STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455895	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Five Points at Lake Highlands Nursing and Rehab	9009 White Rock Tr Dallas, TX 75238

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on observations, interviews, and interviews the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for one (Resident #98) of five residents reviewed for environment. The facility failed to ensure Resident #98's windowsill was repaired after it was broken leaving damaged wood and debris exposed to the room. This failure could place residents at risk for a diminished quality of life due to the lack of a homelike environment. Findings included: Record review of Resident #98's Admission Record dated 12/8/24 reflected a [AGE] year-old female admitted to the facility on [DATE]. Record review of resident #98's Quarterly MDS assessment dated [DATE] reflected she was rarely or never understood and had severe cognitive impairment. Her diagnoses included kidney failure, pneumonia, aphasia (inability to speak), respiratory failure, stroke, seizure disorder, and anoxic brain damage (caused by lack of oxygen to the brain. She was fed by a feeding tube and received oxygen through a tracheostomy (catheter inserted into the windpipe) which required suctioning. Record review of a Task List report (maintenance log) for Resident #98's unit dated from 6/13/14 through 12/9/24 reflected there were no entries related to resident #98's windowsill. Record review of a Champion Team Concern Form dated 12/8/24 reflected it was completed by the Social Worker reflected, Broken window sill [sic]. Social worker notified by house keeping [sic] that the window sill [sic] in [Resident #98's room number] needed repair. Social Worker saw the broken window sill [sic] and complete Champion Team concern form. Will place in maintenance care and further discuss on Monday with Maintenance Supervisor . (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455895	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview on 12/8/24 at 2:45 PM revealed Resident #98 was sleeping in her bed which was situated against the far wall in her room and beneath her window. She was lying on her right side facing the wall. She had a tracheostomy in place and was receiving oxygen via a collar over her tracheostomy site. The board covering the windowsill was broken approximately in in the middle leaving half the board attached. The portion of the board that remained revealed a portion of the veneer covering the board had peeled off leaving exposed adhesive and particle board beneath. The particle board had partially disintegrated and there was approximately 2 inches of loose wood debris on the bare windowsill section. LVN R entered the room and stated the windowsill had been that way as long as he had been there and stated he began working at the facility in October 2024. He stated he thought it had been reported but was unsure whether there were any plans for a repair. An observation and interview on 12/9/24 at 9:10 AM revealed the Administrator was standing outside Resident #98's room and stated they were moving Resident #98 and her roommate to another room so that repairs could be made. She stated maintenance personnel were aware of the issue and were getting a replacement board for the repair. The Administrator stated she was uncertain when they became aware of the issue. She stated the risk to residents included having a negative effect on anyone possible breathing it in. An observation and interview with Maintenance Staff S on 12/9/24 at 10:48 AM revealed he was carrying supplies into Resident #98's room to be used for repairs. Resident #98 and her roommate had been moved to another room. Maintenance Staff S stated he became aware of the issue on 12/8/24 when someone called to let him know. He stated the facility used a logs system and any staff could enter any maintenance issues that needed to be addressed and they could also call them for any urgent issues that needed to be addressed. He stated he had checked the log and did not see the windowsill listed. Maintenance Staff S stated he was unsure of any physical risk the broken windowsill posed but it was not something anyone would want to look at. During an interview on 12/10/24 at 8:09 AM, the Maintenance Supervisor stated he had first learned about the broken windowsill in Resident #98's room on 12/8/24. He stated he had picked up a replacement board for the room on the morning of 12/9/24. He stated it was his departments responsibility to make necessary repairs within the facility and he was unsure whether it had been previously reported by staff. He stated he was unsure whether it was a safety risk to residents, but it was aesthetically not pretty, an eyesore. In an interview on 12/10/24 at 8:31 AM, the Social Worker stated she learned about the Resident #98's broken windowsill on 12/8/24 and had planned to discuss the matter with the Maintenance Director on 12/9/24 in their daily meeting. The Social Worker stated the Champion Rounds were completed daily by department heads and included visiting each resident room, checking on the resident, and checking for any functional or housekeeping issues in the rooms. She stated they took any concerns they had to their daily meeting and shared the information with staff responsible for the concern. The Social Worker stated Resident #98's room was one of the rooms she visited daily and she did not know how she had missed it. She stated, aesthetically it did not look good and residents needed to feel good about their surroundings. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy undated titled, Resident Rights reflected, .The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-1. A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. a. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk .2. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior .

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on interviews and record review the facility failed to ensure all Pre-Admission Screening and Resident Review (PASARR) level 1 residents with mental illness were provided with a PASARR level 2 evaluation for 7 of 10 residents (Resident #104, Resident #82, Resident #5, Resident #14, Resident #21, Resident #64's, and Resident #76), reviewed for resident assessment. Resident #104, Resident #21, Resident #64, and Resident #76 PASARR's level 1 screening form did not reflect mental illness and the residents did not have a PASARR level II evaluation. Resident #82 was not referred to the Local Mental Health Authority (LMHA) for PASARR Level 2 screening. Resident #5 and Resident #14 did not have a PASARR level 1 or 2 evaluation completed. These failures could place residents at risk of not receiving necessary specialized services to meet their individual needs. The findings were: Resident #104 Record review of Resident #104's quarterly MDS assessment, dated 08/17/24, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. The resident's BIMs score was 5 indicating the resident's cognition was severely impaired. Her diagnoses included schizophrenia, psychotic disorder, depression, and non-Alzheimer's dementia. Record review of Resident #104's Care Plans reflected: *04/05/23: The resident was receiving services to assist with her diagnosis of schizophrenia. *12/12/23: The resident had behaviors which included paranoid delusions that a substance was coming through the walls and getting in her blood stream and others were out to get her through the technology in the building and was fearful for her safety. Record review of Resident #104's PASARR level 1 screening, dated 07/28/23, reflected the resident did not have a serious mental illness and serious mental illness was checked as no. Record review of Resident #104's Electronic Health Record revealed no PASARR level 2 evaluation was completed. An interview on 12/10/24 at 1:54 PM with the DON revealed she did not know why Resident #104 had a negative PASARR Level 1 screening. She said the MDS staff were responsible for checking for accuracy and the resident was at risk of not receiving services she could qualify for. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 12/10/24 at 2:17 PM with MDS Nurse G revealed he did not know why Resident #104 had a negative PASARR level 1 screening. He said that PASARR level 1 screening forms were only reviewed if the resident went to the hospital and returned. He said the resident was at risk of not having correct care and management with a negative PASARR level 1 screening. Resident #82 Review of Resident #82's MDS assessment completed on 11/14/24, reflected he was a [AGE] year-old male with an original admitted [DATE], and a re-entry admitted [DATE]. He had a BIMS score of 13 with the following diagnoses: Schizophrenia, Seizure Disorder, Anxiety Disorder, Depression, Psychotic Disorder (Other than schizophrenia). Record review of Resident #82's PASSR Level 1 screening was completed by the facilities MDS nurse on 7/29/2023. The screening indicated yes to question: Is there evidence or an indicator that this is an individual that has a Mental Illness? Record review of Resident #82's Care Plan reflected the last Care Plan Reviewed was completed on 12/04/2024 stated: Resident #82 has MI (mental illness) is PASARR positive. Resident #82 will have the specialized services recommended by local authority (LA) per PASARR Specialized Services program as needed. The LA will be invited annually to the care plan meeting for review of Specialized Services. During an interview on 12/10/2024 at 2:00 p.m., MDS Nurse G stated he was unable to confirm if Resident #82 was referred to the Local Mental Health Authority (LMHA) for PASARR Level 2 screening. The MDS Coordinator stated there was no record of the screening occurring. The MDS coordinator stated it usually does not take over a year to get a screening, he stated it will usually take 2-3 weeks to get the PASSR Level II screening. During an interview on 12/10/2024, Facility Social Worker (SW) reported there was a meeting with the LMHA interdisciplinary Team (IDT) coordinator today. The SW reported she was told by the IDT coordinator that the LMHA did not have any record of Resident #82. Resident #5 Record review of Resident #5's quarterly MDS assessment, dated 11/10/24, reflected the resident was an [AGE] year-old female admitted to the facility on [DATE]. The resident's BIMs score was 14 indicating the resident's cognition was intact. Her diagnoses included unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Record review of Resident #5's Care Plans reflected: *07/14/21: The resident was receiving services to assist with her diagnosis of anxiety. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*12/28/22: The resident had behaviors which included refusing to be weighed, not allowing assist with ADL's, not allowing staff to assist with Nebulizer therapy, not allowing staff to assist with O2 therapy, non-compliant with changing out equipment ie: tubing, mask, and humidifiers and ordering supplies from outside venders. not allowing room to be cleaned, not being compliant with ordered diet, refusal to throw trash away, hoarding items brought in from the outside as well as from the other residents in the facility and refusing therapy services at times. Record review of Resident #5's Electronic Health Record revealed no PASARR level 1 or 2 evaluation was completed. An interview on 12/10/24 at 3:45 PM with MDS Nurse H stated the resident was at risk of not having correct care and management without a PASARR level 1 screening. An interview on 12/10/24 at 4:43 PM with the DON revealed she did not know why Resident #5 PASARR Level 1 screening was not completed. She said the MDS staff were responsible for checking to make sure they had one completed and the resident was at risk of not receiving services she could qualify for. Resident #14 Record review of Resident #14's quarterly MDS assessment, dated 08/17/24, reflected the resident was an [AGE] year-old female admitted to the facility on [DATE]. The resident's BIMs score was 12 indicating the resident had moderate cognitive impairment. Her diagnoses included alcohol dependence with alcohol-induced persisting dementia, schizophrenia, unspecified, major depressive disorder, single episode unspecified, unspecified psychosis not due to a substance or known physiological condition. Record review of Resident #14's Care Plans reflected: *08/22/22: The resident was receiving services to assist with her diagnosis of anxiety. Record review of Resident #14's Electronic Health Record revealed no PASARR level 1 or 2 evaluation was completed. An interview on 12/10/24 at 3:45 PM with MDS Nurse H stated the resident was at risk of not having correct care and management without a PASARR level 1 screening. An interview on 12/10/24 at 4:43 PM with the DON revealed she did not know why Resident #14 PASARR Level 1 screening was not completed. She said the MDS staff were responsible for checking to make sure they had one completed and the resident was at risk of not receiving services she could qualify for. Resident #21 Record review of Resident #21's quarterly MDS assessment, dated 11/20/24, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. The resident's BIMs score was 15 indicating the resident's cognition was intact. Her diagnoses included depression, psychotic disturbance, mood disturbance, and anxiety. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #21's Care Plans reflected: *05/04/22: The resident was receiving services to assist with her diagnosis of depression. *09/23/24: The resident had behaviors which included accusatory towards others (staff) and refusal of therapy. Record review of Resident #21s PASARR level 1 screening, dated 09/15/23, reflected the resident had a serious mental illness. Record review of Resident #21's Electronic Health Record revealed no PASARR level 2 evaluation was completed. An interview on 12/10/24 at 3:45 PM with MDS Nurse H revealed he did not know why Resident #21 did not have a PASARR level 2 evaluation. He said that PASRR level 1 screening forms were only reviewed if the resident went to the hospital and returned. He said the resident was at risk of not having correct care and management with a positive PASRR level 1 screening. An interview on 12/10/24 at 4:43 PM with the DON revealed she did not know why Resident #21 did not have a PASARR Level 2 evaluation. She said the MDS staff were responsible for checking for accuracy and the resident was at risk of not receiving services she could qualify for. Resident #64 Record review of Resident #64's quarterly MDS assessment, dated 07/26/24, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. The resident's BIMs score was 15 indicating the resident's cognition was intact. His diagnoses included depression, anxiety, and schizophrenia. Record review of Resident #64's Care Plans reflected: *08/14/22: The resident receives frequent counseling sessions. *08/19/22: The resident was receiving services to assist with his diagnosis of schizophrenia. Record review of Resident #64's PASARR level 1 screening, dated 08/01/23, reflected the resident had a serious mental illness. Record review of Resident #64's Electronic Health Record revealed no PASARR level 2 evaluation was completed. An interview on 12/10/24 at 3:45 PM with MDS Nurse H revealed he did not know why Resident #64 did not have PASARR level 2 evaluation. He said that PASARR level 1 screening forms were only reviewed if the resident went to the hospital and returned. He said the resident was at risk of not having correct care and management with a negative PASRR level 1 screening. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 12/10/24 at 4:43 PM with the DON revealed she did not know why Resident #64 did not have a PASARR Level 2 evaluation. She said the MDS staff were responsible for checking for accuracy and the resident was at risk of not receiving services she could qualify for. Resident #76 Record review of Resident #76's quarterly MDS assessment, dated 11/06/24, reflected the resident was an [AGE] year-old male admitted to the facility on [DATE]. The resident's BIMs score was 11 indicating the resident has moderate cognitive impairment. His diagnoses included schizophrenia, psychotic disorder, mood disturbance, anxiety, depression, and unspecified dementia. Record review of Resident #76's Care Plans reflected: *08/13/24 The resident will identify strengths, positive coping skills. *08/13/24: The resident was receiving services to assist with his mood diagnosis. Record review of Resident #76's PASARR level 1 screening, dated 12/22/23, reflected the resident did not have a serious mental illness and serious mental illness was checked as no. An interview on 12/10/24 at 3:45 PM with MDS Nurse H revealed he did not know why Resident #76 had a negative PASRR level 1 screening. He said that PASARR level 1 screening forms were only reviewed if the resident went to the hospital and returned. He said the resident was at risk of not having correct care and management with a negative PASARR level 1 screening. An interview on 12/10/24 at 4:43 PM with the DON revealed she did not know why Resident #76 had a negative PASARR Level 1 screening. She said the MDS staff were responsible for checking for accuracy and the resident was at risk of not receiving services she could qualify for. Review of the facility policy, PASARR Maintenance in the Active Paper Medical Record, dated January 2018, reflected: .If the Residents is PASARR positive the following forms will follow: LA (Local Authority) PASARR Evaluation (PE) Form for all confirmed Negative or Positive PE Forms. (Obtained from the LA). LA 1014 or Individual Service Plan (ISP) Forms. (Obtained from the LA). IDT Meeting (Printed from Simple LTC along with any handwritten notes or the handwritten IDT form prior to data entered and submitted to Simple LTC) LA PSS (PASARR Specialized Service) (if applicable) . 47161 Resident #5 (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR 12/10/24 11:50 AM Interview with social worker [NAME] stated she does not complete PASARRs, she only does PASARRs for residents that are transferred to another facility. What medications do you get and why do you need to take them? Lorazepam for anxiety, Quetiapine Fumarate antipsychotic,trazodone for depression and bupropion for depression Did you have this diagnosis/condition prior to your admission to this facility? yes Do you receive any specialized services to help with your mental health or disability concerns? yes What are they doing to address your mental health or disability concerns? take medications and see a psychiatrist. No PASARR on file Resident #14 PASARR 12/10/24 01:45 PM Resident HOH unable to answer questions No Pasarr on file Resident #21 PASARR Resident #64 PASARR 12/10/24 01:02 PM Can you tell me about your current diagnosis/condition? Anxiety, depression, bipolar, adhd Did you have this diagnosis/condition prior to your admission to this facility? bipolar was diagnosed after admission. Do you receive any specialized services to help with your mental health or disability concerns? counseling What are they doing to address your mental health or disability concerns medication and counseling (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #76 PASARR 12/09/24 10:21 AM RR revealed PASSAR 1 completed. Resident has a diagnosis of Schizophrenia. No PASSAR II on file. 51181 Resident #82 PASARR 12/09/24 10:22 AM PASSR I completed, no record of PASSR II - resident has diagnosis of psychiatric/Mood Disorder Anxiety Disorder, Depression (other than bipolar), Bipolar Disorder, Psychotic Disorder (other than schizophrenia) Schizophrenia 12/10/24 11:47 AM Social Worker [NAME] - She does PASSR 1 when a resident is sent out to another facility. That is all of her capacity in dealing with PASSR. 12/10/24 02:00 PM Benga Fasusirn, MDS Coordinator, also does PASSR for residents. In looking at MDS for this resident, when a resident comes to facility, review PASSR and if anything showing mental, IDD, etc. he will let social worker know, then they send a list of those to Metro Care. Then Metro Care will set up an appointment. He does not know the duration of time, it depends on the metro care. The social worker will follow up with Metro care if meeting is not completed. When resident comes in with PASSR, complete in Simple he enters the information. If it is triggered for PASSR 2, he will let social worker know to contact Metro. How do you contact SW? Regarding Mr. [NAME] - IDT has been scheduled, [NAME] from Metro Care will send the appointment info. Should it have already occurred? He could not tell you the date of PASSR level 2 screening. The lady IDT was here today and said it was scheduled, his was done in July 2023, he said it doesn't usually take this long. It usually takes 2-3 weeks. He cannot answer why it has taken over a year to get level 2 PASSR. Can you confirm that metro was notified that they were notified he was triggered, it is up to the social worker.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47030 Based on observations, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident to meet the resident's medical and nursing needs for one (Resident #57) of four reviewed care plans. The facility failed to develop a care plan to address Resident #57 smoking. This failure could place residents who smoke at harm due to not completing safe smoking assessment. Findings included: Review of Resident #57's quarterly MDS Resident Assessment, dated 10/03/24, revealed he was a [AGE] year-old male who admitted to the facility on [DATE]. His active diagnoses included Non-Alzheimer's Dementia, Malnutrition, Asthma, and Chronic Obstructive Pulmonary Disease. MDS revealed Resident #57's ADLs related to going from sitting to standing, transferring from chair to bed and back to chair, and walking 50 feet with 2 turns requiring Moderate Assistance helper does less than half the effort in lifting, and supporting resident's trunk. Review of Resident #57's Safe Smoking Assessment on 12/02/24 revealed he required supervision when smoking. Review of Resident #57's Comprehensive Care Plan dated 10/15/24 revealed there was no care plan for his smoking. In an interview on 12/8/2024 at 1:30pm Resident #57 revealed he was good but he did not elaborate even when asked for more details. Resident #57 did not respond when attempting to inquire about his smoking habit. In an interview on 12/10/2024 at 3:08pm with the Administrator revealed Resident #57's smoking was not care planned. The Administrator revealed the importance of care planning Resident #57's smoking is to make sure staff as other providers are aware the resident smokes. Review of undated Facility Policy titled Comprehensive Care Planning revealed, the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observation, interview and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for one (Resident #104) of four residents reviewed for ADL care. 1. The facility failed to provide Resident #104 with thorough incontinence care on 12/08/24. This failure could place residents at risk for a skin breakdown and infection. Findings included: 1. Record Review of Resident #104's quarterly MDS assessment, dated 08/17/24, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. The resident's BIMs score was 5 indicating the resident's cognition was severely impaired. The resident was dependent on staff for all personal hygiene. The resident was always incontinent of bowel and bladder. Her diagnoses included non-Alzheimer's dementia, muscle weakness, and lack of coordination. Record review of Resident #104's Care Plans, revised 04/08/24, reflected the resident had an ADL self-care performance deficit and required assistance by one staff with personal hygiene. The resident required assistance by staff for toileting. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455895	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER: Five Points at Lake Highlands Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE: 9009 White Rock Tr Dallas, TX 75238	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations and interviews on 12/08/24 at 12:37 PM revealed Resident #104 was in bed. The resident was awake, alert, but non-verbal. She did not respond to the Surveyor's questions. Her blanket had a soiled, large tan stain on it around the area of her brief. She appeared to be heavily soiled. The Surveyor walked out of the room and asked if a staff could assist the resident. CNA D entered the room. He looked at the soiled blanket and left the room. The Surveyor stayed outside of the room observing to see if anyone would assist the resident. At 12:48 PM the Surveyor asked again for staff to assist the resident. LVN G entered the resident's room and said she was her nurse. LVN G then walked out of the resident's room. The surveyor asked if she was going to assist the resident and LVN G said no, there was supposed to be an CNA assigned to the hall and an aide assigned to the dining room. She said it was currently lunch time. The Surveyor stayed to see if a staff was going to assist the resident. At 1:03 PM, CNA D entered the room and said he was going to provide incontinence care. The resident's brief was soiled with bowel movement and urine. CNA D folded down the resident's brief. CNA D used toilet paper and wipes to clean the peri-area and vagina. There was a large amount of bowel movement present. CNA D did not clean all of the bowel movement from the resident's peri-area. The resident was turned to her left side and CNA D used toilet paper and wipes to clean the bowel movement from the buttocks. CNA D pulled out the soiled brief. CNA D laid down a new brief and put it on the resident. The resident's peri-area area was still soiled with bowel movement. CNA D covered the resident's peri-area with the brief. The CNA started to fasten the brief. Surveyor asked CNA D if he was going to finish cleaning the resident. CNA D left the room and said he was going to get more help. At approximately 1:20 PM CNA D returned with CNA E. CNA D donned gloves and folded down the new brief and began cleaning and wiping the peri-area and vagina with wipes. CNA E told CNA D to be gentle. CNA D cleaned the bowel movement off the vagina and peri-area. CNA D changed gloves but did not perform hand hygiene. CNA D put on new gloves, rolled the resident to her side, and cleaned the resident's buttocks again. CNA D removed the soiled brief. CNA D put a new brief on the resident and removed his gloves. CNA E told CNA D that the resident needed more linen. CNA D left the room and returned with more linen. CNA D put on new gloves but tore his right glove. CNA D did not change gloves to apply the fresh linen. Incontinence care was completed at approximately 1:35 PM. An interview on 12/08/24 at 2:10 PM with CNA D revealed he did not thoroughly clean Resident #104's peri-area. He said he did not clean all of the bowel movement because he said maybe he did not see it because his peripheral vision was bad. He said if he did not thoroughly clean the resident, then she could get a bacterial infection. An interview on 12/09/24 at 3:34 PM with LVN F revealed she was the infection preventionist. She said she did an incontinence care check-off for CNA D on 12/08/24 and he passed after two tries. An interview on 12/10/24 at 1:56 PM with the DON revealed CNA D had to do a return demonstration check for incontinence care before he could return to working. She said she was not aware that CNA D said he had problems with his vision. The DON said the resident was at risk for infection if she was not cleaned thoroughly. Review of the facility policy, Nursing: Personal Care, dated 05/11/22, reflected: Purpose This procedure aims to maintain the resident dignity and self-worth and reduce embarrassment by providing cleanliness and comfort to the resident, preventing infections and skin irritation, and observing the resident's skin condition .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observations, interviews, and record review, the facility failed ensure that a resident who was incontinent of bowel received appropriate treatment and services to restore as much normal bowel function as possibleto for 1 (Resident #104) of 4 residents reviewed for incontinence care. 1. CNA D failed to clean Resident #104's peri-area during incontinence care provided on 12/08/24. These deficient practices affect residents who depend on nursing care and could place residents at risk for infection and harm. The findings included: 1. Record Review of Resident #104's quarterly MDS assessment, dated 08/17/24, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. The resident's BIMs score was 5 indicating the resident's cognition was severely impaired. The resident was dependent on staff for all personal hygiene. The resident was always incontinent of bowel and bladder. Her diagnoses included non-Alzheimer's dementia, muscle weakness, and lack of coordination. Record review of Resident #104's Care Plans, revised 04/08/24, reflected the resident had an ADL self-care performance deficit and required assistance by one staff with personal hygiene. The resident required assistance by staff for toileting. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 12/08/24 at 1:03 PM revealed Resident #104 was in bed. She was awake, alert, and non-verbal. CNA D entered the room to provide incontinence care. The resident's brief was soiled with bowel movement and urine. CNA D folded down the resident's brief. CNA D used toilet paper and wipes to clean the peri-area and vagina. There was a large amount of bowel movement present. CNA D did not clean all of the bowel movement from the resident's peri-area. The resident was turned to her left side and CNA D used toilet paper and wipes to clean the bowel movement from the buttocks. CNA D pulled out the soiled brief. CNA D changed gloves but did not perform hand hygiene. CNA D bagged the dirty laundry, removed his gloves and performed hand hygiene. CNA D donned new gloves. CNA D laid down a new brief and put it on the resident. The resident's peri-area area was still soiled with bowel movement. CNA D covered the resident's peri-area with the brief. CNA D was about to fasten the resident's brief. The Surveyor asked CNA D if he was going to finish cleaning the resident. CNA D left the room and said he was going to get more help. CNA D returned with CNA E. CNA E said she was not taking over incontinence care for the resident, but she was there to assist CNA D. CNA D said he was new to the facility but had been a CNA since 2016. CNA D donned gloves and folded down the new brief and began cleaning and wiping the peri-area and vagina with wipes. CNA E told CNA D to be gentle. CNA D cleaned the bowel movement off the vagina and peri-area. CNA D changed gloves but did not perform hand hygiene. CNA D put on new gloves, rolled the resident to her side, and cleaned the resident's buttocks again. CNA D removed the soiled brief. CNA D did not change gloves or perform hand hygiene. CNA D put a new brief on the resident and removed his gloves. He did not perform hand hygiene and proceeded to turn and reposition the resident with no gloves. CNA E told CNA D that the resident needed more linen. CNA D left the room and returned with more linen. CNA D put on new gloves but tore his right glove. CNA D did not change gloves to apply the fresh linen. CNA D removed gloves and picked up the soiled linen bag and the soiled trash bag with his bare hands and left the room. An interview on 12/08/24 at 2:10 PM with CNA D revealed he did not thoroughly clean Resident #104's peri-area. He said he did not clean all of the bowel movement because he said maybe he did not see it because his peripheral vision was bad. He said if he did not thoroughly clean the resident, then she could get a bacterial infection. CNA D said he started working at the facility on 09/28/24 and said he was going to be checked off on incontinence care on 12/08/24. He said his training included 2-3 days of training with another staff. CNA D said he was not supposed to wear torn gloves and he was supposed to preform hand hygiene when changing his gloves. He said hand hygiene was important to prevent spreading feces, urine, flu, and COVID. An interview on 12/09/24 at 3:34 PM with LVN F revealed she was the infection preventionist. She said for staff doing incontinence care, they needed to change gloves and do hand hygiene when going from dirty to clean. She said there was a risk of infection if hand hygiene was not performed. She said she did an incontinence care check-off for CNA D on 12/08/24 and he passed after two tries. An interview on 12/10/24 at 1:56 PM with the DON revealed CNA D had to do a return demonstration check for incontinence care before he could return to working. She said staff were supposed to change their gloves when going from dirty to clean areas and they were not supposed to wear torn gloves. The DON said staff were supposed to use gloves to remove trash. She said she was not aware that CNA D said he had problems with his vision. The DON said the resident was at risk for infection if she was not cleaned thoroughly. The DON said there was a risk of infection when staff did not change gloves and perform hand hygiene. Record review of the facility's Peri-Care Audit Tool, not dated, reflected CNA D was checked of on incontinence care and hand hygiene on 08/29/24 and 12/08/24. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy, Nursing Assistant Clinical Skills Checklist and Competency Evaluation, dated February 2019, reflected: Provides Perineal Care (Peri-Care) for Female 4. Puts on clean gloves before washing perineal area. 5. Places pad/linen protector under perineal area including buttocks before washing. 6. Exposes perineal area (only exposing between hips and knees). 7. Applies soap to wet washcloth. 8. Washes genital area, moving from front to back, while using a clean area of the washcloth for each stroke. 9. Using clean washcloth, rinses soap from genital area, moving from front to back. while using a clean area of the washcloth for each stroke. 10. Dries genital area moving from front to back with dry cloth towel/washcloth. 11. After washing genital area, turns to side, then washes rectal area moving from front to back using a clean area of washcloth for each stroke .

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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. 37193 Based on observation, interview, and record review it was determined the facility failed to ensure drugs and biologicals were stored and labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions, and the expiration date when applicable on one of five carts the medication cart. Medication cart contained an insulin pen of Humalog open with no open date. This failure could place residents receiving medications at risk for drug diversion, drug overdose, and accidental or intentional administration to the wrong resident which could lead to exacerbation of their disease process and deterioration in general health. Findings include: During observation/interview on 12/11//24 at 02:10 PM of the medication cart with LVN A, observation of top-drawer holding insulin, found an insulin pen of Humalog insulin with no open date. LVN A stated insulin expired 28 days after opening it and a negative outcome could be the medication loses potency and could be ineffective. During an interview on 12/10/24 at 03:29 PM with the DON she stated weekly the unit manager (ADON's) were supposed to check for any expired medications in the medication carts and the pharmacists checked the medication carts monthly. The DON stated she expected the nurses to label and dates all insulin in the cart. This was supposed to be completed to prevent side effects like being ineffective if they were expired, also chemical composition of the medications could change if the medication was expired. During an interview on 12/10/24 at 03:51 PM with ADON C she stated with the other ADON's they were to check the medication carts weekly and removed all the expired medication and check for medications that was supposed to be labelled to make sure it was labeled. ADON C stated Humalog insulin was good for 28 days and it was supposed to be dated when it was opened. ADON C stated the insulin was to be dated to prevent administering medication that was expired which could be infective to the resident. Facility policy review titled Recommended Medication Storage, revised 07/2012 reflected, INSULINS (Vials, Cartridge, Pens) Humulin R, N, 70/30 and Mix Humalog and Humalog Mix Humalog FlexPen 75/25 and 50/50 pens expire 10 days after opening. Novolog and Novolog Mix Insulin Glargine (Lantus) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Insulin Glargine (Apidra) Expires 28 days after initial use regardless of product storage (refrigerated or room temperature). Insulin Detemir (Levemir) Expires 42 days after initial use regardless of product storage (refrigerated or room temperature).

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observation, interview, and record review, the facility failed to ensure each resident received food prepared in a from designed to meet individual needs for one (Resident #6) of 3 residents reviewed for nutrition services. The facility failed to ensure the lunch meal served to Resident #6 on 12/08/24 had the appropriate consistency for the meat serving for the mechanical soft diet. The deficient practice could affect residents who received mechanical soft meals from the kitchen by contributing to choking, poor intake, and/or weight loss. The findings included: 1. Record review of Resident #6's annual MDS assessment, dated 11/13/24, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His BIMS score was 13 which indicated his cognitive status was intact. The resident required supervision for eating. His diagnoses included difficulty swallowing and respiratory failure. The resident required a mechanically altered diet. Record review of Resident #6's care plans, dated 08/29/24, reflected he was on a mechanical diet. Facility interventions included: Determine food preferences and provide within dietary limitations. Encourage meal completion and document amount consumed. Monitor weight per facility protocol. An interview on 12/08/24 at 11:10 AM with Resident #6 revealed he was awake, alert, and oriented. He was laying in bed. He said he had problems chewing his food. He said the vegetables were not soft and he needed his meat to be ground up. He said he did not have enough strength to chew meat that was chopped instead of ground. An observation on 12/08/24 at 1:35 PM revealed Resident #6 was finishing his meal. He said he was not able to eat the meat. The meat was still on his plate and was in big chunks on his plate. It was not finely chopped or ground. The resident's meal ticket said he was on a mechanical soft diet. An interview on 12/08/24 at 2:33 PM with the Dietary Manager revealed the meat served on the lunch meal tray for 12/08/24 was pot roast. She said the mechanical soft diet should have had ground pot roast. The Dietary Manager said with Resident #6 he did not like his hamburgers to be ground up. She said she had spoken to him before about his meals. She said she did not realize the resident was not able to eat his pot roast because it was not ground up. The Dietary Manager said it was important for the meat to be served the right texture so that the resident would not choke or aspirate. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 12/10/24 at 12:15 PM with ADON I revealed the nurse on duty checked the food trays. She said for the mechanical soft diet, the meat was supposed to be soft and finely chopped. She said for Resident #6, sometimes he did not want his meat ground up. She said she was not aware of other residents getting the wrong textured meat and that no residents had choking incidents. An interview on 12/10/24 at 1:48 PM with the DON revealed she did not know why Resident #6 did not receive ground meat on his lunch tray on 12/08/24. She said the resident did like to eat outside food and was able to eat whole hamburgers. She said she did not know what the facility policy said about mechanical soft diets. She said a resident who received the wrong textured meat was at risk for choking. Review of the facility policy, Recommended Diets, dated 2019, reflected: Mechanical Soft Diet This diet is based on the Regular Diet or any other therapeutic diet. Modifications are made only in texture. This diet is designed for persons with chewing or swallowing difficulty. In addition to minced and moist meat or flaked fish served in sauce or gravy, with an average particle size of approximately 4 mm (slightly less than half a centimeter) in width and less than 15 mm (1 1/2 centimeters) in length, some modifications are also made to the fruits and vegetables; most fruits and vegetables are not served raw, and others may be finely or coarsely chopped .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45053 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen safety. 1. The facility failed to ensure food in the facility's dry storage, refrigerator, and freezer areas were labeled and dated according to guidelines. 2. The facility failed to seal open items in plastic bags in the dry storage pantry, refrigerator, and freezer areas. 3. The facility failed to ensure that expired items in the dry storage pantry, refrigerator and freezer areas were removed. These deficient practices could affect residents who received meals and/or snacks from the main kitchen and place them at risk for cross contamination and other air-borne illnesses. Findings Included: Observation of the kitchen during the brief initial tour of the kitchen on [DATE] at 9:33 AM, revealed the following: Dry storage area *One box of twenty-five 4 fl. oz. of thickened unflavored water that expired on [DATE], *One box of thirty-eight 4 fl. oz. of thickened orange juice with an expiration date of [DATE], *3 juice containers of 46 fl. oz. thickened cranberry cocktail with an expiration date of [DATE], *1 juice container of 46 fl. Oz. thickened sweet tea with an expiration date of [DATE], *One box of forty-eight fl. oz. of thickened orange juice with a sticker labeled [DATE] with an expiration date on the box of [DATE], *One bag of Spaghetti Noodles that was encased with unsealed saran wrap, *18 boxes of 16 oz. of pure baking soda with an expiration date of [DATE]. *3 containers of 12 oz. of squeezable honey that were unsealed. *Three 5 lb. jars of creamy peanut butter that were unsealed. Freezer (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	area contained *one 46 fluid . oz. container of Thickened Cranberry Cocktail with an expiration of [DATE]. Refrigerator * 1 grey plastic container labeled, item: fruit, date: [DATE], and use by [DATE]. The grey plastic container of fruit included mixed slices of honeydew melon, watermelon and cantaloupe, the container was sealed with partially with saran wrap and was unsealed. There was a white sticker label on the grey container of mixed fruit . *1 tray of 22 cups of ketchup that sealed with partially with saran wrap and was unsealed. In an interview with the Dietary Manager on [DATE] at 11:34 AM, she stated she has been employed at the facility as the Dietary Manager for 1 year. She stated all staff are responsible for ensuring items in the kitchen's dry pantry, refrigerator, and freezer areas are not expired and unsealed. She stated she would audit everything in the kitchen to ensure there were not any unopened and expired items in the dry pantry, refrigerator and freezer areas. She stated she would throw away all expired items in the kitchen and the unsealed items as well. She stated her expectation was for staff to throw away any items that are expired or opened in the kitchen's dry pantry, refrigerator and freezer areas and notify herself or the Dietary Aide of what they found. She stated staff have received several in-services relating to food preparation, store, labeling and immediately removing expired items. She stated staff have been trained and educated when they are restocking to place the items already on the shelf in the front and the new items behind the items that were already shelved. She stated she would throw away the expired items in the kitchen and retrain and reeducate the staff via in-service trainings. She stated the facility had ran out of the tops for the ketchup containers, therefore they used the saran wrap to cover the entire sheet pan. She stated the saran wrap over the ketchup should have been securely sealed. In an interview with [NAME] Q on [DATE] at 12:01 PM, she stated that she had been employed at the facility for 1 year. She stated that she was unaware that there were expired and unsealed items in the dry storage, refrigerator, and freezer areas. She stated that all the staff were responsible for storing the items on the shelf and checking the expiration dates on everything in the kitchen. She reported that weekly assigned staff members are to look at the items in the kitchen, including the dry storage, freezer and refrigerator to ensure that the items are sealed, labeled, dated and not expired. She stated that staff are in-serviced on different subject matter every week. She stated that she had taken in-service trainings on food preparation and storage and her last in-service training was last week. She stated that if a staff member sees an item(s) that are expired, the staff member was to throw the item away in the trash can and then inform the Dietary Manager or Dietary Aide what they threw away. She stated that everything in the dry storage, freezer and refrigerator should be labeled and dated. [NAME] Q stated that if someone ingested food that had been cross-contaminated, there was a risk that someone could get an airborne illness and potentially cause harm and sickness. She stated that with food in the dry pantry, refrigerator and freezer areas being unsealed and expired items can cause anyone who ingests the food to have an airborne illness an become sick and cause them harm. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Dietary Aide on [DATE] at 12:16 PM, she stated that she had been employed at the facility for 2 years. She stated that she was unaware that there were expired and unsealed items in the dry storage and freezer areas. She advised that all the staff were responsible for storing the items on the shelf and checking the expiration dates on everything in the kitchen. She stated that her expectations for all staff in the kitchen is to use the First In, First Out Method, which means that kitchen staff should label the food with the dates they store them, and when staff are restocking the shelves, they are to put the older foods in front or on top so they can be used first. She stated that this system allowed the kitchen staff to find the food quickly and use it more efficiently. She stated that she and the Dietary Manager have weekly meetings to reiterate what their expectations are relating to food storage. She stated she and the Dietary Manager In-Services staff every month on food storage, labeling and dating and removing expired items from the shelves in the dry pantry, freezer, and refrigerator areas. She stated that there are risks of airborne illness anytime someone that ingest food items from the kitchen any items that have not been label and stored properly. She stated that she does not feel that there was any harm done in relation to the findings that she was informed about because no residents were harmed due to the items immediately being thrown away. Record review of the facility's policy titled Food Storage and Supplies, dated, 2012 reflected, All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies . Procedure: 3. Dry bulk foods (e.g. flour, sugar) are stored in seamless metal or plastic containers with tight covers or bins which are easily sanitized. Containers are labeled. Best practice is that scoops should not be left in food containers or bins, but if so, handles should be upright and not contacting the food item. Containers are cleaned regularly. 4. Open packages of food are stored in closed containers with covers or in sealed bags, and dated as to when opened. 6. When items are received from the vendor, they should be first examined for expiration date, and if an expiration date is present, it is beneficial to mark it by circling it so it is readily visible and noticeable .Any product with a stamped expiration date will be discarded once that date passes. 7. According to the USDA fact sheet on Food Product dating, product dating on manufactured goods is not required by federal regulations except baby formula. For this reason, products without a dated shipping label should be dated when they are received by the facility so there is a method to keep track of the age of the product. These dates do not indicate that the product is no longer safe after one year, but give a method to track the age of a product so that it can be evaluated for quality before service. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. On perishable foods, microorganisms such as molds, yeasts, and bacteria can multiply and cause food to spoil. Spoiled foods will develop an off odor, flavor or texture due to naturally occurring spoilage bacteria. If a food has developed such spoilage characteristics, it should not be eaten. There are two types of bacteria that can be found on food: pathogenic bacteria, which cause foodborne illness, and spoilage bacteria, which causes foods to deteriorate and develop unpleasant characteristics such as an undesirable taste or odor making the food not wholesome, but do not cause illness. Perishable foods have been processed/treated and sealed to eliminate pathogenic bacteria, but spoilage bacteria can multiply and this is what causes the food to deteriorate in quality and taste. If perishable food items are not stored at the proper temperature, spoilage bacteria can grow faster than anticipated and food becomes spoiled and should not be served. Food items such as loaves of bread or dairy products with a stamped best-by or use by date do not need to be labeled when opened as this will not affect the date by which they should be used. However, if possible food spoilage is observed prior to the best by date, the product will be discarded . Record review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S , d+[DATE].18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts ,d+[DATE] - ,d+[DATE].

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 37028 Based on observation, interviews, 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 three (Resident #104, Resident #62, and Resident #89) of nine residents observed for infection control. 1. The facility failed to ensure CNA D performed hand hygiene while providing incontinence care to Resident #104. 2. The facility failed to implement enhanced barrier precautions for Resident #62 and Resident #89. These failures placed residents at risk for healthcare associated cross contamination and infections. Findings included: 1. Record Review of Resident #104's quarterly MDS assessment, dated 08/17/24, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. The resident's BIMs score was 5 indicating the resident's cognition was severely impaired. The resident was dependent on staff for all personal hygiene. The resident was always incontinent of bowel and bladder. Her diagnoses included non-Alzheimer's dementia, muscle weakness, and lack of coordination. Record review of Resident #104's Care Plans, revised 04/08/24, reflected the resident had an ADL self-care performance deficit and required assistance by one staff with personal hygiene. The resident required assistance by staff for toileting. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 12/08/24 at 1:03 PM revealed Resident #104 was in bed. She was awake, alert, and non-verbal. CNA D entered the room to provide incontinence care. The resident's brief was soiled with bowel movement and urine. CNA D folded down the resident's brief. CNA D used toilet paper and wipes to clean the peri-area and vagina. There was a large amount of bowel movement present. CNA D did not clean all of the bowel movement from the resident's peri-area. The resident was turned to her left side and CNA D used toilet paper and wipes to clean the bowel movement from the buttocks. CNA D pulled out the soiled brief. CNA D changed gloves but did not perform hand hygiene. CNA D bagged the dirty laundry, removed his gloves and performed hand hygiene. CNA D donned new gloves. CNA D laid down a new brief and put it on the resident. The resident's peri-area area was still soiled with bowel movement.CNA D covered the resident's peri-area with the brief. CNA D was about to fasten the resident's brief. The Surveyor asked CNA D if he was going to finish cleaning the resident. CNA D left the room and said he was going to get more help. CNA D returned to the room. CNA D donned gloves and folded down the new brief and began cleaning and wiping the peri-area and vagina with wipes. CNA D cleaned the bowel movement off the vagina and peri-area. CNA D changed gloves but did not perform hand hygiene. CNA D put on new gloves, rolled the resident to her side, and cleaned the resident's buttocks again. CNA D removed the soiled brief. CNA D did not change gloves or perform hand hygiene. CNA D put a new brief on the resident and removed his gloves. He did not perform hand hygiene and proceeded to turn and reposition the resident with no gloves. CNA D left the room and returned with more linen. CNA D put on new gloves but tore his right glove. CNA D did not change gloves to apply the fresh linen. CNA D removed gloves and picked up the soiled linen bag and the soiled trash bag with his bare hands and left the room. An interview on 12/08/24 at 2:10 PM with CNA D revealed he was not supposed to wear torn gloves and he was supposed to preform hand hygiene when changing his gloves. He said hand hygiene was important to prevent spreading feces, urine, flu, and COVID. An interview on 12/09/24 at 3:34 PM with LVN F revealed she was the infection preventionist. She said for staff doing incontinence care, they needed to change gloves and do hand hygiene when going from dirty to clean. She said there was a risk of infection if hand hygiene was not performed. An interview on 12/10/24 at 1:56 PM with the DON revealed staff were supposed to change their gloves when going from dirty to clean areas and they were not supposed to wear torn gloves. The DON said staff were supposed to use gloves to remove trash. The DON said there was a risk of infection when staff did not change gloves and perform hand hygiene. 2. Record review of Resident #62's Admission Record dated 12/9/24 reflected a [AGE] year-old male admitted to the facility on [DATE]. Record review of Resident #62's Admission MDS assessment dated [DATE] reflected he was rarely/never understood and had severely impaired cognition. His diagnoses included Hypertension (high blood pressure), stroke, dependence on dialysis; wound infection, dysphagia (inability to swallow), and Stage 4 (full thickness) pressure ulcer sacral region. He was dependent on staff for all ADLs, was fed via tube feeding, he had a Stage 4 pressure ulcer, venous or arterial ulcers present and was receiving dialysis. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #62's Care Plan dated 11/26/24 revealed he had a Stage 4 pressure injury to the sacrum, left stump arterial wound, right lateral leg arterial wound, right heel arterial wound, and right foot stump arterial wound. He required tube feeding and had a Midline IV. There no care plan entry for enhanced barrier precautions. Record review of Resident #62's Order Summary Report dated 12/9/24 reflected the following: -Enteral Feed Order every shift for PEG tube Administer Nepro or Novasource Renal 55 cc/hr x 20 hours a day. -Meropenem 500 mg intravenously every 12 hours for sacral wound. -Multiple daily medications to be administered via PEG tube. -PICC line dressing change to be completed every 7 days. -Wound care orders for dressing changes to be completed every Monday, Wednesday, and Friday on his left heel, left lateral leg, left stump wound, right foot stump wound, and sacral wound. -There were no orders for Enhanced Barrier Precautions. An observation and interview on 12/9/24 at 7:44 AM, revealed Resident #62 did not have enhanced barrier precautions signage outside his room. Resident #62 was observed lying in bed. He had a PEG tube feeding infusing at 55 cc/hr. He had a peripherally inserted central catheter (PICC) in his right upper arm. RN B prepared the resident's medications, washed his hands and donned gloves. RN B administered his medications which included flushing Resident #62's PICC line with normal saline and hanging his IV antibiotic. He disconnected the resident's PEG tube feeding and administered six different medications via the tube with water flushes between each the medications. RN B reconnected his tube feeding following the medication administration. RN B never donned a gown. RN B stated Resident #62 was not on enhanced barrier precautions, so a gown was not necessary. He stated the resident did not have the type of infection that would warrant enhanced based precautions. RN B stated the facility's Infection Preventionist determined whether the resident's required precautions. He stated he had other residents on enhanced based precautions which were important to maintain the safety of residents and staff and to keep them from getting infections. 3. Record review of Resident #89's Admission Record reflected a 74-year-oled male admitted to the facility on [DATE]. Record review of Resident #89's Admission MDS assessment dated [DATE] reflected his BIMS score was 12 indicating moderately impaired cognition. His diagnoses included coronary artery disease, end-stage renal disease, cellulitis (bacterial skin infection) of the right lower limb, and a pressure ulcer of the right heel. He was dependent on staff for toileting, bathing and hygiene and was receiving dialysis. Record review of Resident #89's Care Plan dated 10/1/24 reflected he had an unstageable pressure injury to his right heel, a diabetic foot ulcer to his left plantar (bottom) left foot and lateral left foot, and he required assistance with toileting and bathing. There was no care plan entry reflecting enhanced barrier precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #89's Order Summary Report dated 12/9/24 reflected he had order to monitor his PermaCath (tube inserted into his chest to be used for dialysis treatments) for signs and symptoms of infection every shift as well as wound care orders for his diabetic and pressure wounds on both feet to be completed every Monday, Wednesday and Friday. During observations and interviews on 12/9/24 at 11:00 AM revealed Resident #89 had no enhanced barrier precaution signage outside his room. Resident #89 was sitting on the side of his bed with his feet on the floor. Dressings were observed on both his feet which were dated 12/9/24. He had a permacath observed on his right chest, the insertion site was covered with a dressing and the tubing was capped and hanging beneath the dressing. CNA O, CNA P, and the RN N entered the room, washed their hands and donned gloves. No gowns were worn by any staff. Resident #89 was assisted with repositioning in the bed by the CNAs and RN N. RN N removed the resident's dressings from his feet for skin observations. She performed hand hygiene between the dressing removals and reinforced the dressings once complete. CNA O and CNA P performed incontinent care for Resident #89 and assisted him with getting dressed. No Gowns were donned throughout the care. RN N stated Resident #89 was not on enhanced barrier precautions because he had no active infections. She stated the decision to place a resident on enhanced barrier precautions was made by the DON and the infection preventionist. During an interview on 12/10/24 at 3:11 PM, ADON C identified herself as the Infection Preventionist for the facility. She stated she reviewed hospital paperwork and physician notes to determine the precautions needed for each resident. ADON C stated she had somehow missed Resident #62 and Resident #89 and both should have previously been placed on enhanced barrier precautions based on their assessments. She stated the risk of failing to implement enhanced barrier precautions was transmission of infection. Review of the CDC website on 12/10/24 reflected: https://www.cdc. gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html reflected: Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices) . Enhanced Barrier Precautions expand the use of gown and gloves beyond anticipated blood and body fluid exposures. They focus on use of gown and gloves during high-contact resident care activities that have been demonstrated to result in transfer of MDROs to hands and clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated. Enhanced Barrier Precautions are recommended for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Standard Precautions still apply while using Enhanced Barrier Precautions. .Enhanced Barrier Precautions require the use of gown and gloves only for high-contact resident care activities (unless otherwise indicated as part of Standard Precautions). .Assuming Contact Precautions do not otherwise apply, Enhanced Barrier Precautions are recommended for residents with any of the following: 1) infection or colonization with a MDRO or 2) a wound or indwelling medical device, even if the resident is not known to be infected or colonized with a MDRO . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy, Infection Control, dated March 2024, reflected: Infection Control The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection . The facility will require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. The facility will require staff to donn and doff PPE before and after contact with resident who needs isolation to prevent the spread of infection to others in the facility . 1. Hand Hygiene Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene: o When coming on duty; o When hands are visibly soiled (hand washing with soap and water); Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice) . o Before and after entering isolation precaution settings . o Before and after assisting a resident with personal care (e.g., oral care, bathing) . o Upon and after coming in contact with a resident's intact skin, (e.g., when taking a pulse or blood pressure, and lifting a resident); o After personal use of the toilet (hand washing with soap and water); o Before and after assisting a resident with toileting (hand washing with soap and water) . o After handling soiled or used linens, dressings, bedpans, catheters and urinals . o After removing gloves or aprons . Enhanced Barrier Precautions. Multidrug-resistant organism (MDRO) transmission is common in long term care (LTC) facilities. Many residents in nursing homes are at increased risk of becoming colonized and developing infections with MDROs. 'Enhanced Barrier Precautions' (EBP) refer to an infection control intervention designed to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities .EBP are indicated for residents with any of the following: Colonization with CDC-targeted MDRO when contact precautions do not otherwise apply .or; wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage . (e.g., Band-Aid(R)) or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. Indwelling medical device examples include central lines, urinary catheters, feeding tubes . A peripheral intravenous line (not a peripherally inserted central catheter) is not considered an indwelling medical device for the purpose of EBP . A chart titled, Donning PPE for Residents Based on Activity Provided/Assistance While in Resident Room reflected staff should don gloves and gown during the following activities: Administer medications enterally [such as through a gastrostomy tube], Perform wound care: any skin opening requiring a dressing, and Device care or use: central line .feeding tube .