STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455904	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rowlett Health and Rehabilitation Center	9300 Lakeview Pkwy Rowlett, TX 75088

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for one (Resident #78) of eight residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #78's rooms were in a position that was accessible to the residents. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. Findings included: Review of Resident #78's Face Sheet, dated 06/19/2024, reflected that resident was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included difficulty walking, unsteadiness of feet, and weakness. Review of Resident #78's Quarterly MDS Assessment, dated 04/19/2024, reflected Resident #78 had a moderate impairment in cognition with a BIMS score of 11. Resident #15 required moderate assistance for upper body dressing and lower body dressing. Review of Resident #78's Comprehensive Care Plan, dated 05/02/2024, reflected Resident #78 was at risk for falls related to poor balance and lack of coordination, and weakness and one of the interventions be sure the call light is within reach and encourage to use it to call for assistance as needed. Review of Resident #78's Joint Mobility Evaluation, dated 05/22/2024, reflected resident had limited range of motion to both shoulders, both elbows, and both wrists. Review of Resident #78's Fall Risk Assessment, dated 05/16/2024, reflected resident had a minimum risk for fall. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with Resident #78 on 06/18/2024 at 11:25 AM revealed that Resident #78 was sitting at the side of her bed. Resident #78's call light was noted pinned between the bed and the wall. Resident #78 reached out her left arm and tried to pull the cord of the call light but stated she cannot pull it because it was trapped between the bed and the wall. She stated that whoever fixed her bed did not notice that the call light could not be accessed and was not able to pull it back to put it on top of the bed. She stated she would use her roommates call light if she needed assistance. She said the staff should put her call light where she could reach it because her arms were not strong enough to pull it. Observation on 06/19/20204 at 7:55 AM revealed that Resident #78 was sitting on her bed talking to a visitor. Her call light was still pinned between the bed and the wall and resident still cannot pull it. In an interview with CNA C on 06/19/2024 at 10:57 AM, CNA C stated she was assigned on Resident #78's hall. CNA C said she did her round at the start of her shift to check if any resident needed to be changed or transferred to the wheelchair. She said she also monitor if the call lights were with the residents. She said she did not notice that Resident #78's call light was pinned between the bed and the wall and cannot be pulled. She said Resident #78 seldom use the call light but said she must still make sure the call light was accessible when needed. She said call light must always be accessible because the residents use them to call the staff for any need and in cases of emergencies. CNA C added that if the call lights were not with the residents, the needs of the resident will not be known and addressed. She said she was responsible in ensuring the call lights were accessible for her assigned residents. She said she would her round and make sure the call lights were accessible to her assigned residents. In an interview with the DON on 06/19/2024 at 11:18 AM, the DON stated the call lights were inside the residents' rooms for a reason. He added the residents used the call lights to call for assistance, for a glass of water, for a pain medication, or for incontinent care. The DON added without the call lights, the residents would not be able to tell the staff what they needed and eventually their needs would not be met. The DON further added when the residents cannot pull or access their call lights, unfavorable incidents like falls, minor hurts, or major injuries could happen. The DON said the expectation was for the staff to ensure that the call lights were within reach of the residents at all times. The DON concluded that moving forward, he would educate the staff of the importance of call lights for the residents and would include the issue on their morning meeting. In an interview with LVN A on 06/20/2024 at 7:32 AM, LVN A stated call lights should be within the reach of the residents at all times. LVN A said the call lights should not be in position where the resident cannot pull it or access it. She said for some residents, the call light was their sense of protection that if something happened to them, they would be able to call the staff for help. She said the residents also use the call lights if they needed to be changed or they needed a pain medication. LVN A said the residents might fall trying to get up and get what they needed. LVN A said everybody was responsible in making sure the call lights were with the residents, whether the resident was independent or not. She said she would check her rooms to see if the residents had their call lights (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's policy Call Light/Bell Policy/Procedure - Nursing Clinical revised 05/2007 revealed, Policy: It is the policy of this facility to provide the resident a means of communication with nursing staff . Procedures . 5 . Place the call device withing resident's reach before leaving room.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observations, interviews, and record review the facility failed to provide a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for areas in the facility for 6 (Resident room [ROOM NUMBER], #513, #515, #517, #519, and #522) of 14 resident rooms observed for a safe, clean, comfortable, and homelike environment. The facility failed to ensure that Residents room [ROOM NUMBER], #513, #515, #517, #519, and #522 were cleaned and sanitized. This deficient practice could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life. Findings included: An observation on 06/18/24 at 10:50 AM of Resident room [ROOM NUMBER]'s reflected the air conditioning located in the room had dirt particles and black dirt grime on the top and between the vents of the units. The air filters had a thick layer of dust on them. One of the two lights in the resident bathroom was out. The corners of the bathroom floor had built up thick dirt and grime. An observation on 06/18/24 at 10:54 AM of Resident room [ROOM NUMBER] reflected the air conditioning located in the room had dirt particles and black dirt grime on the top and between the vents of the units. The air filters had a thick layer of dust on them. The corners of the bathroom floor had built up thick dirt and grime. The faucet on the bathroom sink had thick built up calcium deposits along the base of the faucet. An observation on 06/18/24 at 10:58 AM of Resident room [ROOM NUMBER] reflected the air conditioning located in the room had dirt particles and black dirt grime on the top and between the vents of the units. The air filters had a thick layer of dust on them. The corners of the bathroom floor had built up thick dirt and grime. The faucet on the bathroom sink had thick built-up calcium deposits along the base of the faucet. The top of one of the nightstands had thick milky stains all over the top of it. An observation on 06/18/24 at 11:02 AM of Resident room [ROOM NUMBER] reflected the air conditioning located in the room had dirt particles and black dirt grime on the top and between the vents of the units. The air filters had a thick layer of dust on them. An observation on 06/18/24 at 11:04 AM of Resident room [ROOM NUMBER] reflected the air conditioning located in the room had dirt particles and black dirt grime on the top and between the vents of the units. The air filters had a thick layer of dust on them. The corners of the bathroom floor had built up thick dirt and grime. The faucet on the bathroom sink had thick built-up calcium deposits along the base of the faucet. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 06/18/24 at 11:07 AM of Resident room [ROOM NUMBER] reflected the air conditioning located in the room had dirt particles and black dirt grime on the top and between the vents of the units. The air filters had a thick layer of dust on them. The airduct along the wall had black dirt stains. An interview on 06/19/24 at 1:33 PM with Housekeeping D, she stated she had been at the facility for 18 months. She stated that when she first started, she was told to pick up trash, mop and sweep floor, wipe down doors, windowsills, and the nightstands. She stated they are supposed to clean the air conditioner unit. She stated they are supposed to clean the outer part of the unit. She stated that she thinks maintenance cleans the air filters. She was shown pictures of the concerns observed in the resident room [ROOM NUMBER], #513, #515, #517, #519, and #522, and she stated that maintenance was needed to replace the heavily stained faucets, fix the tiles, and clean the air filters. She stated she would get someone from maintenance to clean the air filters. She stated the housekeeping supervisor was on vacation this week and she was in charge until their return. She stated the risk of the filters not being cleaned thoroughly could prevent the resident from getting fresh air. An Interview on 06/19/24 at 1:46 PM with the Maintenance Director, he stated he had been at the facility for two years. He stated maintenance was supposed to change the air filters quarterly. He stated housekeeping was supposed to clean the air filters in the air condition unit in the rooms while they are cleaning the unit itself. He was shown pictures of the concerns observed in rooms #511, #513, #515, #517, #519, and #522, he stated that maintenance only cleans the unit in the ceiling and the main unit. He stated he would coordinate with housekeeping to ensure that the filters in the 500-hall were cleaned. He was advised of the faucets in the resident rooms that had a lot of calcium buildup. He stated the risk of the air condition units not being cleaned thoroughly could cause medical issues for the resident. Review of the facility's policy on Safe/Comfortable/Homelike Environment (Revised 2022) reflected Housekeeping and Maintenance services include the cleaning, sanitization, and care for rooms and common areas of the facility to ensure that the facility is safe for all who reside, work, and visit.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observations, interviews and record reviews, the facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents ' choices for 1 (Resident #46) of 1 resident reviewed. for quality of care. The facility failed to to obtain physician orders and assess Resident #46 for a scoop mattress and obtain physician orders prior to installing the scoop mattress. This failure could prevent the resident to be free from of any physical or chemical restraints. Findings included: Record review of Resident #46's Face Sheet, dated 06/19/2024, revealed she was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included unspecified dementia (memory decline), lack of coordination, and repeated falls. Record review of Resident #46's Quarterly Minimum Data Set (MDS) dated [DATE] revealed, she had a Brief Interview for Mental Status (BIMS) score of 06 (severe cognitive impairment) and for ADL care it stated, for transfers, toileting, and bathing, the resident required moderate assistance. Record review of Resident #46's physician orders dated 06/19/24 revealed no orders for a scoop mattress. Observation on 06/18/24 at 11:03 AM of Resident #46's bed revealed she was observed having a scoop mattress. An interview and observation on 06/19/24 at 10:00 AM with LVN L, she stated she was the nurse for Resident #46. She stated the resident is totally independent and did not require assistance to get into or out of her bed. She stated the resident should not have a scoop mattress. LVN L went into Resident #46's room and observed that the resident did have a scoop mattress on her bed. She stated she was not sure how the resident got the mattress. She stated the resident had just changed rooms and they may have just left the scoop mattress and not replace it. She stated the risk of the resident having the scoop mattress without physician orders or an assessment could result in the result having a fall when trying to get into and out of bed. An interview on 06/20/24 at 10:45 AM with the DON, he stated he was made aware of Resident #46 having a scoop mattress. He stated the residents had recently changed rooms and when the resident was moved into the room, staff failed to change the mattress. He stated they have since changed out the mattress to a more appropriate one. He stated the risk of the resident having a scoop mattress could result in her injuring herself. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy on Physician orders, dated 08/2007, stated It is the policy of this facility to ensure that no resident is placed in physical restraints for the purpose of discipline or convenience and that restraints are only applied to treat the resident's medical symptoms. All residents requiring physical restrains will be assessed for least restrictive measures prior to restraint application and restraints will be reduced as appropriate to the resident's medical condition. No resident will have a physical restraint placed for positioning purposes unless there is clearly no other alternative.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review, the facility failed to ensure that Residents, who needed respiratory care, was provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 2 (Resident #321 and Resident #322) of ten residents reviewed for respiratory care. The facility failed to ensure Resident #321's nebulizer masks and nasal cannula was properly stored. The facility failed to ensure Resident #322's nasal cannula was properly stored. The facility failed to ensure a Physician's Order was in place for Resident #322's oxygen administration. These failures could place the residents at risk for respiratory infection and not having their respiratory needs met. Findings included: Resident #321 Review of Resident #321's Face Sheet, dated 06/19/2024, reflected that resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs) with exacerbation and acute respiratory failure with hypoxia (insufficient amount of oxygen in the body). Review of Resident #321's Comprehensive MDS Assessment, dated 06/08/2024, reflected resident had a severe impairment in cognition with a BIMS score of 07. The Comprehensive MDS Assessment indicated Resident #321's primary medical condition was chronic obstructive pulmonary disease with exacerbation. Review of Resident #321's Comprehensive Care Plan, dated 06/08/2024, reflected resident had an altered cardiovascular status related to COPD (chronic obstructive pulmonary disease) and respiratory failure and the interventions were to administer nebulizer treatment and oxygen as ordered. Review of Resident 321's Physician Order, dated 06/04/2024, reflected, Ipratropium-Albuterol Solution 0.5-2. 5 (3) MG/3ML. 1 vial inhale orally three times a day for wheezing, sob (shortness of breath). Review of Resident 321's Physician Order, dated 06/18/2024, reflected, O2 AT 2-4 L/MIN CONTINUOUS PER via NC, every shift. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with Resident #321 on 06/18/2024 at 9:40 AM revealed that Resident #321 was on her bed resting. Resident #321 was on oxygen administration via nasal cannula. It was also noted that her mask for breathing treatment was on top of the side table. The breathing mask was not bagged. Resident #321 also had a portable oxygen tank at the back of her wheelchair. A nasal cannula was attached to the portable oxygen tank. The tubing of the nasal cannula was hanging on the backrest of the wheelchair with the prongs of the nasal cannula touching the seat of the wheelchair. The nasal cannula was not bagged. According to the resident, she had breathing treatment every morning. She said the nurse would put it on and would take it off. Observation and interview with CNA B on 06/19/2024 at 7:51 AM, CNA B stated the Resident #321's nasal cannula was hanging at the backrest of her wheelchair. She said the nasal cannula should not be hanging and touching the wheelchair because the wheelchair could be dirty. She said it should be bagged when the resident was not using it so the nasal cannula will not be contaminated. She said whoever assist the resident from transferring from wheelchair to bed should put the nasal cannula in a bag. CNA B went inside the room to get the nasal cannula but then stopped halfway and said she would call the nurse to replace the nasal cannula. Observation and interview with LVN A on 06/19/2024 at 8:38 AM, LVN A stated the breathing mask and the nasal cannula should not have been exposed nor touching anything because it could cause contamination and possible infection. LVN A said the breathing mask and the nasal cannula should be bagged when not in use. LVN A went to Resident #321's room and saw the nasal cannula at the back of the wheelchair. LVN A disconnected the nasal cannula from the portable oxygen and threw it on the trash can. She said she would get a new nasal cannula for Resident #321. She said she would also change Resident #321's breathing mask because it was placed on top of the table. Resident #322 Review of Resident #322's Face Sheet dated 06/19/2024 reflected that resident was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included chronic obstructive pulmonary disease and chronic respiratory failure with hypoxia (long term condition where the lungs cannot get enough oxygen into the blood). Review of Resident #322's Care Plan on 06/19/2024 reflected no care plan for oxygen administration. Review of Resident #322's Physician Order on 06/19/2024 revealed no Physician Order for oxygen administration. Observation and interview with Resident #322 on 06/18/2024 at 9:48 AM revealed Resident #322 was on her bed, resting. It was noted that the resident had an oxygen concentrator at bedside. The oxygen concentrator was off. A nasal cannula was connected to the oxygen concentrator. The nasal cannula was hanging on top of the concentrator and was not bagged. Resident #322 stated she only use the oxygen if she needed it, like if she was having a hard time to breath. She said she had no recollection when was the last time she used her oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with LVN A on 06/19/2024 at 8:41 AM, after coming out of Resident #321's room, LVN A then went to Resident #322's room and saw the nasal cannula hanging on the oxygen concentrator. LVN A disconnected the nasal cannula hanging on the oxygen concentrator and threw it on the trash can. She went to the supply room to get a new nasal cannula, a breathing mask, and plastic bags. LVN A stated she needed to change the nasal cannula and the breathing mask to prevent any respiratory infection. Observation and interview with LVN A on 06/20/2024 at 8:12 AM, LVN A stated Resident #322's order for oxygen was PRN. She logged on to her laptop to verify the order. LVN A said there was no order for oxygen. She said there should be an order for Resident #322's oxygen supplement so the staff would know that the resident had respiratory needs. She said the order for oxygen should be reflected on the resident's physician orders on the system. LVN A said since resident #322 as her resident, she was responsible in putting in the order for oxygen. She added she would put in the order and then started typing the order in the system. In an interview with the DON on 06/19/2024 at 11:18 AM, the DON stated the breathing mask and the nasal cannula should be bagged when not in use. The DON said it was the proper way to store the breathing mask and the nasal cannula. He said if those breathing apparatus were not bagged, exposed, or touching surfaces that were not clean, then oxygen administration could be compromised. The DON said it could also result to contamination and infection. He said the staff, including him, were responsible for monitoring that the nasal cannula and the breathing mask were bagged when not in use. He said that if a resident was using some oxygen, there should be an order specific for oxygen concentration to reflect the amount of oxygen, the duration, and the delivery device. He said the order is essential so the staff would be on the same page in caring for the respiratory need of the resident. He said without the order, the respiratory need of the resident will not be met. He said the expectation was for the breathing mask and the nasal cannula would be stored properly. He continued that another expectation was the staff to put the order on the system if there was an order for oxygen administration. The DON concluded that moving forward, he would educate the staff and would continually remind them to be diligent in making sure the procedures for respiratory care were followed. Record review of facility's policy, Oxygen Administration Nursing Manual - Nursing Care rev. 06/2020 revealed Purpose: To prevent or reverse hypoxemia and provide oxygen to the tissues . III. Infection Control . A. All oxygen tubing, humidifiers, masks, and cannulas . B. Oxygen items will be stored in a plastic bag at the resident's bedside to protect the equipment from dust and dirt when not in use. Record review of facility's policy, Physician's Order, Telephone Orders and Recapitulation Process revised 11/2007 revealed, Policy: 1. Physician's orders shall be obtained prior to the initiation of any medication or treatment . Guidelines . 1 . order to the facility is necessary to show that the resident was admitted by a physician to this level of care . b.) Medication (Name, strength/dose, frequency, route of administration, diagnosis, PRN is to include specific reason).

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observation, interviews, and record reviews the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food storage, labeling, dating, and kitchen sanitation. The facility failed to ensure food in the facility's refrigerator, was labeled and dated according to guidelines. The facility failed to ensure food in the facility's freezer, was labeled and dated according to guidelines. The facility failed to ensure the ice machine scoop holder, located in the facility's kitchen, was cleaned. The facility failed to ensure kitchen equipment (storage bins) was cleaned and sanitary. These failures could place residents at risk for cross contamination and other air-borne illnesses. Findings included: Observations on 06/18/24 from 09:05 AM to 09:25 AM in the facility's only kitchen reflected: Observation of the ice machine, in the facility kitchen revealed the ice scoop was stored in a blue container, and the bottom of the containers had black stains in it. Two large white storage bins containing sugar and flour had black dirt stains along the outer and inner entrance of the container. The sugar had black particles in it. Two medium white storage bins containing brown sugar and rice had black dirt stains along the outer and inner entrance of the containers. One large bag of bread sticks with the date 6/17, and there was no other expiration or discatrd date. Facility policy dictates that the month, day and year should be listed, not just day and month. One bag of large pretzels with the date 6/7 and there was no other expiration or discatrd date. Facility policy dictates that the month, day and year should be listed, not just day and month 10 large frozen tubes of meat were unlabeled undated. The items apppeared to be in its original package but there were no visible label indicating the type of meat and date items were receiverd. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455904	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rowlett Health and Rehabilitation Center	9300 Lakeview Pkwy Rowlett, TX 75088

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview on 06/19/24 at 1:00 PM with the Dietary Manager and the dietitian, they were advised of the findings in the kitchen. The Dietary Manager advised that she had made all the corrections that were observed during the initial walkthrough on 06/18/24. The Dietary Manager advised that she had dropped the ball in ensuring that the foods were stored, labeled, and dated correctly. She stated that all of the items mentioned should include the full [NAME] day and year when labeling items being stored upon arrival. The DM stated that she would in-service her team on proper labeloinng and dating items upon arrival and ensure the bins are checked for cleanliness for frequently. They advised the risk of these concerns not being addressed could result in cross contamination and airborne illnesses. An interview on 06/20/24 at 10:45 AM with the DON, he was made aware of the findings in the kitchen. He stated that he expects his kitchen staff to meet all required expectations. He stated the risk of the concerns not being addressed could result in residents getting sick. Record Review of the Facility's policy on Food Storage dated 08/2007, revealed It is the policy of this facility that food storage areas shall be maintained in a clean, safe, and sanitary manner. 1. Food storage areas shall be clean at all times. 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 3-202.18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based observation, interview, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (Resident #49 and Resident #89) of eight residents observed for infection control. The facility failed to ensure that CNA D changed his gloves and perform hand hygiene while providing incontinent care to Resident #49 and Resident #89. This failure could place the residents at risk of cross-contamination and development of infection. Findings included: Resident #49 Review of Resident #49's Face Sheet, dated 06/19/2024, reflected resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included hemiplegia (paralysis of one side of the body) and weakness. Review of Resident #49's Comprehensive MDS Assessment, dated 04/13/2024, reflected Resident #49 had a severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated Resident #49 was always incontinent for bowel and bladder. Review of Resident #49's Comprehensive Care Plan, dated 06/06/2024, reflected resident was incontinent of bowel and bladder related to impaired mobility and one of the interventions was to wash, rinse, and dry perineum (the space between the anus and the genitals). Observation on 06/18/2024 at 10:27 AM revealed CNA D was about to transfer Resident #49 to bed from the shower chair via mechanical lift. While waiting to be transferred, Resident #49 had a bowel movement and soiled the Hoyer sling. CNA D put on some gloves and continued to transfer the resident with the assistance of another staff. He did not wash his hands before putting on the gloves. After the transfer, CNA D rolled the resident towards the wall, rolled the soiled Hoyer sling and bed padding towards the center of the bed and tucked them under the resident. After tucking the soiled Hoyer sling and padding, CNA D took the new brief and placed it at the side of the resident. He did not change his gloves nor sanitized his hands before touching the new brief. CNA D then cleaned the resident's bottom. After cleaning the resident's bottom, CNA D took the new brief and put it under the resident's bottom and then rolled back the resident. He did not change his gloves nor sanitized his hands before putting the new brief on the resident's bottom. He then pulled the soiled Hoyer sling and padding, fixed the brief, and taped it on both sides. He took off his gloves but did not wash his hands after the incontinent care. Resident #89 Review of Resident #89's Face Sheet, dated 06/19/2024, reflected resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included hemiplegia and weakness. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #89's Comprehensive MDS Assessment, dated 04/13/2024, reflected Resident #49 had a severe impairment in cognition with a BIMS score of 06. The Comprehensive MDS Assessment indicated Resident #89 was always incontinent for bowel and bladder. Review of Resident #89's Comprehensive Care Plan, dated 04/22/2024, reflected resident had an ADL self-care performance deficit related to CVA (cerebrovascular disease: stroke) and one of the interventions was for staff to assist with ADLs with needed assistance. Observation on 06/18/2024 at 10:59 AM revealed CNA D was about to transfer Resident #89 to his wheelchair. CNA D stated he would clean the resident first and change his clothes. CNA D put on his gloves. He did not wash his hands before putting on his gloves. CNA D unfastened the tape on both sides of the brief, pushed it between the legs of the resident, then rolled the resident to one side. He then proceeded to clean the resident's bottom. After cleaning the resident's bottom, CNA D pulled the soiled brief. He then changed his gloves but did not sanitize his hands. CNA D then took the new brief that was placed on the side of the resident's leg. The brief fell on the floor. CNA D picked it up and placed it on the resident's bottom. CNA D did not get another brief to replace the brief that fell on the floor. CNA D instructed and assisted the resident to roll back. CNA D then cleaned the front part of the resident, pulled the front part of the brief, and taped it on both sides. CNA D did not change his gloves nor sanitize his hands after cleaning the front part of the resident and before touching the new brief again. He then went to the resident's drawer to get new shorts. CNA D did not change his gloves nor sanitize his hands before touching the clean shorts. CNA D then took off the resident's hospital gown and put on the t-shirt that was prepared earlier and the shorts that was taken from the resident's drawer. CNA D took off his gloves and threw them in the trash can. He did not wash his hands after incontinent care. In an interview with CNA D on 06/18/2024 at 1:40 PM, CNA D stated he did not wash his hands before and after cleaning Resident #49 and Resident #89 but did put on new gloves before doing incontinent care. CNA D acknowledged that he did not change his gloves after cleaning the residents and before touching the new brief. He said he should had taken off his gloves, washed or sanitized his hands, and then put on new gloves after cleaning the resident and before getting the new brief. He said he should have replaced the brief that fell on the floor. He said not washing the hands before and after incontinent care, not changing the gloves before touching the new brief and clothes, not sanitizing the hands in between changing of gloves, and not replacing the brief that fell on the floor could cause cross contamination and infection. He said they do have in-services for infection control, handwashing, and incontinent care always. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 06/19/2024 at 11:18 AM, the DON stated he was made aware by the CNA involved about the infection control issue during incontinent care. The DON said every staff should wash their hands before and after every care. He said gloves should be changed and the hands should be sanitized after cleaning the resident's buttocks or the resident's front part before touching the any clean items. He said not washing the hands, not changing the gloves, and not sanitizing the hands in between changing of gloves could result to cross contamination and infection. The DON also added if the brief had fallen to the floor, it should not be used anymore for a simple reason that it was already dirty. The DON said the expectation was for the staff would remember to wash their hands and change their gloves when transitioning from a dirty area to a clean area, sanitize their hand when changing their gloves, and not to use items that had fallen to the floor. The DON said he already did a one-on-one in-service with CNA D but would do an infection control in-service for all the staff. He concluded that he would continually remind the staff to be attentive to the procedures for infection control and that he would personally monitor infection control. In an interview with LVN A on 06/20/2024 at 7:32 AM, LVN A stated the right procedure was to wash the hands and change the gloves after cleaning the bottom of the resident and before getting the new brief. She said the purpose of the method was to prevent cross contaminations and infections. She said microorganism could easily transfer if the gloves were not changed throughout incontinent care. LVN A added microorganisms could transfer from the soiled gloves to the new brief as well as to the clothes of the resident. She also said the brief should have been replaced because it already fell on the floor. She said the CNA should have not picked it up in the first place. She said she would remind the CNAs on her hall about the importance of washing hands before and after every care, changing gloves from dirty area to clean area, and sanitizing the hands in between changing of gloves. Record review of facility's policy, Hand Hygiene Infection Control Prevention and Control Program revealed Policy: This facility considers hand hygiene the primary means to prevent the spread of infections . b. Before and after direct contact with residents . h. Before moving from a contaminated body site to a clean body site during resident care . i. After contact with a resident's intact skin . j. After contact with blood or bodily fluids . m. After removing gloves . hand hygiene is the final step. Record review of facility's policy, Infection Control Prevention and Control Program revealed Policy: The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program . Goals: Promote individual resident's rights and well-being while trying to prevent and control the spread of infection.