STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455799	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Austin Wellness & Rehabilitation	11406 Rustic Rock Drive Austin, TX 78750

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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 - Some	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** Based on observations, 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, recognizing each resident's individuality and failed to protect and promote the rights of the residents for 7 of 12 (Resident # 4, Resident #27, Resident #41, Resident # 48, Resident # 66, Resident # 76 and Resident #186) residents reviewed for resident rights. 1. The facility failed to promote Resident # 4, Resident #27, Resident #41, Resident # 48, Resident # 66, and Resident # 76's dignity while dining when staff did not complete serving meals to one table at a time before moving to the next table to serve meals without finishing serving meals at the prior table. 2. The facility failed to promote Resident # 186's dignity when staff delivered her lunch meal and left the meal on the tray without setting it up or removing delivery tray. These failures put residents at risk of experiencing humiliation, degradation, and a decreased quality of life. The findings included: 1. Record review of Resident # 4's admission face sheet dated 3/6/25 reflected a [AGE] year-old female admitted on [DATE] and readmitted on [DATE]. Resident # 4 had diagnosed of traumatic subdural hemorrhage (brain bleed), dysphagia (swallowing difficulty of food and liquids), protein calorie malnutrition, dementia (a group of thinking and social symptoms that interferes with daily functioning), hypertension (elevated blood pressure), repeated falls, cognitive communication deficit (communication difficulty arising from problems with cognition), and osteoporosis (weak and brittle bones). Record review of Resident # 4's MDS assessment dated [DATE] reflected a BIMS score was not recorded. Section GG (functional abilities) reflected extensive assistance was required for all ADLs. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident # 4's care plan indicated focus of ADL self-care performance deficit related to musculoskeletal impairment dated 12/29/22 with target date of 5/27/25. Interventions included the resident required eating assistance with setup and cueing to eat. Further review indicated the resident had the potential for nutritional problems related to the risk for malnutrition. Interventions included the resident had a hospice aide in facility 2 times a day, 5 times per week to assist patient with meals. The facility was to monitor, record, and report to the MD PRN signs and symptoms of malnutrition, emaciation (abnormally thin or weak), cachexia(great loss of weight and muscle), muscle wasting, significant weight loss: 3 pounds in 1 week, more than 5% in 1 month, more than 7.5% in 3 months, more than 10% in 6 months. Record review of Resident # 4's physician orders reflected she was ordered a regular, pureed texture diet, with a house shake supplement ordered with meals ordered 1/14/25, and med pass dietary supplement ordered 2 times daily ordered 4/24/23. 2. Record review of Resident # 27's admission face dated 3/6/24 reflected a [AGE] year-old male admitted on [DATE] and readmitted on [DATE]. Resident # 27 diagnosis of autistic disorder (neurodevelopmental disorder characterized by repetitive, restricted, and inflexible patterns of behavior), adult failure to thrive, convulsions, protein calorie malnutrition, anemia (lack of blood), muscle wasting and atrophy(muscle loss), bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), epilepsy (seizure disorder), developmental disorder of speech and language, hypothyroidism (underactive thyroid), and cognitive communication deficit (communication difficulty arising from problems with cognition). Record review of Resident # 27's MDS dated [DATE] reflected a BIMS score not recorded. Section GG functional abilities indicated extensive assistance required for all ADL's. Record review of Resident # 27's care plan dated 3/8/24 reflected an ADL self-care performance deficit related to activity intolerance. Interventions of eating the resident requires 1 staff participation to eat. Record review of Resident # 27's physician orders reflected regular diet pureed texture ordered 4/22/24. 3. Record review of Resident # 41's admission face sheet dated 3/6/25 reflected a [AGE] year-old male admitted on [DATE] and readmitted on [DATE]. Resident # 41 diagnosis of chronic obstructive pulmonary disease (a group of lung disease characterized by airflow obstruction that makes breathing difficult), type 2 diabetes (long term condition in which the body has trouble controlling blood sugar levels), dysphagia (difficulty swallowing liquids and solids), peripheral vascular disease (a condition in which the blood vessels outside the heart and brain become narrow or blocked and restrict blood flow), developmental disorder, hypertension (high blood pressure), and cognitive communication deficit (communication difficulty arising from problems with cognition). Record review of Resident # 41's MDS dated [DATE] reflected a BIMS score of 12 indicating moderate cognitive impairment. Section GG functional abilities indicated resident is independent for eating. Further review indicated resident is Moderate assistance for toileting, bathing, dressing, and transfers. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident # 41's care plan dated 1/30/23 revised on 6/1/24 reflected an ADL self-care performance deficit related impaired balance. Interventions of eating resident requires set up assistance to eat. Record review of Resident # 41's physician order reflected an order of regular diet mechanical soft texture with chopped meat ordered 8/11/22. 4. Record review of Resident # 48's admission face sheet dated 3/6/25 reflected a [AGE] year-old female admitted on [DATE] and readmitted on [DATE]. Resident # 48 diagnosis of dementia (a group of thinking and social symptoms that interferes with daily functioning), dysphagia (swallowing difficulty with liquids and solids), chronic kidney disease stage 3, hypertension (high blood pressure), protein calorie malnutrition, cerebral infarction (stroke), and need for assistance with personal care. Record review of Resident # 48's MDS dated [DATE] reflected a BIMS score of 3 indicating severe cognitive impairment. Section GG functional abilities indicated set up assistance for eating. Max assistance for dressing, toileting, bathing, and transfers. Record review of Resident # 48's care plan dated 3/28/23 and revised on 12/16/24 reflected an ADL self-care performance deficit. Interventions had no documentation concerning eating. Record review of Resident # 48's physician orders reflected regular diet pureed texture house shake included with meals ordered 2/3/25. Med pass supplement ordered 3/13/23. 5. Record review of Resident # 66's admission face sheet dated 3/6/25 reflected a [AGE] year-old male admitted on [DATE] and readmitted on [DATE]. Resident # 66 diagnosis of GERD (a chronic condition where stomach contents including acid flow back up into the esophagus causing irritation, pain, and potential damage), anemia (lack of blood), protein calorie malnutrition, dysphagia (difficulty swallowing liquids or solids), chronic obstructive pulmonary disease (a group of lung disease characterized by airflow obstruction that makes breathing difficult), aphasia(difficulty speaking), cerebral infarction (stroke), type 2 diabetes (long term condition in which the body has trouble controlling blood sugar levels), cognitive communication deficit (communication difficulty arising from problems with cognition), protein calorie malnutrition, and kidney failure. Record review of Resident # 66's MDS dated [DATE] reflected a BIMS score not recorded. Section GG functional abilities indicated supervision of set up assistance for eating. Extensive assistance for toileting, transfers, and bed mobility. Record review of Resident # 66's care plan dated 11/17/23 revised on 12/17/24 reflected an ADL self-care performance deficit related to amputation and stroke. Interventions not documented for resident eating assistance. Record review of Resident # 66's physician orders reflected regular diet mechanical soft texture mildly thick consistency ordered 4/24/24. Med pass supplement ordered 1/10/24. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Record review of Resident # 76's admission face sheet dated 3/6/25 reflected a [AGE] year-old male admitted on [DATE]. Resident # 76 diagnosis of dementia (a group of thinking and social symptoms that interferes with daily functioning), chronic pain, hyperlipidemia (elevated level of fat particles in the blood), hypertension (high blood pressure), congestive heart failure, and cognitive communication deficit (communication difficulty arising from problems with cognition). Record review of Resident # 76's MDS dated [DATE] reflected a BIMS score of 12 indicating moderate cognitive impairment. Section GG functional abilities indicated 1-person physical assist for eating and bed mobility, and limited assist for toileting and transfers. Record review of Resident # 76's care plan dated 9/28/24 reflected an ADL self-care performance deficit. Interventions of eating resident can hold cup, feed self, eats finger foods independently. Record review of Resident # 76's physician orders reflected regular diet mechanical soft texture thin consistency double portions ordered 9/27/24. 7. Record review of Resident # 186's admission face sheet dated 3/6/25 reflected a [AGE] year-old female admitted on [DATE]. Resident # 186 diagnosis of dementia (a group of thinking and social symptoms that interferes with daily functioning), depression, bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), type 2 diabetes (long term condition in which the body has trouble controlling blood sugar levels, hyperlipidemia (elevated levels of fat particles in the blood), hypertension (high blood pressure), cerebral infarction with hemiplegia and hemiparesis affecting right dominant side (stroke with paralysis affecting right dominant side). Record review of Resident # 186's MDS dated [DATE] reflected a BIMS score not recorded. No functional abilities were documented. Record review of Resident # 186's care plan dated 3/3/25 reflected an ADL self-care performance deficit. Interventions eating resident can hold cup, feed self, eat finger foods independently. Record review of Resident # 186's physician orders reflected a regular diet and texture ordered 2/14/25. Observation of lunch meal service on 3/3/25 revealed the following starting at 12:06 PM: All residents at sitting at 8 tables were not being served before the staff moved on to serving the next table. First table, Resident # 48 received meal tray at 12:06 PM, Resident # 76 received tray at 12:08 PM, and Resident # 186 received tray at 12:15 PM. When Resident # 186 received meal tray, food items were not removed from tray and set up for resident. Meal tray was set in front of resident while staff went to continue passing more meal trays. Second table, Resident # 66 received meal tray at 12:06 PM, Resident # 41 received meal tray at 12:12 PM. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Third table, Resident # 27 received meal tray at 12:04 PM, and at 12:17 PM, CNA F set down to feed Resident # 27. At 12:20 PM, CNA F left from feeding Resident # 27 after attempting 2 bites. At 12:25 PM, Treatment Nurse sat down to feed Resident # 27, at which time, 3 more bites were fed to Resident # 27 before the feeding of Resident # 27 stopped. No other attempts were made to feed Resident # 27 nor was an alternative or supplement offered the remainder of the meal service. Resident # 4 received meal tray at 12:10 PM and was told by staff I will come back to feed you. At 12:20, DON sat down to feed Resident # 4. DON attempted to feed Resident #4. 3 bites were offered, then DON got up and told another staff member that Resident # 4 refused to eat. No other attempts were made to feed Resident # 4 nor was an alternative or supplement offered the remainder of meal service. Interview on 3/3/25 at 1:00 PM with CNA F revealed CNA F stated Resident # 27 refused to eat and kept spitting food out so I quit attempting to feed him and told staff he refused. CNA F stated I then left the dining room because I had other duties to attend to. CNA F stated I can't make a resident eat. Interview with ADM on 03/05/25 07:05 PM revealed ADM stated it was his expectation that proper hand hygiene bee performed during meal tray and that all residents at a table are served before moving to the next table and beginning service there. ADM was unsure if serving part of the resident s at the table and not serving the rest before moving to another table was a dignity issue or not. ADM stated it was the responsibility of all staff in the dining room to ensure hand hygiene was happening and to ensure all residents at a table had been served before moving to the next table. Record review of dining services standards policy dated December 2020 reflected under heading purpose: Residents are provided a positive meal experience. Under heading policy: The facility staff will ensure the residents are provided with a positive meal experience. Under heading procedure: Meal Distribution: i. Meals are served table by table. ii. All items are removed from trays and are appropriately placed in front of the patient/resident, packages are opened, and lids are removed. iii. Substitutions are offered. . b. Assistance- adaptive devices are provided; foods, and beverages are set-up to promote independence; patients/residents are properly positioned, encouraged, cued, and assisted as needed. Patients/Residents are properly dressed, with dentures, glasses, and hearing aids in place as needed.

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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** Based on observations, interviews, and record reviews, the facility failed to ensure residents received services in the facility with reasonable accommodations of each resident's needs for 1 of 7 residents (Residents #38) reviewed for resident rights in that: The facility failed to ensure Residents #38 had a call device within reach from 3/3/25-3/6/25. This failure could affect residents who needed assistance with activities of daily living and could result in needs not being met. Findings included: Record review of Resident # 38's admission face sheet dated 3/4/25 reflected a [AGE] year-old male admitted on [DATE]. Resident # 38 had diagnoses of cerebral infarction (stroke), hypertension(elevated blood pressure), traumatic subdural hemorrhage (bleeding in the brain), quadriplegia(paralysis that affects all 4 limbs), dysphagia(swallowing disorder), cognitive communication disorder (difficulties in communicating), type 2 diabetes (a long term condition in which the body has trouble controlling blood sugar levels), protein calorie malnutrition, major depressive disorder (clinical depression), seizures (uncontrolled jerking loss of consciousness, blank stares, or other symptoms caused by abnormal electrical activity in the brain), paraplegia (paralysis that affects the lower half of the body), chronic pain due to trauma, aphasia (language disorder that affects communication ability), and need for assistance with personal care. Record review of Resident # 38's quarterly MDS assessment dated [DATE] reflected a BIMS score of 00 indicating severe cognitive impairment. Section GG (functional abilities) reflected substantial/maximal assistance for eating, upper body dressing, and oral hygiene. Dependent for toileting hygiene, bathing, lower body dressing, personal hygiene, putting on/taking off footwear, sit to lying, rolling from side to side and all transfers. Record review of Resident # 38's care plan dated 1/3/22 with target date of 2/2/25 reflected resident had paraplegia related to traumatic brain injury. Intervention included for staff to assist the resident with ADLs and locomotion as required. Resident had an ADL self-care performance deficit related to paraplegia and cognitive impairment. No interventions regarding call device documented. Observation/Interview with Resident # 38 on 03/03/25 at 02:22 PM revealed resident stated he is hot and needs some water. Resident states he can't use the call light as his arms don't work correctly. No water in reach for resident. Observation/Interview with Resident # 38 on 03/04/25 10:54 AM Resident observed in bed resting with splint on left hand. Resident states he is ok. Resident call light clipped on the sheet in front of resident in reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation/Interview with Resident # 38 on 03/05/25 02:29 PM Resident stated he was thirsty and needs a drink. Observation revealed resident's drink was on the overbed table pushed up against the wall. Resident states when he needs assistance, he had to holler out for the nurse since he can't use the call light. Resident states he has never been offered a call push pad device that he can operate by pressing with his head. Interview with LVN C on 3/5/25 at 2:40 PM revealed Resident # 38 was not able use the call lights due to his condition. LVN C states she believes different call devices have been attempted for use with resident, but he is unable to use those as well as he has no feeling in his feet or legs, and he shakes his head continuously so nothing can be put by his head to push. LVN C states the resident just hollers out when he needs something. LVN C states the facility offers a hydration program taking cookies and drinks around to the residents. LVN C states she offers the resident a drink every 2 hours. Interview on 3/6/25 at 12:35 PM with DON and ADON revealed Resident # 38 would yell when assistance was needed. DON stated and ADON agreed Resident # 38 has a call device that is a pad call light, a gray pad. It gets misplaced sometimes. The staff place it on the side of resident. Record review of Resident Rights-Quality of Life policy dated August 2020 reflected under heading purpose: To ensure that all residents are treated with the level of dignity they are entitled to while residing at the Facility. Under heading policy: Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, and individuality. Under heading procedure: XI. Facility Staff provides care and services that ensure that resident's abilities in activities of daily living, including hygiene, mobility, elimination, dining, communication, speech, language and other methods of communication do not diminish while in the care of the Facility, except when unavoidable as evidenced by clinical condition.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure all residents had the right to request, refuse, and/or discontinue treatment to participate in or refuse to participate in experimental research, and to formulate an advance directive for 5 of 30 residents (Residents #22, #81, #235, and #40) reviewed for advanced directives. 1. The facility failed to ensure Resident # 22's admission face sheet included an accurate advanced directive, as it listed both Full Code and a DNR (Do Not Resuscitate) on file. Resident # 22's care plan included documentation of the DNR on file. 2. The facility failed to ensure Resident # 81 had documentation on file in their records concerning their wishes on their advance directive status. 3. The facility failed to ensure Resident # 235 had documentation of their advanced directive on the admission face sheet, although the care plan included documentation wishing to be a Full Code. No Full Code documentation in Resident # 235 records. 4. The facility failed to ensure Resident #40 had an advanced directive documented on his summary report These failures could place residents at risk for not having their end of life wishes honored and incomplete records. Findings include: 1. Record review of Resident #22 admission face sheet, dated [DATE], reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #22 had diagnoses which included metabolic encephalopathy (brain dysfunction caused by imbalances in the body's chemical processes and systemic illness), acute kidney failure, multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves), repeated falls, cognitive communication deficit (difficulties in communicating), depression, anxiety disorder, muscle wasting and atrophy, asthma and polyneuropathy. Resident #22 listed as a Full Code under Advance Directives. Record review of Resident #22 Comprehensive MDS, dated [DATE], reflected a BIMS score of 12, which indicated moderate cognitive impairment. Section GG functional abilities reflected mobility device of wheelchair, independent for eating, partial to moderate assist for (toileting, dressing, putting on/taking off footwear, and transfers), maximum assist for bathing. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #22 care plan, dated [DATE], reflected the resident had a DNR on file. Resident # 22 has an ADL self-care performance deficit related to hemiplegia, limited mobility, and musculoskeletal impairment with interventions of limited assistance with toileting, dressing, and transfers. Extensive assistance required with bathing and extensive assistive device usage with transfers. Record review of Resident #22 OOHR-DNR order, dated [DATE], reflected document was complete with signatures of Resident # 22, physician and witnesses. 2. Record review of Resident #81's face sheet, dated [DATE], reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #81 had diagnoses which included Cerebral Infarction (an ischemic stroke, is the pathologic process that results in an area of necrotic tissue in the brain), Hyperlipidemia (imbalance of cholesterol in your blood), Hypertensive Heart Disease (conditions caused by high blood pressure), Angina Pectoris (chest pain caused by reduced blood flow to the heart), Myalgia (pain in a muscle or group of muscles), Acute Kidney Failure (illness, infection, or injury damages the kidneys), and Cognitive Communication Deficit (brain injuries that affects a person's ability to communicate effectively). Record review of Resident #81's Minimum Data Set Assessment, dated on [DATE], reflected a BIMS score of 11, which indicated moderate cognitive impairment. Minimum Data Set Assessment didn't reflect any Full Code or Do Not Resuscitate information. Record review of Resident #81's Care Plan, last revised on [DATE], reflected a focus on Resident #81 having Cognitive Communication Deficit, Hypertensive Heart Disease, Angina Pectoris, and Acute Kidney Failure in which there was no form of documentation found reflecting appropriate advanced directive actions for Full Code and or Do Not Resuscitate protocols. Record review on of care plan, admission, and Point Click Care documentation for Resident #81 didn't reflect having any documentation for advance directives. 3. Record review of Resident #235 admission face sheet, dated [DATE], reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident # 235 had diagnoses which included rhabdomyolysis (a breakdown of muscle tissue that releases a damaging protein into the blood), tremors (a rhythmic involuntary movement of a body part), atrial fibrillation (irregular heart rate), autistic disorder (a lifelong developmental disability that affects how a person communicates, interacts with others, learns, and behaves), obsessive compulsive disorder (excessive thoughts that lead to repetitive behaviors), cerebral palsy (a congenital disorder of movement, muscle tone, or posture), anxiety disorder (persistent and excessive worry that interferes with daily activities) and lack of normal physiological development in childhood. No advance directive documentation was recorded on the admission face sheet. Record review of Resident #235 admission MDS, dated [DATE], did not reflect a BIMS score or functional abilities recorded. The Comprehensive MDS was in progress at time of the review. Record review of Resident #235 care plan, dated [DATE], reflected Resident #235 was a Full Code status. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Record review of Resident #40's face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included cerebral infarction (stroke), need for assistance with personal care, dementia, acquired absence of right leg below knee, acquired absence of left leg above knee, aphasia (a disorder that affects how you communicate), diabetes mellitus type 2 (a form of diabetes mellitus that is characterized by high blood sugar, insulin resistance, and relative lack of insulin), hypertension (high blood pressure), and gastrostomy status (an enteral feeding tube). Resident #40's face sheet did not indicate any Advanced Directives. Record review of Resident #40 's Quarterly MDS assessment, dated [DATE], did not reflect a BIMS score. Resident #40 required substantial/maximal assistance for all activities of daily living. Record review of Resident #40's Care Plan, dated [DATE], reflected Resident #40 had a Full Code CPR order in place with initial date of [DATE]. The goal was the request for CPR to be initiated would be followed. Interventions included review of Resident #40's medical record to ensure proper documents were signed, consult with nursing staff on changes in health, and counsel with the resident and family regarding any emotional concern arising from the decision. Record review of Resident #40's Order Summary Report, dated [DATE], reflected he had an order for Full code may use AED, dated [DATE]. In an interview on [DATE] at 3:24 PM with the Social Worker stated the facility is in charge of putting in Full Code and Do Not Resuscitate information into the care plan, but there wasn't a designated person in charge of handling Full Code and Do Not Resuscitate information. The Social Worker stated this information was usually already filled out before they saw the resident. The Do Not Resuscitate or Full Code request was not on the medical face sheet of each client, which meant it's more than likely not within the system electronically and believed this was something entered by the nursing department or a doctor. The Social Worker provided Determination of Life Prolonging Procedures form for Resident #81 in which it didn't specify the information needed as well as it was, dated on [DATE], after the Department discovered it wasn't inputted or documented into the facility's Point Click Care sections for residents for Do Not Resuscitate in which it was not located in the residents face sheet, care plan, or anywhere else. Its important to know what actions need to take place to follow the advance directives. In an interview on [DATE] at 2:35 PM with the ADON, she stated the facility had a hard copy of Do Not Resuscitate and it's supposed to be in the resident's care plans. Everything would be in the care plans. She stated the social worker, and the nurses were to check for a Do Not Resuscitate if it's been scanned in. If they didn't have it, they're full code until they could physically see or scan it in. She met the family and asked them what they wanted as well. There's no system in place and couldn't provide a reason for as to why nor who is in charge. At the nurse's station they had a book that had their Do Not Resuscitate status book and were at both nurse's station. She stated it's important to have Do Not Resuscitate or Full Code in resident's charts. It's important because potentially there could be an issue if it's not in the chart for Do Not Resuscitate. Record review of the facility's Advance Directives policy, revised 08/2020, reflected: Advance Directives Operational Manual - Social Services (continued on next page)

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	455799	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Austin Wellness & Rehabilitation	11406 Rustic Rock Drive Austin, TX 78750

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I. At the time of admission, admission Staff or designee will inquire about the existence of an Advance Directive. The admission Staff will inform and provide written information to all adult residents concerning the right to accept or refuse medical treatment. II. The Facility will honor resident's Advance Directives and will provide the resident with;- information related to Advance Directives upon admission III. If no Advance Directive exists, the Facility provides the resident with an opportunity to complete the Advance Directive Form upon resident request.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care within 48 hours of admission that included the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 2 of 10 residents (Resident #185, and Resident #135) reviewed for baseline care plans. The facility failed to ensure baseline care plans were completed for Resident #185 and Resident #135. The facility failed to develop a baseline care plan that reflected the need for Resident #185's wandering and agitation for Resident #185 The facility failed to develop a baseline care plan that reflected the individuals needs of Resident #135. This failure puts all residents at risk of not getting their needs met. Findings included: 1. review of Resident #185's face sheet reflected a [AGE] year-old male admitted to the facility on [DATE] with pertinent diagnoses of depression, unspecified dementia (degenerative brain disease causing memory loss), and insomnia (the inability to sleep.) Review of resident #185's MDS dated [DATE] states he has a BIMS score of 4, indicating severe cognitive impairment and needs supervised assistance for ADL's. Review of Resident #185's Comprehensive Care Plan dated 03/03/25 reflected he had an ADL self-care deficit and facility staff should encourage resident to participate to the fullest extent possible with each interaction. Review of Resident #185's progress notes dated 02/15/25 revealed 3:00 pm Resident #185 was very agitated and having behaviors. No PRN medications were available. Contacted NP on call, new medication orders received. 5:00 pm medication was not effective patient persists with behavior and being physically aggressive with staff when trying to redirect. Review of Resident #185's progress notes dated 02/16/25 at 5:58 pm revealed Resident is awake and alert however resident wanders down the hallway and into other resident's rooms. Resident takes redirection well at first, but then becomes somewhat agitated after multiple redirections. Resident is ambulatory and requires assist with ADL care, and bed mobility. Resident makes needs known. Observation and interview of Resident #185 at 10:35 am revealed he was muttering to himself. He stated that he was trying to find his room because he had to use the bathroom but wasn't sure where it was. He stated he was frustrated because he hadn't been able to find it all day. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LVN B on 03/05/25 at 2:25 pm, she stated that Resident #185 had a hard time adjusting to the facility. He was aggressive but had settled down recently. LVN B stated that she was aware of Resident #185's behaviors by observing him but had not read his care plan. She stated she might find other things to help ideas to calm him down on the care plan. When asked about the progress note from 02/16/25, she stated that information should probably be on the care plan. She stated it's the DON or ADON's job to place items on the care plan. 2. Resident #135 is a [AGE] year-old female admitted to the facility on [DATE] with pertinent diagnoses of muscle wasting and weakness, unspecified dementia (a degenerative brain disorder causing memory loss) and a cognitive communication deficit (inability to understand or communicate effectively.) Review of Resident #135's admission MDS was completed 02/14/25 and did not have relevant information to functional capacities or BIMS scores. Review of Resident #135's Comprehensive Care Plan had a single focus of Elopement Risk and a goal that the resident will remain safe within the facility. Observation of Resident #135 on 03/04/25 at 2:15 pm revealed 4 mm long fingernails that were chipped and had sharp edges. Resident's toenails were visibly protruding through her socks. Interview with Resident #135 on 03/04/25 at 2:15 she stated that she doesn't know why her fingernails were so long. Normally, her daughter would come take her to the nail salon, but it's been a couple months. She was unsure when she would get her nails done next, but always liked to have her nails done. Interview with CNA on 03/05/25 at 3:30 pm revealed that Resident #135 should have her fingernails done on shower day. She said she is forgetful and sometimes she is unsure where she is at. She stated she did not know why they were not completed, and it is the CNA's job to groom the resident's fingernails. She stated that she should look in the care plan to find a resident's preference for assisting her in her ADL's. Interview on 3/5/25 at 7:05 PM with Admin revealed he expected the staff to follow regulations and all pertinent information be included on care plans. Admin stated it was the responsibility of the IDT team to complete care plans. Admin stated if care plans are not completed and accurate that it could negatively affect the quality of life of the residents. Interview with the ADON on 03/06/25 at 12:30 pm, she stated everything should be in the care plans. She was supposed to do a part of the baseline care plans and they tried to get the comprehensive care plans done once a week. Even if they were to admit on a Saturday, she would go up and do the care plans. She stated the nurses were able to place items on a new care plan and could be done by anyone in the facility. She was unsure why multiple residents' baseline care plans had not been completed. She stated that if they did not have a care plan, they may not address all their issues. No Care Plan policy was provided from the admin before exit.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, designed to meet the interests and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for 2 of 8 residents (Residents #31, and #38) reviewed for activities. The facility failed to provide Residents #31 and #38 with individual or group activities. This failure could place residents at risk for a decline in their physical, mental, and psychosocial well-being. Findings include: 1. Record review of Resident #31's face sheet, dated 10/01/2024, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #31 had diagnoses which included Spastic Diplegic Cerebral Palsy (both of the legs have abnormal stiffness), Dysphagia (difficulty swallowing), Aneurysm (abnormal bulge or ballooning in the wall of a blood vessel), Cognitive Communication Deficit (brain injuries that affects a person's ability to communicate effectively), Lack of Coordination (difficulties in smoothly and accurately executing voluntary movements. It can impact daily activities and is often associated with neurological disorders or injuries), Muscle Weakness (lack of muscle strength, doesn't produce a normal muscle contraction or movement), Reduced Mobility (refers to limitations in a person's ability to move or use a vehicle due to physical, sensory, or mental disabilities, age, or other reasons), and Seborrheic Dermatitis (skin condition that causes scaly patches, inflamed skin and stubborn dandruff). Record review of Resident #31's annual Minimum Data Set Assessment, dated 02/14/2025, reflected a BIMS score of 00, which indicated low cognitive impairment. Section GG functional abilities reflected Eating: Not applicable, not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. Oral hygiene, Toileting hygiene, Shower/bathe self, Upper body dressing, Lower body dressing, putting on/taking off footwear, and Personal hygiene: Dependent, helper did all of the effort. Resident did none of the effort to complete the activity. Or the assistance of 2 or more helpers was required for the resident to complete the activity. Record review of Resident #31's Care Plan, last revised on 10/01/2025, reflected a focus on Resident #31 having impaired cognitive function/dementia or impaired thought processes neurological symptoms. Engage the resident in simple, structured activities that avoid overly demanding tasks. Resident was dependent on staff. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #31's care plan, dated 03/05/2025 at 2:40 PM, reflected the resident has impaired cognitive function/dementia or impaired thought processes neurological symptoms. Engage the resident in simple, structured activities that avoid overly demanding tasks. The resident prefers (specify the activities). Keep the resident's, routine consistent and try to provide consistent caregivers as much as possible in order to decrease confusion. The resident was dependent on staff for activities, cognitive stimulation, social interaction cognitive deficits, disease process (pneumonitis, Inflammation of lung tissue), immobility, and physical limitations. All staff to converse with resident while providing care. Introduce resident to residents with similar background, interests and encourage/facilitate interaction. Invite resident to scheduled activities. Record review was conducted reflected 1:1 activity binder log being provided for Resident #31 for the month of February 2025 didn't show any documentation for the resident being provided 1:1 activities, nor was there any updated list for the month of March 2025 and any past months reflecting 1:1 activities being documented for the resident. Record review of Point Click Care (where the facility documents resident information) didn't show any documentation for 1:1 activities being completed or noted for Resident #31. In an observation and attempted interview with Resident #31 on 03/03/2025 at 12:10 PM, The State Surveyor attempted to speak with Resident #31 and ask questions, but the resident was unable to speak. The resident is confirmed nonverbal. Resident #31 was not participating in 1:1 activities or group activities. In an observation on 03/04/2025 at 2:30 PM, revealed Resident #31 was not participating in 1:1 activities or group activities. In an observation on 03/05/2025 at 3:00 PM, revealed Resident #31 was not participating in 1:1 activities or group activities. In an observation on 03/06/2025 at 12:00 PM, revealed Resident #31 was not participating in 1:1 activities or group activities. In an interview with the Activity Director on 03/05/2025 at 3:15 PM, the Activity Director stated Resident #31 was bed bound in which they played music to him, read to him, spoke to him, he watched television in his room, passed out snacks if his diet allowed when they had events that involved food, or if there was an event in which other's got a gift then she took him a gift as well. She tried to help make him part of activities although he was bed bound. She didn't provide any documentation or reasons for why activities weren't documented for residents as she is new to the facility and implementing logs. In an interview with CNA G on 03/05/2025 at 4:25 PM, CNA G stated Resident #31 was bed bound. He was usually in the bed watching television and she hadn't seen him participate in activities or activities being provided in his room outside of television. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident # 38's admission face sheet, dated 3/4/25, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #38 had diagnoses which included cerebral infarction (stroke), hypertension (elevated blood pressure), traumatic subdural hemorrhage (bleeding in the brain), quadriplegia (paralysis that affects all 4 limbs), dysphagia (swallowing disorder), cognitive communication disorder (difficulties in communicating), type 2 diabetes (a long term condition in which the body has trouble controlling blood sugar levels), protein calorie malnutrition, major depressive disorder (clinical depression), seizures (uncontrolled jerking loss of consciousness, blank stares, or other symptoms caused by abnormal electrical activity in the brain), paraplegia (paralysis that affects the lower half of the body), chronic pain due to trauma, aphasia (language disorder that affects communication ability), and need for assistance with personal care. Record review of Resident #38's quarterly MDS, dated [DATE], reflected a BIMS score of 00, which indicated severe cognitive impairment. Section GG functional abilities reflected substantial/maximal assistance for eating, upper body dressing, and oral hygiene. Dependent for toileting hygiene, bathing, lower body dressing, personal hygiene, putting on/taking off footwear, sit to lying, rolling from side to side and all transfers. Record review of Resident # 38's care plan, with a creation date of 10/9/23 and a target date of 2/2/25, reflected a focus which included the following: Resident #38 needs in room socialization and sensory stimulation with intervention of the activity director will provide the resident with one-on-one visits with sensory stimulation at least 3 times per week. Focus Resident # 38 is dependent on staff for activities, cognitive stimulation, social interaction related to immobility and physical limitations. Interventions of all staff to converse with resident while providing care. Introduce resident to other residents with similar background interests and encourage/facilitate interaction. Establish and record resident prior level of activity involvement and interest by talking with resident, caregivers, and family on admission and as necessary. Record review of one-on-one activity log for February 2025 reflected no recorded documentation of one-on-one activities provided to Resident #38. March one on one activity log was not provided for review. Prior months one on one activity log were not provided for review. Observation and interview on 3/3/25 at 2:22 PM revealed. Resident #38 stated he did not do activities since he couldn't get out of bed or move his arms or legs. Observation and interview on 03/04/25 at 10:54 AM revealed Resident #38 was in bed resting with splint on left hand. Interview on 3/5/25 at 2:40 PM with LVN C revealed Resident #38 could not use the call lights due to his condition. LVN C stated she believed different call devices were attempted for use with the resident, but he was unable to use those as well as he had no feeling in his feet or legs, and he shook his head continuously so nothing could be put by his head to push. LVN C stated the resident just hollered out when he needed something. LVN C stated the facility offered a hydration program and took cookies and drinks around to the residents. LVN C stated she offered the resident a drink every 2 hours. Interview on 3/6/25 at 12:35 PM with the DON and the ADON revealed Resident #38 went to activities a few times a week. He'd be pushed into whatever activity was going on. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/6/25 at 1:44 PM with the Admin revealed the activities staff should be doing 1-1 and the family or resident would tell the activity staff what they liked. The Admin stated I'm not sure what the regulations were for activities. The Admin stated the Activities Director was responsible for documenting 1-1 activities with residents. The Admin stated if residents who needed 1-1 activities were not getting these then this could negatively affect residents by depression and feelings of isolation. In an interview on 03/06/2025 at 2:35 PM, the ADON and the DON stated they were trained in activities that residents had the right to say no. The residents did group activities, crafts, bingo, beads, outings, and going to Target and Walmart. For 1:1 activities, they provided reading, and talking to the residents. Residents who were bed bound, the Activity Director went in to do hand massages, paint nails, exercise resident's hands which was with physical therapy, but they didn't know much for 1:1 activities was being done for bed bound residents. They couldn't think of all residents who required 1:1 activities. Resident #31 loved the television, and they couldn't think of any activities that were done for him. They hadn't seen anything completed for him in prior months with activities or 1:1 activities. The Activity Director was in charge of monitoring activities and making sure all resident's had access to participating in activities. Activities were offered to all residents, and if the resident didn't want to, the Activity Director would offer coloring books and any other activities from her office. They are unaware of activity coverage on the weekends or what activities take place, but there were volunteers who came in to sing to residents and sound baths provided by hospice in which were done weekly. There were church services offered. All residents were offered to participate in activities, but they may need more encouraging at times. They were unaware of documentation occurring for residents' participation nor 1:1 activities prior to now. They didn't know of any other 1:1 activities being offered to Resident #31 or the activities they just advised us. They stated it could affect a resident's quality of life by making the resident feel alone and not have social stimulation. It could have long-term effects on residents if they didn't receive activities. In an interview on 03/06/2025 at 1:43 PM with Administrator, he stated residents who were bed bound, what was done for them was 1:1 activities and speaking with families to see what the resident liked. The Activity Director was responsible for making sure 1:1 residents received activities. A negative outcome if a resident didn't receive 1:1 activity services, could be that it could make a resident feel isolated. Record review of the facility's Activities Program Policy, revised date 6/2020, reflected: Activities Program Operational Manual - Activities Purpose To encourage residents to participate in activities to make life more meaningful, to stimulate and support physical and mental capabilities to the fullest extent, and to enable the resident to maintain the highest attainable social, physical and emotional functioning. Policy I. The Facility provides an Activity Program designed to meet the needs, interests, and preferences of residents. The activities are varied and work to address the needs and interests identified through the assessment process.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview and record review the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrated that this was not possible or resident preferences indicated otherwise for one of eight residents (Resident #37) reviewed for nutrition status maintenance. 1. The facility failed to obtain consistent weights for Resident #37. These failures could place residents at risk of further weight loss, malnutrition, and a decreased quality of life. Record review of the dietitian's orders, dated 01/22/25, stated resident was on house supplement with meals. Recommended 1:1 assistance with meals. Record review of physician's notes from a visit, dated 12/31/24, reflected Resident #37 was on a mechanical soft with chopped meat texture, thin liquids. Refer to RD for evaluation and treat for weight loss recommendations. Observation and interview with Resident #37 on 03/03/25 at 2:45 PM revealed the resident in bed watching TV. She stated she had not been to eat recently and was not hungry. Interview with RA on 03/06/25 at 10:25 AM revealed she was in charge of weighing residents for 8 years. She was trained by the assistant director of nursing when she first stated. Her routine was to weigh all the residents between the 1st and the 5th of each month. If they were 5 pounds or less, she would weigh them again at a later time. If the weight loss continued, she would inform the ADON. If the weight loss triggered for significant the ADON would tell her to add that resident to a weekly weights list she kept in her office. She stated if she saw someone losing weight, she would ask them to be weighed immediately to make sure they were stable. She knew Resident # 37 should have been weighed weekly, but thought she was better after her last doctor's visit. She was unsure why she stopped even though she wasn't told to. She stated the resident could have been sicker or they wouldn't catch anything that could be seriously wrong with the residents. Interview with the ADON on 03/06/25 at 12:30 PM revealed she was aware Resident #37 had been losing weight. She knew the resident was on house shakes, but was not aware they were not making it to her trays. She knew the resident needed assistance getting to the dining room, but did not keep track of her attendance. She stated when weight loss was triggered, she would contact the doctor, the family, and the dietitian if the doctor ordered it. She stated the dietitian recommendations should have been followed. She stated people who were new admits should be weighed weekly as well as people who were triggered for weight loss. She stated it was her job to communicate to the Restorative Aid who would weigh the residents and report back to her any further weight loss. She was unsure how Resident #37 stopped being weighed weekly. She stated if someone isn't weighed weekly, they could develop further illness and it could contribute to an early death. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Admin on 03/06/25 he expected the Restorative Aid to weigh any resident weekly who had triggered for weight loss. He stated any weight loss should be reported to the DON, ADON, and the doctor. He expected all staff to follow the dietitian and doctor's recommendation. He was unsure why the recommendations were not followed and why she was not weighed weekly. He stated the policy for people with unintended weight loss was to weigh them weekly. Attempted interview with Resident #37's RP on 03/03/25 was unsuccessful. Record review of the facility's policy titled, Assessment and Management of Resident Weights, dated 06/2020, reflected F. Residents with significant weight change will be weight at least weekly and discussed at the Resident at Risk or other clinical meeting to determine possible causes of weight gain or loss including goals of care. Record review of Evidence Based Practice Guidelines of Unintended Weight Loss in Older Adults from the Academy of Nutrition and Dietetics, dated 01/04/16, reflected, Strong Imperative for Monitoring and Evaluating Anthropometric Measurements. The Registered Dietitian should monitor and evaluate weekly body weights of older adults with unintended weight loss until the body weight has been stabilized to determine effectiveness of medical nutrition therapy. Studies support an associate between unintended weight loss and increased mortality.

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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** Based on observations, interviews and record reviews the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 2 of 5 residents (Resident #186 and Resident #32) reviewed for pharmaceutical services. The facility failed to document controlled medications from the medication cart on the narcotic count sheets for Resident #186 and Resident #32. This failure could place residents at risk to medication errors . Findings include: 1. Record review of Resident #186's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included hemiplegia and hemiparesis following cerebral infarction (weakness and loss of strength in upper and lower limbs), diabetes mellitus type 2, hypertension (high blood pressure), dementia (memory problem), hyperlipidemia (elevated lipids circulating in the blood), bipolar disorder (a state of abnormally elevated arousal, affect, and energy level), and depression (low mood/chemical imbalance). Record review of Resident #186's Care Plan, dated 02/14/25, reflected she had impaired cognitive function/dementia or impaired thought processes. The goal was for Resident #186 to be able to communicate basic needs on a daily basis by staff identifying who they were and using her preferred name at each interaction, face the resident when speaking and make eye contact, reduce any distractions, and speak in consistent, simple, directive sentences. Record review of Resident #186's Progress Note entry, dated 03/05/25, reflected the resident received a dose of Tramadol 50mg 1 tablet PO Q6H PRN for pain on 03/05/25 at 08:17 AM and at 11:41 AM. Record review of a Medication Administration Record for Resident #186 reflected: Tramadol 50mg 1 tablet PO Q6H PRN for pain level 5-10 given to the resident on 03/01/25 at 03:21 AM and on 03/05/25 at 08:17 AM. Record review of the Individual Control Drug Record, dated 02/15/25, reflected the last medication count of the blister pack was on 03/04/25 and had 19 pills left. LVN A had written 18 in the amount remaining space but did not sign the medication out with a date, time, or number of pill(s) given. Observation of the medication cart on 03/05/25 at 4:30 PM revealed Resident #32's blister pack of Tramadol, dated 02/15/25, had 18 pills left in the blister pack. Observation of the medication cart on 03/05/25 at 4:30 PM revealed LVN A counted the Tramadol in the blister pack and viewed the Individual Control Drug Record, dated 02/15/25, with no signature, date, time, and number of pill(s) given in front of the state surveyor . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #32's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Addisonian crisis (acute adrenal insufficiency), cognitive communication deficit (difficulty communicating), acute respiratory failure with hypoxia (inflammatory lung injury), major depressive disorder (A period of at least two weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities, and had a majority of specified symptoms, such as problems with sleep, eating, energy, concentration, or self-worth), anxiety , borderline personality disorder (a mental health condition characterized by pervasive instability in moods, behavior, self-image, and functioning), hypothyroidism (underactive thyroid gland), epilepsy (seizures), cerebral palsy (group of movement disorders that appear in early childhood), unsteadiness on feet, and adult failure to thrive (happens when an older adult has a loss of appetite, eats and drinks less than usual, loses weight, and is less active than normal). Record review of Resident #32 's Quarterly MDS assessment, dated 11/23/24, reflected a BIMS score of 15, which indicated cognition was little to not affected. The MDS reflected Resident #32 required partial/moderate assistance for her activities of daily living, and she used a wheelchair . Record review of Resident #32's Care Plan, dated 01/23/24, reflected Resident #32 used anti-anxiety medications, Alprazolam, related to adjustment issues and anxiety disorder. The goal was Resident #32 would show decreased episodes of signs and symptoms of anxiety. Interventions included giving anti-anxiety medication as ordered by the physician, and monitoring/documenting side effects and effectiveness. Record review of Resident #32's Physician Orders reflected an order date of 02/20/25 for Alprazolam 1mg 1 tablet PO Q12H PRN for anxiety, muscle spasms for 14 days. The Physician Orders had an end date of 03/06/25. Record review of the Individual Control Drug Record, dated 03/03/25, reflected the last medication count of the blister pack was on 03/04/25 and had 10 pills left in the blister pack. LVN A wrote 9 in the amount remaining space but did not sign the medication out with a date, time, or number of pill(s) given. Record review of Resident #32's Progress Note entry, dated 03/05/25, reflected the resident received a dose of Alprazolam 1mg 1 tablet PO Q12H PRN for anxiety, muscle spasms for 14 days on 03/05/25 at 08:50 AM, and documented as effective on 03/05/25 at 10:50 AM. Record review of Resident #32's Medication Administration Record dated 03/05/25 reflected: Alprazolam 1mg 1 tablet PO Q12H PRN for anxiety, muscle spasms for 14 days given to the resident on 03/05/25 at 08:50 AM. Observation of the medication cart on 03/05/25 at 4:30 PM revealed a blister pack of Alprazolam, dated 03/03/25, which had 9 pills left in the blister pack. Interview on 03/05/25 at 04:34 PM revealed LVN A administered the prescribed PRN medication to Resident #186 and Resident #32 during her shift, but she did not complete the narcotic count sheets . LVN A stated she should have completed the narcotic count and signed the medication out before administering to the resident, and the risks to the residents were not getting their medication in a timely manner, increased pain, and increased anxiety. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/06/25 at 12:45 PM with the ADON, who stated she did a weekly narcotic count and needed to be more diligent to look at the narcotic book and count. She stated narcotic count was conducted at the beginning and at the end of each shift by two nurses. The ADON stated it was now her responsibility to conduct monitoring of controlled substance count/medication administration and ordering resident medications. The ADON stated a potential negative outcome to the residents when controlled substances were not signed out/medications were not given on time included an overdose could occur, or the resident could have a lot of side effects from not getting a medication on time. The ADON stated she conducted training recently on narcotic counts because she found an incomplete narcotic count sheet. Record review of the facility's policy titled Inventory Control of Controlled Substances, dated 12/01/17, reflected: Facility should maintain separate individual controlled substance records on all Schedule II medications and any medication with a potential for abuse or diversion in the form of a declining inventory using the Controlled Substances Declining Inventory Record. These records should include: 1.1.1 Resident name, 1.1.2 Prescription number, 1.1.3 Medication name, strength, dosage form, dosage, 1.1.4 Total quantity received by facility, 1.1.5 Date and time of administration, 1.1.6 Quantity remaining, and 1.1.7 Name and signature of person administering the medication.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received and the facility provided food and drink that was palatable, attractive and at a safe and appetizing temperature for residents who consumed foods orally for 3 (Resident # 10, Resident # 35, and Resident # 42) of 10 residents reviewed for food preferences and for 1(Lunch on 3/4/25) of 5 meals observed in that: 1. The test tray of the lunch meal on 03/04/25 was unappetizing in appearance (no seasoning observed, and the pureed food items had all run together) a. the rolled silverware for the regular texture tray napkin was wet and soggy b. the pureed carrots for the pureed texture tray tasted only of very tart orange juice c. the pureed dinner roll tasted very doughy and underdone. 2. The facility failed to obtain food preferences for 3 residents (Resident # 10, Resident # 35, and Resident # 42). This failure could place residents at risk of decreased food intake, hunger, unwanted weight loss, and diminished quality of life. The findings include: 1. Record review of Resident # 10's admission face sheet dated 3/6/25 reflected an [AGE] year-old female admitted on [DATE]. Resident # 10 diagnoses of dementia (a group of thinking and social symptoms that interferes with daily functioning), dysphagia (swallowing difficulty with liquids and solids), bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), major depressive disorder (clinical depression), hypertension (elevated blood pressure), hyperlipidemia (increased fat particles in the blood), chronic kidney disease, adult failure to thrive, chronic pain syndrome, and GERD (a chronic condition where stomach contents including acid flow back up into the esophagus causing irritation, pain, and potential damage). Record review of Resident # 10's MDS assessment dated [DATE] reflected a BIMS score of 14 indicating intact cognition. Section GG (functional) abilities indicated supervision required for bed mobility, eating, and toileting, and extensive assistance required for transfers. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident # 10's care plan dated 6/2/24 reflected an ADL self-care performance deficit. Interventions included the resident needed assistance with bathing, dressing, and bed mobility. No interventions for eating were documented. Record review of Resident # 10's physician orders reflected a diet order of Regular diet with mechanical soft texture ordered 2/24/25. 2. Record review of Resident # 35's admission face sheet dated 3/6/25 reflected a [AGE] year-old female admitted on [DATE]. Resident # 35 diagnosis of bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), anxiety disorder, GERD (a chronic condition where stomach contents including acid flow back up into the esophagus causing irritation, pain, and potential damage), depression, hepatitis A, and anemia (lack of blood). Record review of Resident # 35's MDS dated [DATE] reflected a BIMS score of 13 indicating intact cognition. Section GG functional abilities for Resident # 35 indicated supervision or set up assistance for bed mobility, eating and toileting. Record review of Resident # 35's care plan dated 7/5/24 reflected an ADL self-care performance deficit with eating interventions of the resident being able to hold cup, feed self, and eat finger foods independently. Record review of Resident # 35's physician orders reflected a diet order of regular diet regular texture ordered 6/20/24. 3. Record review of Resident # 42's admission face sheet dated 3/6/24 reflected a [AGE] year-old male admitted on [DATE]. Resident # 42 diagnosis of heart failure, cirrhosis of liver (chronic liver damage), protein calorie malnutrition, chronic kidney disease stage 3, type 2 diabetes (long term condition in which the body has trouble controlling blood sugar levels), hypertension (high blood pressure), amputation of right leg below knee, amputation of left great toe, atrial fibrillation (rapid heart rate), and cognitive communication deficit (communication difficulty arising from problems with cognition). Record review of Resident # 42's MDS dated [DATE] reflected a BIMS score of 3 indicating severe cognition impairment. Section GG functional abilities indicated Resident # 42 required limited assistance for bed mobility, transfers, and toileting, and Supervision setup required for eating. Record review of Resident # 42's care plan dated 6/2/24 reflected an ADL self-care performance deficit related to amputation. Interventions include for task of eating the resident can feed self, eat finger foods independently. Record review of Resident # 42's physician orders reflected a diet order of regular diet regular texture, thin consistency, low protein and NAS related to protein calorie malnutrition. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Observation of lunch test tray on 3/4/25 at 12:50 PM revealed regular texture meal consisted of cheesy Dijon chicken, broccoli rice casserole, glazed carrots, dinner roll, and chocolate cake. No condiments or beverage were provided on meal tray. Silverware rolled in paper napkin was wet and soggy. Meal was appropriate temperature and had good flavor. Cake for dessert was very dry and needed moisture or frosting for palatability. Pureed texture meal tray consisted of pureed chicken, pureed broccoli rice casserole, pureed carrots, pureed dinner roll, and chocolate pudding. No condiments or beverage were provided on meal tray. Meal was appropriate temperature, and the appearance of meal tray was unappetizing as all food items had run together with carrot liquid all over plate. Chicken and broccoli rice casserole had good flavor. Dinner roll flavor was very doughy and undercooked. Carrot flavor had a very overpowering of tart orange juice and did not taste of carrots at all. Interview with Resident # 42 on 3/3/25 at 1:40 PM Resident #42 stated the food is terrible and wants more choices. Resident overbed table has a bowl of boiled eggs, a piece of pork loin, and several packages of cookies. Resident states he has not talked to any kitchen staff to request his preferences. Resident states the kitchen staff do not speak English and can't read English either. Resident states he wants 2 or 3 over medium eggs, sausage, juice, milk, and coffee for breakfast. Interview with Resident # 10 on 3/3/25 at 2:03 PM revealed she is upset because she did not receive her dinner meal last night. Resident stated she was brought a disposable box with a sandwich and chip crumbs no beverage. Resident states the food is terrible. Resident states she must ask for coffee daily. Resident states no one has ever came to speak with her about her meal preferences. Interview with Resident # 35 on 3/3/25 at 2:35 PM revealed the food was ok, just not her preference, and breakfast are always cold. Resident states she lived there for a year and never had anybody come ask her preferences. Interview on 3/5/25 at 5:40 PM with the DM revealed he had recently taken the position of the DM in November of the prior year. DM stated he had received training for the position from the prior DM and a sister facility DM. DM stated that he would visit with each resident upon admit obtaining meal preferences and that meal preferences are put on the resident meal ticket slip and then written on the dry erase board hanging in the kitchen in front of where trays are assembled. DM stated that if meal preferences or allergies are not documented on the resident meal ticket slip, it could negatively affect residents by potentially receiving food items they do not like or are allergic too which could result in sickness or weight loss. DM stated it was his responsibility to obtain food preferences and to document information on the meal ticket slip. DM stated he was unaware that the test trays had been served without condiments. DM stated he was also unaware about the napkin becoming wet and soggy and could not explain how that occurred. DM stated the cooks taste the food prior to service but he was unsure if the cook had tasted the pureed food prior to service. Interview on 3/5/25 at 7:05 PM with the ADM revealed he expected a food profile completed for all residents and any preferences or allergies to be added to their meal ticket slip. ADM stated if meal preferences or allergies were not added to meal ticket slips, it could negatively affect the residents by potential weight loss and diminished quality of life. ADM stated the DM was responsible for obtaining resident meal preferences and adding them to the meal ticket slips. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of dining service standards policy dated December 2020 reflected under heading purpose: Residents are provided a positive meal experience. Under heading policy: The facility staff will ensure the residents are provided with a positive meal experience. Under heading procedure: Meal Selection- meal selection is done either by patient/resident preference driven selections, pre-selected menus or point of service selection.

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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. Based on observation, interview, and record review, the facility failed to store, prepare, distribute food in accordance with professional standards for food service safety for one of one kitchen reviewed for kitchen sanitation. 1. The facility failed to ensure DS J properly used proper hand hygiene during food preparation. 2. The facility failed to ensure DS L and DS H wore a beard guard while in kitchen. 3. The facility failed to ensure all foods were labeled and dated in the kitchen. 4. The facility failed to ensure all items were covered and stored properly in the kitchen. 5. The facility failed to ensure sanitation practices (cleaning the ice machine, cleaning the inside of the microwave, ensuring staff utilize hair restraints while in kitchen, ensuring trash receptacles in kitchen had lids secured covering contents, proper storage of ice scoop, ensuring cleaning schedules and logs were being utilized, ensuring hand sinks had paper towels, These failures could place residents who ate food from the kitchen at risk for foodborne illness. Findings included: Observation on 3/3/25 at 9:20 AM of 3 kitchen handwash sinks without paper towels. Further observation revealed each hand wash sink had soap dispenser and hand sanitizer dispenser located above sink. Observation on 3/3/25 at 9:21 AM of kitchen pantry revealed: Package of cornbread mix that had been opened unlabeled and undated. Storage container for ground coffee with Styrofoam bowl scoop inside on top of coffee grounds Container of fruit ring dry cereal with lid not secured. Observation on 3/3/25 at 9:22 AM of DS I, DS J, DS K revealed the staff were wearing rings, watches, and bracelets while preparing food and washing dishes. Observation on 3/3/25 at 9:23 AM of kitchen ice machine revealed: Inside upper lid, wall, and inside hook of ice machine with what appeared to be a brown and black substance. Observed dust, dirt, and debris outside of ice machine on top of machine. Observation revealed ice scoop storage receptacle and ice scoop stored on top of the ice machine. Record review on 3/3/25 at 9:24 AM of the walk-in freezer, walk-in refrigerator, dish machine, 3 compartment sink, and reach in refrigerator temperature logs revealed no March documentation recorded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 3/3/25 at 9:25 AM of kitchen walk in freezer revealed: Ice buildup on floor, walls, and roof of freezer. Further observation revealed opened bag of what appeared to be diced chicken unlabeled, undated, and open. Bag of what appeared to be breaded chicken strips unlabeled, undated, and open. Box of garlic bread sticks open, unlabeled, and undated. Observation on 3/3/25 at 9:28 AM of half gallon pitcher of food thickener near food processor unlabeled, undated, and open. Observation on 3/3/25 at 9:29 AM of kitchen stand mixer with dried food debris on mixer and mixer guard. Observation on 3/3/25 at 9:31 AM of kitchen walk in refrigerator revealed: Container of salad dressing opened with date of 11/2 unsure if that was the receipt date, open date, or discard date. Open container of sliced cheese. Container of creamy coleslaw with date of 2/25/25; unsure if that was the receipt date, open date, or discard date. Container of ranch dressing with date of 2/21 unsure if this was receipt date, open date, or discard date. Observation on 3/3/25 at 9:39 AM of storage containers for food thickener and rice had scoops inside of container laying on food product. Observation on 3/3/25 at 9:40 AM of kitchen microwave revealed the inside roof of microwave had dried food debris. Observation on 3/3/25 at 9:41 AM of reach in refrigerator revealed: Half gallon pitcher of orange juice unlabeled and undated Storage container of what appeared to be tea unlabeled and undated. Package of sliced turkey lunch meat opened, unlabeled, and undated. Container of pimento cheese with date of 1/16/25; unsure if this was receipt date, open date, or discard date. Several trays of prepared drinks unlabeled and undated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 3/3/25 at 9:45 AM of storage container where food scoops and utensils were stored with food debris and crumbs in bottom of container. Observation on 3/3/25 at 9:46 AM of kitchen dish room revealed cracks in floor tiles, the wall near the floor, floor drain unsecured to floor, stacks of chipped clean plates, and floor tiles missing on wall in spots. Observation on 3/4/25 at 11:21 AM revealed DS J opened the trash can with (HIS/HER) bare hand. DS J did not perform hand hygiene. DS J then got a hand towel and removed dinner rolls from oven. DS J picked up a dinner roll with (HIS/HER) bare hand to check for doneness. DS J then opened a bag of shredded cheese and put shredded cheese into a container with (HIS/HER) bare hands. DS J then wrapped up the bag of shredded cheese and container of cheese and returned both items to refrigerator. Observation on 3/4/25 at 12:00 PM of DS L in kitchen without beard guard on to cover facial hair putting meal trays into meal carts. Observation on 3/5/25 at 5:25 PM of DS H in kitchen without beard guard on to cover facial hair putting meal trays into meal carts. Further observation revealed DS G to be observed with long fake fingernails assembling meal trays without gloves. Interview on 3/4/25 at 11:40 AM with DS J revealed DS J stated she had worked at the facility for 2 days and were still in training currently. DS J stated that her English was not so good. DS J stated she was still being taught the proper procedures of how the kitchen operated. DS J stated she was unsure if she should have performed hand hygiene after touching the trash can. Interview on 3/5/25 at 5:40 PM with the DM revealed DM stated he had taken the position in November of the prior year and had received training from the prior DM and a DM of a sister facility. DM stated they had cleaning lists but that he has not been utilizing them since taking the position due to low staffing issues. DM states there are monthly and weekly list available and as for daily he utilizes an all-hands-on deck approach to the cleaning of the kitchen. DM stated he expects all food items to be labeled and dated upon receipt and then again after opening or preparation. DM states if food items are not labeled and dated, then residents could potentially receive food items, they are allergic to or become sick. DM states food labeling and dating is the responsibility of the entire kitchen staff, but that the ultimate responsibility falls to the DM. DM states he expects hair restraints, including beard guards, to be worn by all staff while in the kitchen. DM states if hair restraints are not worn, then hair can fall into food. DM states he is responsible for ensuring hair restraints are worn by staff. DM states he has conducted 3 in-service trainings since taking the position all in February as he has been trying to learn his position. Interview on 3/5/25 at 5:54 PM with DS G revealed she had worked at the facility for 5 months. DS G stated hair restraints must be worn by all staff while in the kitchen. DS G stated it could negatively affect residents if hair restraints were not worn by hair in the food and contamination. DS G stated if staff have fake nails, gloves must be always worn. DS G stated if gloves are not worn, it can affect residents negatively by contaminating of food and possible infection. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 3/5/25 at 5:57 PM with DS H revealed he had worked at the facility for 9 months. DS H stated hair restraints must be worn by all staff. DS H stated it could negatively affect residents if hair restraints were not worn by hair being in the food. DS H stated he was unsure if jewelry could be worn in the kitchen, and he was unsure if that could be an infection control issue or contamination issue. DS H stated he had received training about general kitchen sanitation but was unsure about when the last training was conducted. DS H stated most of the kitchen sanitation is just general common sense. Interview on 3/5/25 at 7:05 PM with the ADM revealed Admin stated that he expected all food items to have labeling and dating and be properly stored and sealed. Admin stated food items were labeled and dated upon receipt and again upon opening or preparation. Admin stated if food items are not labeled and dated it could negatively affect residents by possible food borne illness and diminished quality of food. Admin stated it was the responsibility of the DM to ensure food items are labeled and dated. Admin stated it was his expectation that the general sanitation of the kitchen was kept up and that the kitchen was clean. Admin further stated he expected the cleanliness to be maintained daily, weekly, and monthly for resident health. Admin stated it could negatively affect residents if the kitchen was not kept clean by contamination, pests, and food borne illness. Admin stated it was the responsibility of the DM for maintaining the kitchen sanitation. Record review of kitchen in-service training reflected a training had been conducted on 2/24/25 covering cleaning of dining room, trash removal, and resident meal utensils with 4 staff signatures of attendance. Record review of the facility's Food Storage policy dated December 2020 reflected under heading purpose: To establish guidelines for storing, thawing, and preparing food. Under heading policy: Food items will be stored, thawed, and prepared in accordance with good sanitary practice. Under heading procedure: Label and date all food items. Any opened products should be placed in storage containers with tight fitting lids. Label and date storage products. Record review of dining service standards policy dated 12/2022 reflected under heading purpose: To describe important infection control guidelines followed by Nutrition and Food Services to prevent food-related illnesses. Under heading policy: The facility staff will ensure the prevention of infection in the food service department to ensure the residents are provided with a positive meal experience. Under heading procedure: 1. Personnel shall comply with all local, state, and federal laws governing food protection and sanitation of long-term facilities. 2. (continued on next page)

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	455799	A. Building B. Wing	03/06/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Personnel should adhere to the Infection Prevention policy: Hand Hygiene and Use of Antiseptics for Skin Preparation. Hand hygiene will be performed with soap and water before work, after using the toilet, before and after eating, after contact with unclean equipment, work surfaces, soiled clothing, washcloths, etc., and after handling raw food. In patient care areas, an alcohol-based hand rub may be used (e.g., Purell) if hands are not visibly soiled. Adequate numbers of handwashing sink with soap dispensers and single-use towels are provided. Food personnel may not clean their hands in a sink used for food preparation or ware washing. Nutrition and Food Services personnel in direct contact with food will wear plastic or vinyl disposable gloves. Gloves should be removed upon leaving the work area and hand hygiene performed. Hand hygiene should be performed when returning to the work area and new gloves should be worn. Gloves should be changed, and hands washed with soap and water whenever the gloves are contaminated by touching potentially soiled surfaces such as cashier surfaces, floors, waste cans, cardboard boxes. 1. Annual in-service education should include personal hygiene, sanitation, and hand hygiene. Education on infection prevention and control practices is presented by department supervisors or Infection Prevention staff as needed and documented. Basic orientation for all new Nutrition and Food Services personnel should include personal hygiene, sanitation, hand hygiene, isolation precautions, and when to notify their supervisors of illness with an infectious disease. Training should be based on all applicable policies. 2. The Nutrition and Food Service areas and staff must comply with all applicable requirements and the rules governing the food protection and sanitation of long-term care facilities.

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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** Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 5 of 8 staff reviewed for infection control. 1. The facility failed to ensure CNA A conducted hand hygiene when passing resident lunch trays . 2. The facility failed to ensure MA L sanitized the blood pressure cuff after checking a resident's blood pressure . 3. The facility failed to ensure CNA D, LVN B, and the AD conducted hand hygiene between residents during lunch tray pass . These failures could place residents at risk of transmission of disease and infection. Findings include: 1. Record review of Resident #49's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included epilepsy (a group of non-communicable neurological disorders characterized by recurrent epileptic seizures) , reduced mobility, polyneuropathy (damage or disease affecting peripheral nerves [peripheral neuropathy] in roughly the same areas on both sides of the body, featuring weakness, numbness, and burning pain), major depressive disorder (A period of at least two weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities, and had a majority of specified symptoms, such as problems with sleep, eating, energy, concentration, or self-worth.), post-traumatic stress disorder (a mental health condition that's caused by an extremely stressful or terrifying event- either being part of it or witnessing it), dementia (a group of symptoms affecting memory, thinking and social abilities), hypertension (high blood pressure), pain, muscle weakness, and a cognitive communication deficit. Record review of Resident #49's Care Plan, dated 02/15/24, reflected she had impaired cognitive function/dementia or impaired thought processes related to head injury. The goal was for Resident #49 to maintain current level of cognitive function and communicate basic needs daily. Interventions included keeping Resident #49's routine consistent and try to provide consistent caregivers as much as possible to decrease confusion, use preferred name and identify yourself at each interaction. Record review of Resident #49's Quarterly MDS, dated [DATE], reflected a BIMS Score of 15, which indicated little to no cognitive impairment. The MDS also reflected Resident #49 was independent with eating, with assistance with meal set-up, and she used a manual wheelchair. Observation on 03/03/25 at 12:33 PM revealed CNA A took a tray to an unidentified resident room, came out and got a tray for Resident #49 and assisted with setting up the tray. CNA A did not conduct hand hygiene when she came out of the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/06/25 at 12:45 PM with the ADON, who stated the DON and ADON were responsible for ensuring staff were doing hand hygiene/following infection control measures when providing care for the residents. The ADON stated she watched staff performing hand hygiene during rounds, and she also expected the charge nurses to watch staff for hand hygiene. The ADON further stated they had sanitizing wipes, hand sanitizer, and gloves available on every medication and treatment cart. The ADON stated the policy on hand washing and hand hygiene between residents stated to conduct hand hygiene when going from dirty to clean during care and disinfect any medical equipment after using on a resident or placing it back on cart. The ADON further stated they provided every nurse and CNA a bottle of hand sanitizer. The ADON stated a potential negative outcome for the residents would be the spread of infection. Record review of In-Service Training Report, dated 01/08/25, on Evidence-Based Practice Infection Control. CNA A and MA A did not have a signature on the in-service sign in sheet. Record review of the facility's Evidence-Based Best Practices: Infection Prevention and Control Policy & Procedure, dated 12/2022, reflected: The facility's designated Infection Preventionist is responsible for coordinating all infection prevention and control program activities and must have a basic knowledge of care practices and cleaning, disinfection, and sterilization processes. Policies and Procedures - use of standard precautions including hand hygiene and use of alcohol-based hand sanitizer, and disinfecting multiple use equipment and supplies, such as blood glucose monitors, stethoscopes, and pulse oximetry units. Staff Training and Competency Evaluation - Hand hygiene, including proper use of alcohol-based had rub (ABHR), and proper cleaning and disinfection of multi-person use equipment such as blood pressure machines and stethoscopes. Medical Devices - Blood pressure cuffs must be cleaned with a disinfectant wipe between each use. Make sure the cuff stays wet for the appropriate contact time, then allow the cuff to air dry after cleaning. Record review of the facility's, undated, Infection Prevention and Control Program reflected: I. The Facility must establish an Infection Prevention and Control Program under which it A. Identifies, investigates, controls, and prevents infections in the Facility. B. Decides what procedures, such as isolation, should be applied to an individual resident, and C. Maintains a record of incidents and corrective actions related to infections. Record review of Dining Service Standards policy, dated 12/2022, reflected a. Nutrition and Food Services Personnel needs to be familiar with isolation precautions signage and follow all guidelines within the Infection Prevention policy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nutrition and Food Services personnel may be responsible for clearing the bedside table, serving the food tray to the patient, and removing the tray at the completion of the meal. Hand hygiene should be performed prior to entering and after leaving each patient room. Gloves should not be worn except to deliver and pick up trays for patients on Contact Precautions/ Enteric Precautions. If gloves are worn, they must be changed, and hand hygiene performed between each patient room. Record review of Dining Services Standards policy, dated 12/2020, reflected: The facility staff will ensure the residents are provided with a positive meal experience. Under heading Procedure: Proper handwashing and glove usage are utilized when serving food to patients/residents. No bare hand contact is made with ready to eat food.