STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455871	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynwood Nursing and Rehabilitation LP	803 S Alamo Levelland, TX 79336

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 46425 Based on observation, interview, and record review, the facility failed to provide information to resident's and their representatives on their rights related to filing grievances or concerns for 7 of 15 confidential residents. The facility failed to ensure 7 confidential residents were provided, through postings in prominent locations, the Grievance Procedure, was provided access to the Grievance form, was provided information who the facility grievance official was, their contact information, how to file an anonymous grievance, and their right to obtain a written decision related to their grievance. This failure could place the residents at risk of unresolved grievances and decreased quality of life. Findings include: Interviews and record review during Resident Council on, 10/28/2024 at 10:00 a.m., 7 confidential residents, stated they did not know the grievance process, they did not know where to obtain or submit a grievance form, they did not know they could file a Grievance anonymously, the Grievance procedure had never been discussed in Resident Council, and they had not observed a posting of the Grievance procedure in prominent locations. Residents attending the group meeting did not know how to file a grievance. Residents did not know where to acquire a grievance form, who to turn the form into, and what happens once a grievance was filed. The residents did not know they had the right to receive a written decision once their grievance was resolved. Seven residents in attendance had all been residents of the facility for 6 plus months. Record review of the facility Grievance policy on 10/29/2024 at 11:05 a.m., revealed a copy of the Grievance/complaint procedure should be posted on the prominently in the facility. Observation of prominent postings on 10/29/2024 at 11:30 a.m., indicated the facility did not include instructions regarding the Grievance procedure with any of the prominent postings. Grievance forms were not available to residents and there was no access to submit a Grievance anonymously. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the ADM on 10/29/2024 at 12:05 p.m., the ADM stated she was the Grievance Officer for the facility. The ADM stated the Grievance form was kept in her office and the office of the Social Worker. The ADM stated she had been employed at the facility for 6 days; therefore, she has not addressed any Grievances to date. The ADM stated from reviewing the Grievance notebook it was apparent to her the Social Worker and the ADM address the Grievances. The Grievances were completed when a Resident comes to her or another staff member with a complaint, and/or if complaints were voiced in Resident Council. The ADM stated the Grievance Procedure was not posted for residents. The ADM stated the residents cannot file a Grievance anonymously due to the residents not having access to the Grievance form and having no means of submitting a Grievance form anonymously. The ADM stated she was responsible for assigning a Grievance to a staff member to address, she stated her expectation was Grievances be resolved as soon as possible. The ADM stated residents who voice a complaint were interviewed by the staff member assigned to resolve the Grievance; she stated this was the first step in resolving the Grievance. These interviews were documented on the Grievance form. The ADM stated the resolution to the Grievances were documented on the Grievance form. The ADM stated the resolution to Grievances was discussed with residents face to face. The ADM stated would monitor the Grievance process for success by following up with the staff member assigned to resolve the Grievance, the ADM stated she would also meet with the complainant to ensure they were satisfied with the resolution. The ADM stated she was responsible for ensuring staff were trained on the Grievance process. The ADM stated she was not aware the Grievance procedure was not being discussed in Resident Council. Interview with the Social Worker on 10/29/2024 at 1:25 p.m., the SW stated process for completing a Grievance included talking to the resident with a complaint, the SW completing the Grievance form, assigning the Grievance to the appropriate Department head, that Department head investigating and solving the Grievance, and emailing the ADM a copy of the Grievance with the interviews documented as well as the resolution. The SW stated the Grievance form was available at the nurses' station, the SW's office, and the ADM's office if the residents ask for the form. The SW stated the forms were not available for the residents to complete without asking the staff for a form. The SW stated there was no confidential manner for a Grievance to be submitted anonymously. The SW stated the timeframe for addressing a Grievance was as soon as possible, she stated Grievances were discussed at every morning meeting. The SW stated the resident who filed a Grievance should be interviewed by the Department hired to complete the Grievance and this interview would be documented on the Grievance form. The SW stated the resolution to the Grievance should be documented on the Grievance form by the Department head who addressed the Grievance. The SW stated the ADM was responsible for ensuring the Grievance was addressed. The SW stated the ADM was responsible for the education of staff on. the Grievance procedure. The SW stated there was no potential harm to residents if the Grievance procedure was not discussed in Resident Council, there was no potential harm to residents if Grievances were ignored, there was no potential harm to residents if they were not offered an avenue to file a Grievance anonymously, and there was no potential harm to residents if the Grievance procedure was not displayed for residents. The SW stated there was an open-door policy throughout the facility; therefore, residents can discuss any issues they have with staff informally, a formal Grievance does not need to be filed. Record review of the Grievance Policy revised 1/12/2023 indicated: Policy Statement: All grievances filed with the facility will be investigated and corrective action will be taken to resolve the grievances. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Interpretation and Implementation: The facility will make the information for filing a grievance available to residents and their representatives. The ADM will assign the responsibility of investigating the grievance. Each Resident Grievance form will include the date, time, and details of the grievance. The Grievance forms will be maintained all Grievances and evidence related to the Grievance for three years. The Grievance will be resolved within three working days. The Resident or their Representative will be informed of the finding of the Grievance and any corrective action taken within three working days of the filing of the Grievance.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41480 Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care, were provided such care, consistent with professional standards of practice for 2 (Residents #40 and #114) of 2 residents reviewed for respiratory care. 1. The facility failed to ensure that Resident #40 and Resident #114's oxygen tubing was replaced every week on Sunday, according to physician's orders. These failures could place residents at risk for respiratory compromise and infection. Findings included: Resident #40 Record review of Resident #40's clinical record reflected a face sheet, dated 10/28/24, which indicated the resident was an [AGE] year-old female admitted to the facility on [DATE]. Resident #40's diagnoses included chronic obstructive pulmonary disease (lung disease) and dementia (memory loss). Record review of Resident #40's annual MDS dated [DATE] revealed a BIMS score of 04, indicating the resident had severe cognitive impairment. Section O - Special Treatments, Procedures and Programs revealed Resident #40 used oxygen therapy while a resident. Record review of Resident #40's comprehensive care plan, dated 09/26/24, revealed Resident #40 required oxygen therapy related to COPD. Record review of Resident #40's current Physician Orders dated 10/28/24 revealed an order to change oxygen tubing, cannula/mask once a week on Sunday. During an observation on 10/28/27 at 11:10 AM, Resident #40 had oxygen being administered at 3 liters/minute via nasal cannula. Oxygen tubing was not dated. Ziplock bag on oxygen concentrator was dated 10/20/24. Resident #114 Record review of Resident #114's clinical record reflected a face sheet, dated 10/28/24, which indicated the resident was a [AGE] year-old female admitted to the facility on [DATE]. Resident #114's diagnoses included congestive heart failure (decrease pumping power of the heart muscle), chronic respiratory failure, diabetes (high blood sugar), and lung cancer. Record review of Resident #114's annual MDS dated [DATE] revealed a BIMS score of 14, indicating the resident had no cognitive impairment. Section O - Special Treatments, Procedures and Programs revealed Resident #40 used oxygen therapy while a resident. Record review of Resident #114's comprehensive care plan, dated 10/15/24, revealed Resident #114 required oxygen therapy related to decreased cardiac output. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #40's current Physician Orders dated 10/28/24 revealed an order to change oxygen tubing, cannula/mask once a week on Sunday. During an observation on 10/28/27 at 10:32 AM, Resident #114 had oxygen being administered at 4 liters/minute via nasal cannula. Oxygen tubing was not dated. During an interview on 10/29/24 at 10:15 AM with the DON, she stated oxygen tubing should be changed and dated weekly on Sunday. She stated she had agency nurses working on Sunday. She stated all staff have been trained. She stated the ADON and DON were responsible for monitoring compliance. She stated the potential negative outcome was infection control. During an interview on 10/29/24 at 10:35 AM with the ADM, she stated oxygen tubing should be changed according to the physician orders. She stated the tubing should be changed. She stated the nurses, ADON and DON were responsible for monitoring compliance with changing tubing and dating the tubing. She stated the potential negative outcome could be increase negative consequences to the resident related to infection. Record review facility policy titled Departmental (Respiratory Therapy) - Prevention of Infection, revised November 2011 reflected the following: Purpose - The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff . Infection Control Considerations Related to Oxygen Administration . 7. Change the oxygen cannulae and tubing every seven (7) days, or as needed .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49279 Based on observation, interview, and record review the facility failed to ensure that its medication error rates are not 5 percent (%) or greater. The facility had a medication error rate of 20% based on 6 out of 30 opportunities, which involved 2 of 4 residents (Residents #58 and #55) reviewed for medication administration, in that: 1. The facility failed to ensure Resident #55 had Xifaxa n (helps prevent a brain condition that can occur with severe liver disease)550mg, available for administration, resulting in a missed dose. 2. Med Aide C failed to verify the dosage and amount on Resident #55's Lactulos e (treats constipation) resulting in Resident #55 being underdosed. 3. Med Aide C failed to verify the dosage for Resident #58's Magnesium 200mg (treats low magnesium levels), and thiamin B1 (treats low thiamine) 50mg resulting in an incorrect dose given. 4. Med Aid C failed to verify physician order for Resident #58's Multivitamin resulting in the incorrect multivitamin given. 5. Med Aid C administered Ferrous Sulfate (treats low iron) 325mg, without a physician order to Resident #58. These failures could place residents at risk of incomplete therapeutic outcomes, increased negative side effects, and decline in health. Findings included: Resident #55 During a medication administration observation for Resident #55 on 10/28/2024 at 7:30 AM, Med Ai d C poured 15mL of Lactulose into a measuring cup and administered, she did not give Xifaxan 550 mg tablet, it was unavailable. Record review of Resident #55's undated face sheet revealed a [AGE] year-old male originally admitted to the facility on [DATE]. Resident #55 had a medical history of toxic encephalopathy (a neurologic disorder caused by exposure to neurotoxic organic solvents), hypertension (high blood pressure), and alcoholic cirrhosis of liver with ascites (a condition where the liver is scarred due to chronic alcohol use, and fluid builds up in the abdomen). Record review of Resident #55's physician orders revealed an order for lactulose solution 10 gram/15 mL (15 mL); amt: 30 mL BID; oral with a start date of 9/11/2024 to be given between 7AM-10AM and 7PM-10PM. Physician orders also revealed an order for Xifaxan (rifaximin) tablet; 550 mg; amt: 1 tab PO BID; oral with a start date of 9/12/2024 to be given 7AM-10AM and 7PM-10PM. Resident #58 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a medication administration observation on 10/28/2024 at 7:41 AM , Med Aid C administered the following medications to Resident #58: - One-Daily multi-vitamin, 1 tablet -ferrous sulfate 325mg, 1 tablet; -Magnesium 400mg, 1 tablet; and -thiamine 100mg, 1 tablet. Record review of Resident #58's undated face sheet revealed a [AGE] year-old male originally admitted to the facility on [DATE]. Resident #58 had a medical history of disorders of phosphorus metabolism (abnormal levels of phosphorus which can result in various other conditions), schizophreniform disorder (short-term mental health condition that causes psychosis), and hypomagnesemia (low magnesium levels). Record review of Resident #58's physician orders revealed the following active orders: thiamine HCl (vitamin B1) 50 mg, 1 tab PO, QD with a start date of 12/09/2023. magnesium 200mg, 1 tablet, twice a day with a start date of 1/1/2024. Adults Multivitamin (multivitamin-min-iron-fa-vit k) 18 mg iron-400 mcg-25 mcg with a start date of 12/09/2023. Record review of Resident #58's physician orders did not reveal an order for Ferrous Sulfate 325mg. During an interview on 10/28/2024 at 12:03 PM, the Med Aid C stated she gave 15mL of Lactulose to Resident #55 and verified the order stated 30mL. The Med Aid C stated she gave Resident #58 Magnesium 400mg and verified the order was for 200mg of Magnesium. The Med Aid C stated she gave Resident #58 Thiamin 100mg and verified the order was for 50mg. The Med Aid C stated she gave Resident #58 the One Daily multivitamin and added the iron pill because the facility did not have the ordered Adults Multivitamin (multivitamin-min-iron-fa-vit k) 18 mg iron-400 mcg-25 mcg. The Med Aid C stated she had been trained to verify orders and on medication administration rights. She stated her last training was in March 2024 when she was hired. She stated the DON is responsible for her training, but she had been trained by the last med aid who no longer worked at the facility. She stated the previous med aid told her she could supplement the ferrous sulfate 325mg to Resident #58's multi-vitamin since they did not have the right one. The Med Aid C stated she could have cut the Magnesium and Thiamin pills in half to give him the correct dose, but she was nervous and forgot. She stated she had been trained to cut the pills in half if needed. The Med Aid C stated did not know what the potential negative outcome of giving a medication without an order could be. The Med Aid C was unable to verbalize the potential negative outcomes for medication errors. She stated she knew her five rights of medication administration which were the name, time, pill, dose, and documentation. The Med Aid C stated she had been trained to report medication errors to the DON. The Med Aid C reported the medication errors to the ADON. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/29/2024 at 10:26 AM, the ADM stated the ADON and DON were responsible for training the nurses and med aides on medication administration. She stated the potential negative outcome of medication errors and residents not receiving their medication regimen could be any adverse effect and a negative consequence on the resident's health. The ADM stated she was not aware of the Med Aid C giving an iron tablet without an order. She stated staff is not trained to give any medication without an order. The ADM stated the nurses and med aids should follow their five rights of medication administration. During an interview on 10/29/2024 at 10:54 AM with the Clinical Resource Nurse and the ADON, the ADON stated the DON and ADON were responsible for training the nurses and med aids on medication administration. The ADON stated she was not sure when the last training was as she had just been hired at this facility, but she would be providing in-services on medication administration. The Clinical Resource Nurse stated that nursing staff and med aids were trained on the five rights of medication administration and the Med Aid C would be doing a training on medication administration. The Clinical Resource Nurse and ADON stated that a potential negative outcome of residents not receiving their ordered medication could be any adverse effect such as, depending on the type of medication, could be low blood pressure if it's a blood pressure mediation. The ADON stated she was not aware that the Med Aid C had been adding any supplemental medication to Resident #58's multi-vitamin. The ADON stated the nursing staff is not trained to do that without a physician order. The ADON stated the nursing staff and med aids were trained to verify the order and medication and if they do not match, they were to let the charge nurses, ADON and DON know in order to notify the physician for verification or to obtain the correct medication. Record review of facility policy titled MEDICATION ADMINISTRATION-GENERAL GUIDELINES dated 6/1/2022 revealed: A .4) FIVE RIGHTS - Right resident, right drug, right dose, right route, and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away . 6) Tablet Splitting: Splitting of tablets should be avoided and every attempt should be made to obtain an alternative dosage form, medication, or dosing schedule to avoid splitting. If breaking tablets is ultimately necessary to administer the proper dose, hands are washed with soap and water or alcohol gel (and examination gloves worn) prior to handling tablets and examination gloves must be worn to prevent touching of tablets during the process. The following guidelines are followed: a. Assure the tablet is appropriate and able to be split . b. A tablet-splitter is used to ensure accuracy and to minimize contact with the tablet. The splitter blade and surface contacting tablet are cleaned before and after each use. If the tablet is scored, every attempt is made to break along score lines . B .2.) Medications are administered in accordance with written orders of the prescriber.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41480 Based on observations, interviews, and record review the facility failed to, in accordance with State and Federal laws, ensure all drugs and biologicals were stored properly in the treatment cart for 1 of 1 treatment carts observed for drug storage. The facility failed to ensure 2 bottles of wound cleaners was not left on top of the treatment cart unattended. This failure could place residents at risk of access and ingestion of non-narcotic medications. The findings were: During an observation on 10/28/24 at 03:45 PM, LVN A prepared wound care supplies on the treatment cart outside of resident's room. LVN A gathered supplies leaving 2 bottles of wound cleaners on top of treatment cart and entered resident's room. LVN A closed the door to resident's room. During an observation on 10/28/24 at 03:50 PM, the wound cleanser bottle on top of treatment care reflected the following warnings: Keep out of reach of children. If swallowed seek medical attention or call a Poison Control Center. During an interview on 10/28/24 at 03:52 PM, LVN A stated she should not have left the wound cleaners on top of the treatment cart. She stated the wound cleaner's bottle did state Keep out of reach of children. She stated she did not have a reason for leaving the 2 bottles of wound cleaners on top of treatment cart except she just forgot to put it back in the treatment cart. She stated she had been trained on proper medication and supply storage. She stated the potential negative outcome could be a resident opening the bottle and drinking the solution. She stated some could also tamper with the solution adding to it or pouring the solution out. During an interview on 10/29/24 at 10:15 AM, the DON stated the wound cleaner was considered a medication. She stated the nurse was responsible for making sure they store medication and supplies in a locked cart. She stated they all have been trained. She stated the potential negative outcome could be someone drinking the solution, contaminating the solution, or spraying the solution on someone. During an interview on 10/29/24 at 10:35 AM, the ADM stated the wound cleaner should not be stored on top of the treatment cart. She stated all staff have been trained. She stated the DON and ADON were responsible for monitoring storage of medications and wound care supplies. She stated the potential negative outcome could be a resident ingest the solution and could cause harm. Record review of facility policy titled Storage of Medications revised November 2020 reflected the following: Policy: The facility stores all drugs and biologicals in a safe, secure, and orderly manner. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Interpretation and Implementation 1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications .

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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. 41480 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services, in that: 1. The facility failed to store and date foods stored in the refrigerator. 2. The facility failed to store pans upside down on shelfs. These failures could place residents at risk for food contamination and foodborne illness. The findings included: The following observations were made on 10/27/24 at 09:45 AM, during initial observation of the kitchen: Observed the following: Inside the Refrigerator: Three trays with individual deserts in bowl uncovered and no date. -A bowl of puree food covered with plastic wrap with no date. -Two half sandwiches in plastic wrap with no date. Shelf: -One large pot laying on side on bottom shelf in pantry. -Three small pans stored right side up on shelf in kitchen. During an interview on 10/29/24 at 10:35 AM with the ADM, she stated all food should be stored covered and dated. She stated pots/pans should be stored upside down. She stated all kitchen staff have been trained. She stated the DM was responsible for monitoring the kitchen. She stated the potential negative outcome could be harm to the resident. During an interview on 10/29/24 at 10:45 AM with the DM, she stated all food items in the refrigerator needs to be dated and in a sealed container. She stated all pots and pans should be stored upside down on the shelf. She stated all staff have been trained. She stated the DM was responsible for monitoring storage of food and pots and pans. She stated the potential negative outcome of not properly storing food was you do not know how long it has been in refrigerator and could be given to a resident causing them to get sick. She stated the potential negative outcome for not properly storing pots/pans could be the pots/pans could get debris in them and mix with the food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy, titled Food Storage, undated reflected the following: Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes and HACCP guidelines. Procedure: . 2. d. Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approve for food storage.

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	455871	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynwood Nursing and Rehabilitation LP	803 S Alamo Levelland, TX 79336

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 41480 Based on interviews and record review, the facility failed to use the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week in the facility for 10 (4/13, 4/14, 4/28, 5/18, 5/19, 5/26, 6/15, 6/16, 6/23, and 6/29/2024) of 91 days reviewed for RN coverage. The facility failed to maintain RN coverage of eight hours a day for 10 days 4/13, 4/14, 4/28, 5/18, 5/19, 5/26, 6/15, 6/16, 6/23, and 6/29/2024). This failure could place residents at risk of not having their nursing and medical needs met and receiving improper care. Findings included: Record review of the CMS report PBJ Staffing Data Report dated 10/23/24 reflected no RN hours for 4/13, 4/14, 4/28, 5/18, 5/19, 5/26, 6/15, 6/16, 6/23, and 6/29/2024. Record review of the facility''s employee survey roster undated reflected there were seven RNs employed at the facility. Record review of Schedule Sheet dated April 2024 reflected RN A was scheduled to work on (4/13, 4/14, and 4/28/2024). Record review of Schedule Sheet dated May 2024 reflected RN A was scheduled to work on (5/18, 5/19, and 5/26/2024). Record review of Schedule Sheet dated June 2024 reflected RN A was scheduled to work on (6/15, 6/16, 6/23, and 6/29/2024). During an interview on 10/29/24 at 01:00 PM with HR, she stated the previous DON did not clock in or out because she was salary. She stated she was not sure how her time was reported. She stated corporate submits time to CMS for the PBJ but she was not sure how it was done or submits it. During an interview on 10/29/24 at 02:00 PM, the DON stated the previous DON was scheduled to work 4/13, 4/14, 4/28, 5/18, 5/19, 5/26, 6/15, 6/16, 6/23, and 6/29/2024. She stated she was not sure why her hours were not reported. She stated there had been several turnovers in staff at the corporate level and someone just dropped the ball. She stated the ADON and DON were responsible for scheduling the RN coverage. She stated the potential negative outcome for not having an RN eight hours a day could be not having someone to lead and direct the LVN staff related to resident assessment who might need to be sent out to the ER. During an interview on 10/29/24 at 02:00 PM, the corporate resource nurse stated he was not aware there was no RN coverage for 4/13, 4/14, 4/28, 5/18, 5/19, 5/26, 6/15, 6/16, 6/23, and 6/29/2024. He stated the previous ADM did tell him she was worried about RN coverage because there were several days, they did not have coverage. He stated he did not know what days she was referring to. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/29/24 at 02:15 PM, the ADM stated it was the policy to have an RN 8 hours a day 7 days a week. She stated she was not aware of not having RN coverage as she was not in the building at that time. She stated they currently have RN coverage. She stated she was currently working on a new system to track RN hours when the coverage was done by a salaried RN that does not clock in. She stated the potential negative our come of not having an RN in the building 8 hours a day 7 days a week could be missing assessments and not having leadership for the LVN staff. Record review of the policy provided by the facility titled, Staffing, revised 9/28/23 revealed in part the following: Policy Statement - Our center provides sufficient nursing staff with the appropriate skills and competencies necessary to provide care and related services to ensure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with resident care plans and the facility assessment. Policy and Implementation . 4. The facility utilizes the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week . 7. Direct care staffing information per day (including agency and contract staff) is submitted to the CMS payroll-based journal system on the schedule specified by CMS, but no less than once a quarter.

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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** 36954 41480 Based on observation, interview, and record review, the facility failed to maintain an infection control program designed to provide a safe, comfortable, and sanitary environment to help prevent the development and transmission of diseases for 2 of 2 residents (Residents #4 and #38) and 2 of 2 (LVN A and LVN B) staff reviewed for infection control. LVN A failed to wash hands between glove changes during wound care for Resident #38. LVN B failed to wash or sanitize hands after reaching in his pocket and prior to starting wound care. These failures could place residents at risk for spread of infection and cross contamination. Findings include: Resident #4 Record review of Resident #4's clinical record reflected a face sheet, dated 10/29/24, which indicated the resident was a [AGE] year-old female admitted to the facility on [DATE]. Resident #4's diagnoses included dementia (loss of cognitive functioning, thinking, remembering, and reasoning) unspecified open wound right foot (break in the skin exposing underlying tissue), and cellulitis of lower limbs (bacterial infection that affects the deep layers of the skin and underlying tissue). Review of Resident #4s Comprehensive MDS Assessment, dated 09/20/24, reflected the resident was cognitively intact with a BIMS score of 12 . Resident #4 functional abilities and goals reflected resident #4 required substantial/maximum assistance with toileting, upper body dressing and personal hygiene. Resident #4 skin conditions reflected number of stage 4 pressure ulcers as 1, and number of pressure ulcers present at time of admission/entry or reentry as 1. Record review of Resident #4's care plan dated 09/23/24 reflected resident had a pressure ulcer infection on right heel. Approach - use aseptic techniques (disease-free, sterile, uninfected) when preforming dressing changes. Dress and cover wound before dressing other wounds, washing hands and observe aseptic technique. Record review of Resident #4's physician orders dated 10/28/24 reflected Wound Treatment Order: Location: Right heel - clean with wound cleanser, apply calcium alginate, cover with Silicone Foam Dressing once a day on Mon., Wed., Fri., dated 10/24/24. During an observation on 10/28/24 at 3:35 PM, reflected LVN B provided wound care for Resident #4. LVN B reached in his pocket with the gloves on and removed alcohol packets from his pocket and tossed them on the over bed table on the clean alginate. He opened an alcohol pad cleaned around the wound where the previous bandage was. He reached over and moved the alcohol prep packets off the alginate and placed the alginate on the adhesive bandage and placed it over the wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/28/2024 at 4:05PM, LVN B stated he performed wound care when the wound care nurse was not at the facility or if he noticed wound care needs to be completed. He stated that he should have changed gloves and sanitized his hands after he reached in his pocket and removed the alcohol wipe packages. He stated that when he tossed the alcohol wipe packages on the over bed table on the parchment paper and alginate, then placed the alginate over the wound it could have caused an infection. He stated he should have stopped the wound care procedure after he reached in his pocket and grabbed the alcohol wipe packets , then washed his hands and started the wound care over. He stated he was an agency nurse and had not received training on wound care form the facility. Resident #38 Record review of Resident #38's clinical record reflected a face sheet, dated 10/28/24, which indicated the resident was a [AGE] year-old male admitted to the facility on [DATE]. Resident #38's diagnoses included osteomyelitis of vertebra (bone infection), spinal stenosis (narrowing of the spinal canal), hypertension (high blood pressure), and congested heart failure (decrease pumping power of the heart muscle). Review of Resident #38s Comprehensive MDS Assessment, dated 09/26/24, reflected the resident was cognitively intact with a BIMS score of 14 . Resident #38 functional abilities and goals reflected resident had impairment on one side upper and lower. Resident #38 used a wheelchair. Resident #38 requires substantial/maximal assistance with toileting, showering, dressing and personal hygiene. MDS skin conditions reflected Resident #38 had a risk for developing pressure ulcers and had one diabetic ulcer and 1 surgical wound. Record review of Resident #38's care plan dated 09/23/24 reflected no care plan for wounds. Record review of Resident #38's physician orders dated 10/28/24 reflected Wound Treatment Order: Location: Right buttocks clean with normal saline/wound cleanser, pat dry, apply calcium alginate, cover with Opti foam once a day on Tue., Thu., Sat., dated 10/22/24. During an observation on 10/28/24 at 03:45 PM, revealed LVN A cleaned Resident #38's right buttock wound with wound cleanser and gauze and patted dry with gauze. LVN A removed gloves and donned new gloves. LVN A did not wash hands or use ABHR when changing gloves between dirty and clean. LVN A applied calcium alginate to wound bed and covered with Opti foam. During an interview on 10/28/24 at 03:52 PM with LVN A, she stated she should have washed her hands with soap and water or ABHR between gloves changes. She stated there was no reason why she did not wash her hands or use ABHR. She stated she had been trained on infection control and hand washing. She stated the potential negative outcome could be spread of infection to the resident or herself. During an interview on 10/29/24 at 10:40 AM with the Interim DON, she stated hands should be washed with soap and water or ABHR between glove changes. She stated the staff have been trained on handwashing and infection control. She stated the ADON was the infection preventionist. She stated the DON and ADON was responsible for monitoring staff for infection control. She stated the potential negative outcome could be spreading infection . Record review Hand Hygiene Competency Validation, dated 09/11/24 for LVN A, reflected competency goals met. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review facility policy titled Handwashing/Hand Hygiene, undated reflected the following: Policy statement - This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation . 5. Hand hygiene must be performed prior to donning and after doffing gloves. 49279