) observed for timely meal service. The facility failed to serve the breakfast and lunch meals on 10/15/24, at the specific times posted. This failure could place residents at risk of increased hunger, thirst, frustration, and decreased feelings of self-worth. Findings included: Observation on 10/15/24 at 8:26 a.m. revealed the last resident meal tray in the dining room was served. Observation of the kitchen on 10/15/24 from 11:42 am to 2:30 pm revealed the first lunch tray was plated at 12:10 pm and the last tray at was plated at 2:10 pm to be served to the resident. Record review of the Posted Mealtimes outside the dining room revealed: *Breakfast 7:30 AM Hall Carts 4 - 7 AM Hall Carts 3 - 7:10 AM Hall Carts 2 - 7:15 AM Hall Carts 1- 7:20 AM *Lunch 12:30 Hall Cart 4 - 12:00 PM Hall Cart 3 - 12:15 PM Hall Cart 2 - 12:10 PM Hall Cart 1 - 12:20 PM *Dinner 5:30 Hall Carts 4 5:00 PM (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hall Cart 3 5:10 PM Hall Cart 4 5:15 PM Hall Cart 1 5:20 PM During the Confidential Resident Council Meeting on 10/16/24 at 9:51 AM seven, alert lucid residents stated that meals were not always on time. The resident said they had to wait up to 2 hours for a meal because the kitchen also had to cook for the attached Assisted Living. The residents said it happened about once a month. The residents stated it was usually lunch that it happened at and you never knew what time lunch would come out. In an interview on 10/16/24 at 3:10 pm Dietary Manager (DM) stated [NAME] F does not typically cook breakfast, but the morning cook called off. DM stated [NAME] F was off all day because she was normally helping with lunch running the fryer. DM stated she does not think lunch has ever been this late especially since they had moved the mealtimes. DM stated they had moved the mealtimes to allow nursing staff to be available to check meal trays. DM stated they do have four staff for the kitchen hired and in training. DM stated this should allow more staff to cover if someone called off. DM stated she was unavailable to help [NAME] F as she was busy with other things. In an interview on 10/16/24 at 3:24 pm [NAME] F stated she does not normally cook for breakfast and lunch and was thrown off because of it. [NAME] F stated food was not typically late but has never been this late. [NAME] F stated she was the person who normally runs the [NAME] and helped with cooking the trays that are off the alternative menu. [NAME] F stated they were just short staffed because of the other cook called in and the process normally ran smoother than it did. Review of the facilities policy titled Food and Nutritional Services dated October 2017 the policy statement is Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Under policy interpretation and implementation section three states Meals and/or nutritional supplements will be provided within 45 minutes of either resident request of scheduled meal time, and in accordance with resident's medication requirements. Review of In-service with the topic being Hall trays and dining room dated 10/02/2024 reveals objective that states in part All meals should be passed in a timely manner.

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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. 48593 Based on observation and interview the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen. The facility failed to ensure food items in the facility's only kitchen were stored and sealed appropriately. These failures could place residents at risk for food-borne illness, and food contamination. Findings include: Observations of the facilities only kitchen on 10/15/24 at 07:00 AM revealed One clear plastic tote, with no lid, that had approximately six different bags of cereal outside of the dry food storage on a rack with clean kitchen utensils. The bags were partly rolled but not sealed. Interview with the Dietary Manager (DM) on 10/16/2024 at 3:10 pm revealed she was aware the staff were keeping the cereal on the clean utensils rack. DM stated she had removed a dry foods rack recently and the staff would put the bow of cereal on this utensil rack because it was closer. DM stated any food items should be labled and dated with the open date. DM stated she had told staff that all food needs to be in the dry food storage. The DM stated the staff would forget to take the box back into the dry food storage. DM stated this was a risk for cross contamination and will educate the staff on the importance of keeping all dry foods in the dry food storage. No policy was available.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 Based on interview, and record review, the facility failed to ensure in accordance with professional standards of practices, the medical records on each resident were accurately documented for 2 of 7 residents (Residents #13 and #23) reviewed for accurate medical records. The facility failed to document the pulse of the resident's when the physician's orders documented hold parameters for Residents #13 and #23. This failure placed facility residents at risk for incorrect medication administrations due to misinformation by incomplete and inaccurate medical record. The findings included: Resident #13 Review of Resident #13's Admission Record, dated 10/16/24, revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including congestive heart failure (the heart does not pump blood as well as it should). Review of Resident #13's Initial MDS Assessment, dated 7/19/24, revealed: He scored a 15 of 15 on his mental status exam (indicating he was cognitively intact). Active Diagnosis included Heart Failure and hypertension. Review of Resident #13's Care Plan revealed the following care areas: *Revised on 8/7/24 Resident #13 had Congestive Combined Heart failure. The goal was the resident will be free of peripheral edema (swelling to the legs and hands) through the review date. Identified goals included: Give cardiac medications as ordered. Monitor Vital Signs, notify Medical Doctor of significant abnormalities, *Initiated 8/7/24 The Resident had hypertension related to Congestive Heart Failure. The identified goal was the resident will remain free of complications related to hypertension through the review date. Identified interventions included: Give anti-hypertensive medications as ordered, monitor for side effects such as orthostatic hypotension and increased heart rate (Tachycardia) and effectiveness. Review of Resident #13's Order Summary Report, dated 10/16/24, revealed orders: Metoprolol Succinate 50 mg Give 1 tablet by mouth one time a day for hypertension, hold for blood pressure less than 110/60 and pulse less than 60. Start date 7/18/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #13's October 2024 Medication Administration Record(MAR) revealed a row for the blood pressure but no row for the pulse outcomes to be documented. In an interview on 10/16/24 at 4:35 p.m. the DON read Resident #13's order for the Metoprolol including the hold for pulse less than 60. The DON said she did not see a row for the pulse on the MAR. The DON stated she did not know if the staff were holding the medication if the pulse was below 60. The DON stated the ADON put the order in July 2024 and she would talk to her. The DON said she guessed nobody checked for these kinds of errors. The DON said she did not know why the pharmacist did not catch the error because she saw recommendation on blood pressure medications in his recommendations. The DON said she did not know why this was not caught. The DON said she was still new and still working on getting things where she wanted things to be and would do an audit the night of 10/16/24. The DON said the blood pressure cuff took the pulse so she would hope the staff were catching it. Resident #23 Review of Resident #23's Admission Record, dated 10/17/24, revealed he was an [AGE] year-old male admitted to the facility on [DATE] with diagnosis which included hypertension (high blood pressure), atrial fibrillation (irregular heartbeat, usually fast). Review of Resident #23's Quarterly MDS Assessment, dated 8/1/24, revealed: He scored a 14 of 15 on his mental status exam (indicating he was cognitively intact) Active Diagnoses included coronary heart disease (reduced blood flow to heart) and Hypertension. Review of Resident #23's Care Plan documented the following care areas: Revised on 10/12/22 Resident #23 had coronary heart disease related to Atherosclerosis (buildup of plaque in the veins). The Goal was Resident #23 would be free from signs and symptoms of complications of cardiac (heart) problems through the review date. Identified interventions included: Give all cardiac medications as ordered by the physician. Monitor and document side effects. Report adverse reactions to Medical Doctor as needed. Revised on 4/18/24 Resident #23 had history of Hypertension. The Goal was Resident #23 would remain free of complications related to hypertension through the review date. Identified interventions included: Give anti-hypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension (blood pressure drops when standing) and increased heart rate and effectiveness. Obtain blood pressure readings as per physician's orders. Take blood pressure readings under the same conditions each time. For example, resident is sitting, use right arm. Notify physician of any significant abnormalities. Revised on 10/12/22 Resident #23 is at risk for complications related to Atrial Fibrillation/Flutter. The Goal was Resident #23 would exhibit minimal to no complications related to Atrial Fibrillation/Flutter on an ongoing basis thru the next review date. Identified Goals included: Administer medications as per physician's orders, monitor for effectiveness, Check the resident's vital signs as per physician's orders. Review of Resident #23's Order Summary Report, dated 10/17/24, revealed orders: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Amlodipine Besylate Tablet 5mg Give 1 tablet by mouth one time a day for hypertension, hold if Systolic Blood Pressure < 100. Start Dated 4/4/2024. *Metoprolol Tartrate 25 mg Give 1 tablet by mouth two times a day for hypertension related to Atrial Fibrillation, Hypertension. Hold if Blood Pressure Less than 110/60 or pulse < 60 beats per minute. Start date 3/30/23. Review of Resident #23's October 2024 Medication Administration Record revealed the following:*There was no row for the blood pressure reading for the Amlodipine Besylate Tablet 5mg event though it was checked as given 10/1/24 through 10/16/24. *There was no row for the pulse in the Metoprolol Succinate ER 25mg 0800 even thought it was checked as given 10/1/24 through 10/8. *There was no row for the blood pressure nor the pulse on the 1700 (5 p.m.) row even thought it was checked as given 10/9/24, 10/10/24, 10/12/24 through 10/16/24. In an interview on 10/17/24 at 1:08 p.m. the DON stated the results of the parameter audit was over 20 residents who did not have a row for the pulse parameter on the Medication Administration Record. The DON reminded the surveyor, the blood pressure cuff took the pulse of the resident, so the pulse was taken it just was not documented. Review of a letter written by the resident's doctor / Medical Director, dated 10/17/24, revealed: With all hypertensive medications, blood pressure and pulse needs to be monitored and within parameters set by MD. Although both need to be checked, blood pressure is the more critical value. While the pulse was not documented, while the staff check blood pressure the pulse is also taken by the machine. Review of the facility's policy and procedure on Charting and Documentation, revised July 2017, revealed: All services provided to the resident, progress toward the service plan goals, or any changes in the resident's medical, physical, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation The following information is to be documented in the resident medical record: Objective observations; Medications administered; Treatments or services performed;

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 3 (Resident #2, #12 and#66) of 5 residents reviewed for infection control. CNA B failed to change her gloves when going from dirty to clean during peri-care and assisting Resident #12 with her ADLs. CNA B failed to wash her hands after she was finished assisting Resident #12 with personal care and before going on to assist someone else. CNA C failed to wash her hands prior to putting gloves on and assisting Resident #2 with personal care. CNA C failed to change her gloves when going from dirty to clean during peri-care and assisting Resident #2 with her ADLs. LVN D failed to use PPE during wound care performed for Resident #66 as the resident was on EBP precautions. This failure could place residents at risk for cross contamination and the spread of infection. Finding include: Resident #12 Record review of Resident #12's admission record dated 10/16/24 indicated she was admitted to the facility on [DATE] with a diagnosis overactive bladder. She was [AGE] years of age. Record review of Resident #12's care plan dated 06/11/2024 indicated in part: Problem: The resident is incontinent of bowel and bladder. Goal: The resident will remain free from skin breakdown due to incontinence and brief use through the review date An intervention was to Clean peri-area with each incontinence episode. Record review of Resident #12's MDS dated [DATE] indicated in part: BIMS = 6 indicating the resident had severe impairment. Urinary continence = Always incontinent. Bowel continence = Always incontinent . During an observation on 10/15/24 at 09:30 AM CNA B entered the room and after she had washed her hands she put on a pair of new gloves. CNA B undid the resident's brief and with some wet wipes wiped Resident #12's vaginal area. CNA B then turned the resident on her side and wiped the resident's rectal area. CNA B then went to the resident's closet and took some clothes and helped the resident get dressed while she still wore the same gloves that she had performed the peri-care on the resident. While CNA B still wore the same gloves, she assisted Resident #12 to the side of the bed and transferred her to her wheelchair with the sit to stand lift and then removed her gloves. After CNA B assisted Resident #12's she left to throw the trash and then went into another resident's room, and without first sanitizing or washing her hands first she put on a pair of gloves and proceeded to assist another resident. (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 10/15/24 at 11:40 AM CNA B said she had forgotten to change her gloves after she cleaned Resident #12's vaginal and rectal area. CNA B said she should have washed or sanitized her hands before putting on the new pair of gloves. CNA B said she just plain forgot to do those steps. CNA B said she had been trained on handwashing and glove changing. CNA B said if she did not wash her hands or change her gloves at the appropriate time then it could lead to the spread of germs to the residents and other facility staff. Resident #2 Record review of Resident #2's admission record dated 10/16/24 indicated she was admitted to the facility on [DATE] with diagnoses of lack of coordination, stroke, and muscle weakness. She was [AGE] years of age. Record review of Resident #2's care plan dated 04/06/2022 indicated in part: Problem: The resident has New Onset bladder/bowel incontinence r/t Impaired Mobility d/t Right Fibula Fracture. Goal: The resident will remain free from skin breakdown due to incontinence and brief use through the review date. Interventions were to check resident every 2 hours and PRN as required for incontinence. Wash, rinse, and dry perineum. Change clothing PRN after incontinence episodes. Record review of Resident #2's MDS dated [DATE] indicated in part: BIMS = 9 indicating the resident was moderately impaired. Urinary continence = Always incontinent. Bowel continence = Always incontinent . During an observation on 10/15/24 at 10:05 AM CNA C entered the resident's room and proceeded to put on a pair of gloves without first washing or sanitizing her hands. CNA C then undid Resident 2's brief and wiped the resident's vaginal area with some wet wipes. CNA C then turned the resident on her side and wiped the resident's rectal area with some wet wipes and then removed the soiled brief. While wearing the same gloves, CNA C took a clean brief and fastened it to the resident. CNA C then assisted Resident #2 to the side of the bed and then with a sit to stand lift transferred the resident to her wheelchair while still wearing the same gloves. During an interview on 10/15/24 at 11:07 AM CNA C said she forgot to wash or sanitize her hands prior to putting on gloves before she assisted Resident #2. CNA C said that she should have changed her gloves and washed her hands before she took the new brief and fastened it to the resident. CNA C said she had not washed her hands or changed her gloves because she had gotten nervous as she was being observed during the personal care of the resident. CNA C said if she did not wash her hands or changed her gloves when needed that could lead to the spread of infections which could affect the residents. During an interview on 10/17/24 at 03:24 PM the DON said it was expected for the CNAs to wash their hands before they performed personal care for any of the residents. The DON said the CNAs were supposed to change their gloves once before they went from dirty to clean. The DON said after the CNA wiped the resident's peri-area they were expected to have removed their gloves, sanitized, or washed their hands, and then put on the new gloves. The DON said if the CNAs did not do those procedures that could lead to cross contamination. The DON said she was the infection preventionist and that staff had been trained on infection control procedures. The DON said they monitored the staff by having conducting rounds and the CNAs received proficiency checks. The DON said the failure probably occurred because the staff got nervous and forgot the steps. (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 10/17/24 at 04:30 PM the Administrator said the CNAs should have washed their hands and changed their gloves at the appropriate times. The Administrator said if the CNAs did not perform these steps, then it could lead to the spread of infections. Resident #66 Record review of 's admission record dated 10/16/24 indicated she was admitted to the facility on [DATE] with diagnoses of stroke, muscle weakness and dementia. She was [AGE] years of age. Record review of Resident #66's care plan dated 09/17/2024 indicated in part: Problem: Risk for infection-EBP Enhanced Barrier Precaution at all times. The resident has a Stage 4 pressure ulcer Goal: Resident will show no s/s of infections through the next review. Resident's area will remain free of infection Interventions: Initiate the appropriate EBP isolation precautions. Staff is to wear PPE's for all contact with resident as long as the resident is on EBP precautions, for things such as dressing, changing linens, transfers, providing hygiene, wound care, device care (or use), bathing or showering, changing briefs or assisting with toileting. Staff to follow standard precautions, including proper hand washing techniques, dining, and doffing PPE's to minimize microorganism transmission. Resident needs weekly evaluation of wound healing. Record review of Resident #66's MDS dated [DATE] indicated in part: Cognitive Skills for Daily Decision Making indicated the resident was Severely impaired. Determination of Pressure Ulcer/Injury Risk = Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. Does this resident have one or more unhealed pressure ulcers/injuries? Yes. Record review of Resident #66's order summary report dated 10/02/24 indicated in part: C *coccyx stage 4 clean with wound wash or normal saline pat dry with gauze, sprinkle crushed 500 mg Flagyl tablet (antibiotic medication) on wound bed apply collagen powder and alginate cover with bordered gauze dressing. Change if soiled or bandage falls off. Everyday shift for wound management. Order date 10/15/24. *Right and left heel blister apply betadine cover with foam heel protector. Everyday shift for preventative Order date 10/02/24. *PPE required for high resident contact care activities. EBP are indicated for residents with any of the following: Infection or colonization with a CDC targeted MDRO when Contact Precautions do not otherwise apply; or Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. every shift. Order date 09/09/24. (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 10/16/24 at 11:42 AM LVN D prepared the supplies on her treatment cart, placed them on a tray and then entered the resident's room. On the resident's door there was a sign that indicated Stop - enhanced barrier precautions everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities. Wound care: any skin opening requiring a dressing. There was a new a plastic wrapped gown observed on the wall as we entered the resident's room. LVN D entered the room, washed her hands, and put on some gloves then proceeded to perform the wound care. LVN D proceeded and removed the dressing from the resident's coccyx area where the wound was located and performed the wound care to that area and to the resident's heels as well. LVN D only used on pair of gloves during the entire procedure and never put on a gown as indicated on the sign on the door. During an interview on 10/16/24 at 12:04 PM LVN D said that EBP meant that staff was required to wear PPE when they assisted a resident that had things such as catheters and IVs in them. LVN D said she should have used PPE when she performed the wound care for Resident #66 but that she had just forgotten to. LVN D said since she had not applied the EBP when she performed the wound care, she could have transferred whatever infections that resident had to others or introduced some form of infection unto the resident. LVN D said she was aware of the EBP procedure as she had already been trained on the method and when it had to be applied. During an interview on 10/17/24 at 03:22 PM the DON said she had expected for LVN D to have worn PPE when she performed the wound care for Resident #66 since the resident was on EBP precautions. The DON said LVN D had been trained on the use of EBP and when to use it. The DON said the way they monitored staff used EBP when required was by getting them trained and monitored the staff following the procedures. The DON said the failure probably occurred because the LVN got nervous and forgot to put on the gown before she performed the wound care. The DON said if the LVN did not wore PPE it could lead to the spread of infections. During an interview on 10/17/24 at 04:30 PM the Administrator said the LVN was expected to use PPE during the wound care as indicated by EBP procedures. The Administrator said he was not sure why the nurse had not worn the PPE, but they were supposed to, to prevent the spread of infections. Record review of the facility's policy titled Perineal Care and dated 02/2018 indicated in part: Purpose - The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. Wash and dry your hands thoroughly. Put on gloves Wash the rectal area thoroughly wiping from the base of the labia towards and extending over the buttocks. Remove gloves and discard into designated container. Wash and dry your hands thoroughly. (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 Handwashing/Hand Hygiene and dated 10/2023 indicated in part: Policy statement - This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. All personnel are trained and regularly in-serviced on the importance of hand hygiene in the preventing the transmission of healthcare-associated infections. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. Indications for hand hygiene - immediately before touching a resident; after contact with blood, body fluids or contaminated surfaces; after touching a resident; after touching the resident's environment; before moving from work on a soiled body site to a clean body site on the same resident and immediately after glove removal. Single use disposable gloves should be used when anticipating contact with blood or body fluids and when in contact with a resident or the equipment or environment of a resident who is on contact precautions. The use of gloves does not replace hand washing/hand hygiene. Record review of the facility's policy titled Enhanced Barrier Precautions and dated 08/2022 indicated in part: Policy statement. Enhanced Barrier Precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. Enhanced Barrier Precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: Wound care (any skin opening requiring a dressing). EBPs are indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization.