STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455935	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
El Paso Health & Rehabilitation Center	11525 Vista Del Sol Dr El Paso, TX 79936

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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 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** 46998 Based on observation, interview and record review, the facility failed to maintain a safe, sanitary and comfortable environment for 2 (Resident #2 and Resident #5) of 4 residents and 1 (room [ROOM NUMBER]B) of 3 rooms reviewed for environment. The facility failed to ensure Resident #2's blue face of the feeding pump machine had white unknown substance. The top of the feeding pump machine was dirty with a brown-ish substance. Resident #5's feeding pump machine was greasy and dirty. The pole the feeding bag was hung from, and the feeding pump machine was hooked up too had brown-ish substances all around the pole and the black power cord. The Face of the feeding pump machine also on the left side had a reddish substance. The right side of the feeding pump machine had some black smeared substance. Underneath the feeding pump machine was a brown-ish substance. The facility failed to ensure the feeding pump machine in room [ROOM NUMBER]B was not covered with an unknown brown-ish substance. This deficient practice could place residents at risk for infection due to improper care practices. Findings Included: Resident #2 Record review of Resident #2's face sheet dated 08/05/24, revealed, admission on 06/07/24 to the facility. Resident #2 was a [AGE] year-old female diagnosed with gastrostomy status (an opening into the stomach from the abdominal wall, made surgically for the introduction of food), dysphagia (difficulty swallowing), and Oropharyngeal phase (consists of the structures in the back of the throat, including the base of the tongue, palatine tonsils, posterior pharyngeal wall and soft palate). Record review of Resident #2's admission MDS assessment dated [DATE], revealed, there was no BIMS was conducted to evaluate the cognitive status of resident #2. Resident #2 was diagnosed with Malnutrition and oropharyngeal. Resident #2 was marked for feeding tube. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's order recap dated 06/10/24, revealed, Enteral feeding order in the morning start continuous enteral feeding. Formula: Jevity (a 1.1 kcal/ml tube feed with fibre, for people with, or at risk of developing, disease-related malnutrition) 1.2, Rate: 55. Start at 06:00 AM and run until midnight. Record review of Resident #2's care plan dated 06/10/24, revealed she required tube feeding due to dysphagia. The resident was dependent with tube feeding and water flushes. An observation on 08/01/24 at 9:43 AM, revealed, there was a feeding pump machine that was connected to Resident #2 in her room. The blue face of the feeding pump machine had white unknown substance. The top of the feeding pump machine was dirty with a brown-ish substance. Resident #5 Record review of Resident #5's face sheet dated 08/05/24, revealed, admission on 07/03/23 and re-admission on 07/05/24 to the facility. Record review of Resident #5's facility history and physical dated 03/28/24, revealed, a [AGE] year-old male diagnosed with Gastrostomy status and gastro-esophageal reflux disease without esophagitis (a type of GERD that does not involve inflammation of the esophagus). Record review of Resident #5's quarterly MDS dated [DATE], revealed, there was no BIMS score taken to evaluate the cognitive status of resident #5. Resident #5 was diagnosed with malnutrition, gastrostomy, muscle wasting, and muscle weakness. Marked for feeding tube. During an observation on 08/05/24 at 10:19 AM, Resident #5 was in bed with a continuous feeding pump machine on. The face of the feeding pump machine was greasy and dirty. The pole the feeding bag was hung from, and the feeding pump machine was hooked up too had brown-ish substances all around the pole and the black power cord. The Face of the feeding pump machine also on the left side had a reddish substance. The right side of the feeding pump machine had some black smeared substance. Underneath the feeding pump machine was a brown-ish substance. room [ROOM NUMBER]B During an observation on 08/05/24 at 10:29 AM, it was observed the feeding pump machine on the side had brown-ish substance where the tubing was hooked up to the roller on the machine. Underneath the feeding pump machine there was brown-ish substance. During an observation and interview on 08/05/24 at 3:29 PM, the DON stated nursing staff were responsible for cleaning the feeding pump machine and the surrounding area. The DON stated the feeding pumps machines were to be cleaned when they got dirty and as needed. The DON observed Resident #2 and Resident #5's feeding pump machine and stated that they were dirty and had a brown substance. The DON stated she hoped the red mark/stain on Resident #5's feeding pump machine was juice and nothing else. The DON stated there was no log or monitoring tool to ensure that the feeding pump machines were being cleaned. The DON stated the risk of not cleaning the feeding pumps machine and surrounding area could be infection. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/05/24 at 4:09 PM, LVN C stated the nurses were responsible for cleaning the feeding pump machine and cords/pole if it got dirty with formula. LVN C stated the feeding pump machines should be cleaned daily. LVN C stated she did have residents that were on a feeding pump machine but when she came into work that day, she did not check the feeding pump machines to see if they were clean or dirty. LVN C stated the risk of not cleaning could be infection. Record review of the facility Feeding Pump Manual dated 03/2020, revealed, Section VII-Cleaning: cleaning should be performed as needed. It may also be desirable to define cleaning intervals based on knowledge of the environment in which the pump was used. Only trained in the cleaning of medical devices should perform cleaning .Cleaning Frequency - It was recommended that the pump be cleaned after each feeding set use for a minimum duration of 30 seconds, to prevent bacterial contamination of the pump. Record review of the facility Infection Control Plan: Overview policy dated 03/2023, revealed, 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.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on interviews and record reviews, the facility failed to ensure that the assessment accurately reflected the resident's status for 1 (Resident #7) of 5 resident reviewed for accuracy of MDS assessment, in that: The facility failed to ensure Resident #7's quarterly MDS accurately reflected the residents' history of falls. This deficient practice could affect residents at the facility who had been assessed for risk of falls and could contribute to inadequate care. Findings included: Record review of Resident #7's face sheet dated 08/01/24, revealed, admission on 02/22/24 and re-admission on 07/31/24 to the facility. Record review of Resident #7's facility history and physical dated 05/29/24, revealed, an [AGE] year-old male diagnosed with Alzheimer's Disease, difficulty in walking, muscle wasting, muscle weakness, Dementia, lack of coordination, unspecified fall. Record review of Resident #7's quarterly MDS dated [DATE], revealed severely impaired cognition to be able to recall or make daily decision with a BIMS score of 6. Resident #7's ADLs were independence with sit to stand, transfers, and walking. Resident #7 was not marked for any mobility devices. Resident #7 was diagnosed with unspecified fall, difficult in walking, muscle wasting, muscle weakness (no muscle strength), lack of coordination, and Alzheimer's Dementia. Resident #7 was marked for fall history as having no falls since admission or re-entry to the facility. Record review of Resident #7's Care Plan dated 02/28/24, revealed he had the potential for falls related to impaired mobility and history of falls. Interventions: Fall Risk Screening upon admission and quarterly to identify risk factors. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Record review of Resident #7's Event Notes dated 06/23/24 and 06/25/24, revealed Resident #7 had a fall. On 06/23/24, Resident #7 fell on his rear and back hit the wall while trying to sit on a black round stool in the dining area. On 06/25/24, Resident #7 had an unwitnessed fall in his room and was found with his back against the closet door. During an interview on 08/01/24 at 11:17 AM, Family Member D stated Resident #7 had a history of falls. During an interview on 08/01/24 at 11:53 AM, Family Member E stated Resident #7 was having falls every week at the facility. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/05/24 at 10:37 AM, the Physician stated Resident #7 had a history of falls. The Physician stated Resident #7 had no safety awareness. The Physician stated Resident #7's fall history should put in the MDS to alert nursing staff that Resident #7 was a fall risk. The Physician stated the risk of not putting in the MDS would be not alerting nursing staff regarding resident's special care needs. During an interview on 08/05/24 at 11:35 AM, the MDS Coordinator stated the MDS department created the MDSs and were responsible for the MDSs. The MDS Coordinator stated Resident #7 had a history of falls. The MDS Coordinator stated the quarterly MDS dated [DATE], should have been marked indicating Resident #7 had a history of falls after admission or recently. The MDS Coordinator stated it would be important to have the MDS accurately marked because the information from the MDS was taken and put into the care plan and for interventions. The MDS Coordinator stated not marking the MDS accurately would have a negative outcome on the resident. During an interview on 08/05/24 at 3:29 PM, the DON stated Resident #7 had a history of falls. The DON stated the DON would oversee MDS. The DON stated she did not know the process of an MDS. Record review of the facility Resident Assessment Manual dated 2003, revealed, The facility will examine each resident and review the minimum date set expanded core elements specified in the RAI no less than once every three months and as appropriate. Results must be recorded to assure continued accuracy of the assessment. The results of the assessment are used to develop, review, and revise the resident's comprehensive care plan of care.

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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** 46998 Based on interview, and record review the facility failed to develop and implement comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident medical and nursing needs to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being for 1 (Resident #7) of 5 residents reviewed for care plans in that: The facility failed to develop a comprehensive person-centered care plan for Resident #7's history of falls needing to have a fall mat placed when in bed as per physician orders. This deficient practice could place residents in the facility at risk of not receiving the necessary care or services and having personalized plans developed to address their needs. Findings include: Record review of Resident #7's face sheet dated 08/01/24, revealed an admission on 02/22/24 and re-admission on 07/31/24 to the facility. Record review of Resident #7's facility history and physical dated 05/29/24, revealed, an [AGE] year-old male diagnosed with Alzheimer's Disease, difficulty in walking, muscle wasting, muscle weakness, Dementia, lack of coordination, unspecified fall. Record review of Resident #7's quarterly MDS assessment dated [DATE], revealed severely impaired cognition to be able to recall or make daily decision BIMS score of 6. Resident #7's ADLs were independence with sit to stand, transfers, and walking. Resident #7 was not marked for any mobility devices. Resident #7 was diagnosed with unspecified fall, difficult in walking, muscle wasting, muscle weakness (no muscle strength), lack of coordination, and Alzheimer's Dementia. Resident #7 was marked for fall history as having no falls since admission or re-entry to the facility. Record review of Resident #7's Care Plan dated 02/28/24, revealed he had the potential for falls related to impaired mobility and history of falls. Interventions: Fall Risk Screening upon admission and quarterly to identify risk factors. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. There were no interventions indicating placing a fall mat when Resident #7's was in bed. Record review of Resident #7's physician orders dated 08/01/24, revealed, May place floor mat due to high risk for fall. During an interview on 08/01/24 at 11:17 AM Family Member D stated Resident #7 had a history of falls and she had seen Resident #7's bed low. The Family Member D stated she had not seen a fall mat placed next to Resident #7's bed when she visited him. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/01/24 at 11:53 AM, Family Member E stated Resident #7 was having falls every week at the facility. The Family Member E stated he visited Resident #7 once a week and on Sundays and had not seen Resident #7 with a fall mat placed next to his bed when he was in bed. During an interview on 08/01/24 at4:11 PM, LVN G stated Resident #7 had a history of falls. LVN G stated Resident #7 was to have the fall mat placed next to the bed and the bed in a low position. LVN G stated the Physician had given an order for the fall mat and before today (08/01/24) it had not been care planned. LVN G stated it would have been appropriate if the facility had care planned the fall mat into the care plan. LVN G stated not care planning the fall mat could be a risk if staff did not know to place the fall mat for falls. During an interview on 08/05/24 at 10:37 AM, the Physician stated Resident #7 had a history of falls. The Physician stated Resident #7 had no safety awareness. The Physician stated if the intervention for Resident #7 was to place a fall mat and lower bed then it should be care planned in his care plan. The Physician stated the risk of not care planning could be a nurse not familiar with Resident #7 might not know he had no safety awareness and could fall. The Physician stated putting it in the care plan puts nursing staff on alert that the resident was a fall risk. During an interview on 08/05/24 at 9:38 AM, the NP stated she checked on Resident #7 at least once a week and had seen Resident #7 had the bed in the low position, but no fall mat placed. The NP stated that no one had told her that Resident #7 needed to have the fall mat placed next to the bed when he was in bed. The NP stated if there was a physician order to put the fall mat, then the facility would have to follow the order to place the fall mat. The NP stated if the facility policy stated to care plan residents care plans, person centered, then the facility would have to also follow their policy. The NP stated the negative outcome would be a risk of fracture, bleeding, injury. The NP stated the purpose of the care plan was to ensure the safety of the resident to reduce injury and harm. During an interview on 08/05/24 at 11:35 AM, the MDS Coordinator stated the MDS department created the MDSs and were responsible for the care plans. The MDS Coordinator stated if there was an order to place the fall mat, then it should have been care planned. The MDS Coordinator stated Resident #7 had an order dated 07/01/24 to place a fall mat. The MDS Coordinator stated if nursing staff were not placing the fall mat, then there can be accident if Resident #7 had a fall. During an interview on 08/05/24 at 3:29 PM, the DON stated if there was an order for a fall mat to be placed for Resident #7, then it would have had to be care planned. The DON stated not having it in the care plan could cause a negative outcome. The DON did not mention what the negative outcome would be. Record review of the facility Comprehensive Care Plan manual, not dated, 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 identified in the comprehensive assessment .The services that are to be furnished to attain and maintain the resident's highest practicable physical, mental, and psychosocial well-being .The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46998 Based on observation, interview, and record review, the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 2 (Resident #3 and Resident #6) of 5 residents reviewed for quality of life. The facility failed to ensure Resident #3 and Resident #6's fingernails were trimmed and cleaned. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk of infection, and decreased quality of life. Findings include: Resident #3 Record review of Resident #3's face sheet dated 08/05/24, revealed, admission on 06/07/24 to the facility. Record review of Resident #3's outside facility history and physical dated 05/31/24, revealed, an [AGE] year-old male diagnosed with muscle wasting, lack of coordination, Type 2 Diabetes Mellitus, and anxiety. Record review of Resident #3's quarterly MDS assessment dated [DATE], revealed severely impaired cognition to be able to recall and make daily decisions as evidence by a BIMS score of 4. ADLs for personal hygiene were substantial/maximal assistance (nursing staff do more than 50% of the help). Resident #3 was diagnosed with Diabetes Mellitus, Non-Alzheimer's Dementia, muscle weakness, muscle wasting, lack of coordination. Record review of Resident #3's care plan dated 08/18/22, revealed, he had impaired cognition and was at risk of further decline. Resident needs supervision/assistance with all decision making. Diabetes care plan dated 12/29/22, revealed, inspect feet during bathing and as needed for open areas, sores, pressure areas, blisters, edema, or redness and report it to the nurse. ADLs care planned dated 04/15/24, revealed, personal hygiene care: the resident requires extensive assistance by one staff assistance. Resident #6 Record review of Resident #6's face sheet dated 08/05/24, revealed, admission on 10/19/21 and re-admission on 02/29/24 to the facility. Record review of Resident #6's facility history and physical dated 05/29/24, revealed, an [AGE] year-old female diagnosed with muscle wasting, muscle weakness, lack of coordination, pain in the joints, and Type 2 Diabetes Mellitus. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #6's annual MDS dated [DATE], revealed moderately impaired cognition to be able recall or make daily decisions as evidenced by a BIMS score of 9. ADLs for personal hygiene were supervision or touching assistance from staff. Resident #6 was diagnosed with Diabetes Mellitus, muscle weakness, muscle wasting, and lack of coordination. Record review of Resident #6's care plan dated 01/24/22, revealed she required x1 staff for personal hygiene. Diabetes care plan dated 01/24/22, revealed, weekly skin checks to monitor skin for redness, circulatory problems, infection, and breakdown. Notify physician of any new skin conditions. During an interview on 08/05/24 at 11:00 AM with the Resident Council group meeting members revealed they were not receiving nail care. During an observation and interview on 08/05/24 at 1:20 PM, Resident #6 stated it had been a long time since her nails have been cut. Resident #6 fingernails were long and dirty with a dark substance underneath the fingernails. Resident #6 stated it had been more than 4 months since they were cut. During an interview on 08/05/24 at 1:25 PM, CNA I stated that nail care was done by the CNAs and only the fingernails. CNA I stated they cut or trimmed resident nails on Sunday and as needed. During an interview on 08/05/24 at 1:36 PM, CNA J stated residents had not complained about nail care. CNA I stated CNAs cut and trimmed fingernails. During an observation and interview on 08/05/24 at 1:38 PM, Resident #3 stated he could not remember the last time his fingernails or toenails were cut. Resident #5 had long fingernails that were dirty and underneath had a dark black substance. Resident #3 stated he did want his nails cut and had not refused to have them cut. LVN J took Resident #3 into the dining room and began cutting Resident #3's fingernails and washed them in the sink. During an interview on 08/05/24 at 2:00 PM, with ADON A and ADON B. ADON A stated CNAs provided fingernail care such as filing. ADON B stated the nurse could file or cut the fingernails. ADON B stated the CNAs and nurses need to be checking the residents' fingernails to see that they don't have ingrown fingernails or anything wrong. ADON B stated the risk of not providing nail care could be infection or ingrown. During an interview on 08/05/24 at 3:29 PM, the DON stated nail care was done by the CNAs and nurses. The DON stated CNAs cleaned the fingernails, file them but cannot cut them. The DON stated nursing staff cut resident nails as well except if the resident was a diabetic. The DON stated an unknown resident (Could not remember the residents name) had asked her if she could cut her nails. The DON stated the ADONs (ADON A & ADON B) and herself had put out an in-service regarding fingernail care to the nursing staff about nail care for the residents. The DON stated she started working at the facility on 07/15/24 . The DON stated the negative outcome of not doing nail care for the residents could result in infection, and the resident(s) could scratch themselves or someone else. The DON stated there was no way for the CNAs to document that they had conducted nail care but would be adding a widget in the facility system to mark they had done it (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/05/24 at 4:09 PM, LVN C stated she tried to cut the resident fingernails when they needed nail care. LVN C stated there had been residents that complained about fingernail care LVN C stated she had not checked the residents' fingernails lately. LVN C stated the risk would be ingrown fingernails/toenails and infection. Record review of the facility Nail Care manual dated 2003, revealed, Nail management was the regular care of the toenails and fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury from scratching by fingernails or pressure of shoes on toenails .It includes cleansing, trimming, smoothing .Nail care especially trimming was performed by podiatrist in those with diabetes and peripheral vascular disease.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on observation, interview, and record review, the facility failed to provide foot care and treatment, or assist the resident in making appointments with a qualified person for 2 (Resident #3 and Resident #6) of 5 residents reviewed for quality of life. The facility failed to ensure Resident #3 and Resident #6's toenails were trimmed and cleaned, or podiatry appointments scheduled. This failure could place residents at risk of infection or mobility issues. Findings include: Resident #3 Record review of Resident #3's face sheet dated 08/05/24, revealed, admission on 06/07/24 to the facility. Record review of Resident #3's outside facility history and physical dated 05/31/24, revealed, an [AGE] year-old male diagnosed with muscle wasting, lack of coordination, Type 2 Diabetes Mellitus, and anxiety. Record review of Resident #3's quarterly MDS assessment dated [DATE], revealed severely impaired cognition to be able to recall and make daily decisions as evidence by a BIMS score of 4. ADLs for personal hygiene were substantial/maximal assistance (nursing staff do more than 50% of the help). Resident #3 was diagnosed with Diabetes Mellitus, Non-Alzheimer's Dementia, muscle weakness, muscle wasting, lack of coordination. Record review of Resident #3's care plan dated 08/18/22, revealed, he had impaired cognition and was at risk of further decline. Resident needs supervision/assistance with all decision making. Diabetes care plan dated 12/29/22, revealed, inspect feet during bathing and as needed for open areas, sores, pressure areas, blisters, edema, or redness and report it to the nurse. ADLs care planned dated 04/15/24, revealed, personal hygiene care: the resident requires extensive assistance by one staff assistance. Record review of Resident #3's order recap dated 11/07/23, revealed, Podiatrist consult. Resident #6 Record review of Resident #6's face sheet dated 08/05/24, revealed, admission on 10/19/21 and re-admission on 02/29/24 to the facility. Record review of Resident #6's facility history and physical dated 05/29/24, revealed, an [AGE] year-old female diagnosed with muscle wasting, muscle weakness, lack of coordination, pain in the joints, and Type 2 Diabetes Mellitus. (continued on next page)

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	455935	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
El Paso Health & Rehabilitation Center	11525 Vista Del Sol Dr El Paso, TX 79936

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #6's annual MDS dated [DATE], revealed moderately impaired cognition to be able recall or make daily decisions as evidenced by a BIMS score of 9. ADLs for personal hygiene were supervision or touching assistance from staff. Resident #6 was diagnosed with Diabetes Mellitus, muscle weakness, muscle wasting, and lack of coordination. Record review of Resident #6's care plan dated 01/24/22, revealed she required x1 staff for personal hygiene. Diabetes care plan dated 01/24/22, revealed, weekly skin checks to monitor skin for redness, circulatory problems, infection, and breakdown. Notify physician of any new skin conditions. Record review of Resident #6's order recap dated 11/07/23 and end date of order 02/27/24 revealed she may have podiatry care for thick toenails PRN. There were no new orders present. During an interview on 08/05/24 at 11:00 AM with the Resident Council group meeting members revealed they were not receiving nail care. The Resident Council group meeting members stated they had not seen the podiatrist since the facility had changed ownership back in 02/23/24. The Resident Council group meeting members stated they thought they were supposed to see the podiatry every 30 days. The Resident Council group meeting members stated before the ownership change, they were given a consent form to fill out and then taken by the previous Transporter to the podiatrist. During an interview on 08/05/24 at 1:07 PM, Resident #1 stated he had his fingernails cut but not his toenails. Resident #1 stated it had been a long time since he had his toenails cut. During an observation and interview on 08/05/24 at 1:20 PM, Resident #6 stated it had been a long time since her nails have been cut. Resident #6 stated it had been more than 4 months since they were cut. Resident #6 stated the podiatrist would cut her toenails. During an interview on 08/05/24 at 1:25 PM, CNA I stated that nail care was done by the CNAs and only the fingernails. CNA I stated toenails were cut by the doctor. CNA I stated it had been more then 2-3 months since the doctor has come to cut resident toenails. CNA I stated that residents had complained to her that their feet hurt because they had not had their toenails cut. CNA I stated the resident was no longer at the facility. CNA I stated she told the nurse and was told that they were going to make an appointment to the doctor. CNA I stated that days later, the resident still complained about it. During an interview on 08/05/24 at 1:36 PM, CNA I stated toenails are done by a doctor who went to the facility. CNA I stated it had been a long time since the doctor had went to the facility. During an observation and interview on 08/05/24 at 1:38 PM, Resident #3 stated he could not remember the last time his toenails were cut. Resident #3 stated he did want his nails cut and had not refused to have them cut. During an interview 08/05/24 at 1:42 PM, LVN G stated residents' toenails were done by the podiatrist. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 08/05/24 at 2:13 PM, with Resident #3 and LVN G. Resident #3 was in his room and LVN G took off Resident #3's right sock. Resident #3's toenails were yellow, jagged, thick, and broken. LVN G had asked Resident #3 if his toes hurt and Resident #3 shook his head up and down and stated, Si duele (English translation - Yes, it hurts). LVN G was touching Resident #3 toe and toenails and asking him where it hurt. Resident #3 did not answer. LVN G stated he could not recall the last time podiatry had gone to the facility. LVN G stated residents nor his staff had told him that residents were complaining because they want their nails cut. During an interview on 08/05/24 at 2:00 PM, with ADON A and ADON B. ADON A stated CNAs do not provide toenail care for diabetics. ADON A stated the nursing staff set up the residents' appointments to see the podiatrist. ADON A stated the last time podiatry had gone to the facility was back in February 2024. ADON B stated it was very rare that they would get referrals for residents to see podiatry. ADON B stated the CNAs and nurses need to be checking the residents' toenails to see that they don't have ingrown toenails or anything wrong. ADON B stated, before, the Transporter would schedule the appointments and take the residents to see the podiatrist. ADON B stated the risk of not providing nail care could be infection or ingrown. During an interview on 08/05/24 at 3:29 PM, the DON stated diabetic residents are to be seen by the Podiatrist. The DON stated Podiatry had come to the facility as she saw it on a group text from the facility. The DON stated after searching for the text message that she was wrong that Podiatry had not come to the facility. The DON stated an unknown resident (Could not remember the residents name) had asked her if she could cut her nails. The DON stated the ADONs (ADON A & ADON B) and herself had put out an in-service regarding fingernail and toenail care to the nursing staff about nail care for the residents. The DON stated she started working at the facility on 07/15/24 and did not know who was responsible for podiatry and residents seeing podiatry. The DON stated the negative outcome of not doing nail care for the residents could result in infection, and the resident(s) could scratch themselves or someone else. During an interview on 08/05/24 at 4:09 PM, LVN C stated the Podiatrist was going to start going to the facility to cut the residents toenails. LVN C stated there had been residents that complained about toenail care and the facility nurses had tried to set up appointments to go see the podiatrist. LVN C stated the previous Transporter was being given the referrals from the nurses and then she would make the appointment for the residents to go see podiatry but the transporter no longer works at the facility since last week (08/02/24). LVN C stated she made all the appointments for residents herself. LVN C stated she had not made any podiatry appointments lately. LVN C stated she had not checked the residents' toenails lately. LVN C stated the risk would be ingrown toenails and infection. Record review of the facility Nail Care manual dated 2003, revealed, Nail management was the regular care of the toenails and fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury from scratching by fingernails or pressure of shoes on toenails .It includes cleansing, trimming, smoothing .Nail care especially trimming was performed by podiatrist in those with diabetes and peripheral vascular disease.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on the observations, interviews, and record reviews, the facility failed to ensure that the residents environment remains free of accidents hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents for 1 (Resident #7) of 4 residents reviewed for accidents. The facility failed to follow the physicians order to place a fall mat on the floor when Resident #7 remains in bed. This failure could place residents in the facility at risk of not receiving the necessary care of services as ordered by the physician to address their needs, resulting in accidents, falls, and potential harm. Findings include: Record review of Resident #7's face sheet dated 08/01/24, revealed, admission on 02/22/24 and re-admission on 07/31/24 to the facility. Record review of Resident #7's facility history and physical dated 05/29/24, revealed, an [AGE] year-old male diagnosed with Alzheimer's Disease, difficulty in walking, muscle wasting, muscle weakness, Dementia, lack of coordination, unspecified fall. Record review of Resident #7's quarterly MDS dated [DATE], revealed, a severely impaired cognition to be able to recall or make daily decision BIMS score of 6. Resident #7's ADLs was independent with sit to stand, transfers, and walking. Resident #7 was not marked for any mobility devices. Resident #7 was diagnosed with unspecified fall, difficult in walking, muscle wasting, muscle weakness (no muscle strength), lack of coordination, and Alzheimer's Dementia. Resident #7 was marked for fall history as having no falls since admission or re-entry to the facility. Record review of Resident #7's Care Plan dated 02/28/24, revealed, had the potential for falls related to impaired mobility and history of falls. Fall Risk Screening upon admission and quarterly to identify risk factors. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. There were no interventions indicating placing a fall mat when Resident #7's was in bed. Record review of Resident #7's physician orders dated 08/01/24, revealed, May place floor mat due to high risk for fall. During an observation on 08/01/24 at 10:00 AM, Resident #7 was in his room trying to get up from his bed. Resident #7 legs were up in the air high as the Physician and LVN G rushed to enter his room. LVN G told the Physician that Resident #7 had been trying to get up all morning and did not call for help. Resident #7 was on a low bed with no fall mat placed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/01/24 at 3:35 PM, Resident #7 stated he was fine and did not want to talk to the state. During an interview on 08/01/24 at 3:58 PM, CNA F stated Resident #7 would forget his walker and nursing staff had to redirect him to use it. CNA F stated Resident #7 had a history of falls. CNA F stated Resident #7 needed a lot of supervision because he liked to get out of bed without using the call light for assistance. CNA F stated Resident #7 needed to have his fall mat for safety since he liked to get out of bed a lot. CNA F stated anytime Resident #7 was in bed, he needed to have his fall mat placed. CNA F stated the risk could be Resident #7 could have another fall and without the fall mat he could have more injuries. During an interview on 08/01/24 at 4:11 PM, LVN G stated Resident #7 had a history of falls. LVN G stated on Monday (07/29/24), Resident #7 was trying to get out of bed. LVN G stated on 08/01/24, Resident #7 almost had a fall but the Physician and himself went into the room to assist him. LVN G stated Resident #7 was to have the fall mat placed and the bed in a low position. LVN G stated the Physician had given an order for the fall mat and before today (08/01/24) it had not been care planned. During an interview on 08/02/24 at 9:29 AM, LVN H stated Resident #7 was a confused resident who refused care. LVN H stated Resident #7 had a history of falls. LVN H stated Resident #7 had to have the fall mat placed when in bed. LVN H stated Resident #7 got up all the time and the staff were constantly having to redirect the resident. LVN H stated not placing the fall mat could result in a fall with more impact when hitting the floor. During an interview on 08/05/24 at 2:00 PM, with ADON A and ADON B. ADON A stated Resident #7 did not really have a history of falls but was moved closer to the nurse's station to be monitored after his last fall on 07/29/24. ADON A stated Resident #7 was non-compliant with using his walker and would refuse care. ADON B stated Resident #7 having an order for fall mat meant that the facility had to place the fall mat when Resident #7 was in bed. ADON B stated the risk of not putting the fall mat in place would be injury. Record review of the facility Preventive Strategies to Reduce Fall Risk manual dated 2003, revealed, Policy: The goal of fall prevention strategies was to design interventions that minimize fall risk by eliminating or managing contributing factor while maintain or improving the resident's mobility. After risk was assessed, individualized nursing care plans will be implemented to prevent falls. The resident and/or family members will be educated on methods to prevent falls. Interventions will focus on manipulating the environment, educating the resident/family, implementing rehabilitation programs to improve functional ability, and care monitoring of medication side effects. Environment - Keep bed low. On 08/05/24 at 4:45 PM, Administrator stated the facility did not have an Accidents Policy.