STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455940	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lubbock Hospitality Nursing and Rehabilitation Cen	4710 Slide Rd Lubbock, TX 79414

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42515 49279 Based on interview and record review, the facility failed to inform residents in advance of the risks and benefits of proposed care and treatment for 2 of 24 resident reviewed for resident rights. (Resident #40 and Resident #32) 1. The facility failed to obtain consent from Resident #40 or the responsible party for Lorazepam (medication used to treat anxiety disorders). 2. The facility failed to obtain consent from Resident #32 or the responsible party for Lorazepam (medication used to treat anxiety disorders). This failure could place residents at risk for receiving psychoactive medications without consent and knowledge of side effects. The findings include: Record review of Resident #40's undated face sheet revealed a [AGE] year-old male originally admitted to the facility on [DATE]. Resident #40 had a medical history of paranoid schizophrenia (a chronic mental illness characterized by disruptions in thought, perception, emotion, and behavior), rhabdomyolysis (serious condition where damaged skeletal muscle breaks down rapidly), and generalized anxiety disorder. Resident #40 had a legal responsible party listed in the face sheet. Record review of Resident #40's quarterly MDS Section C- Cognitive Patterns dated 2/8/2025 revealed no BIMS score which indicates Resident #40 was rarely/never understood. Record review of Resident #40's physician orders revealed an order for lorazepam - Schedule IV tablet: 0.5 mg . Every 6 Hours - PRN, start date 12/18/2024 with no end date. Physician orders revealed an order for Lorazepam Intensol (lorazepam) - Schedule IV concentrate; 2 mg/mL; amt:0.25mL; oral Every 2 Hours - PRN, start date 1/03/2025 with no end date. Record review of Resident #40s medication administration revealed Lorazepam 0.25mL PRN every 2 hours was administered on the following dates 1/3, and 1/31/2025. Lorazepam 0.5mg tablet every 6 hours was administered on the following dates 1/ 2, 1/9, 1/15 and 2/12/2025. (continued on next page)

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

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #40's medical record did not reveal a signed consent form for the Lorazepam orders by Resident #40 or the responsible party. Record review of Resident #32's undated face sheet revealed an [AGE] year-old female originally admitted to the facility on [DATE]. Resident #32 had a medical history of unspecified dementia (a decline in cognitive function that cannot be attributed to a specific known cause), panic disorder (a mental and behavioral disorder, specifically an anxiety disorder characterized by reoccurring unexpected panic attacks), and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, eventually leading to the inability to perform simple daily tasks). Resident #32 had a legal responsible party listed in the face sheet Record review of Resident #32's admission MDS Section C- Cognitive Patterns dated 12/24/2024 revealed a BIMs score of 00 which indicates Resident #32 had severe cognitive impairment. Record review of Resident #32's physician orders revealed an order for lorazepam - Schedule IV tablet; 0.5 mg; oral Every 6 Hours, start date 12/16/2024 with no end date. Record review of Resident #32s medication administration revealed Lorazepam 0.5mg every 6 hours PRN was administered on the following dates 2/1/2025 and 2/5/2025. Record review of Resident #32's medical record did not reveal a signed consent form for the Lorazepam orders by Resident #32 or the responsible party. During an interview with the DON on 3/13/2025 at approximately 12:15pm, he stated the nurses receiving the physician orders and the ADONs were responsible to ensuring the consent forms are completed. He stated the DON would review and confirm the consent form is signed. He stated they monitor compliance with consent being signed by doing audits monthly and quarterly reviews. He stated the potential negative outcome of not obtaining consent forms were the residents not being informed of potential side effects such as drowsiness, sedation, or increased risk of falls. He stated he was not sure why Resident #32 or Resident #40 did not have the signed consent forms. During an interview with the ADM on 3/13/2025 at 12:55pm, he stated the nurse who takes the initial order should be making sure the consent forms were signed before beginning that medication therapy. He stated the consent form not being signed could cause the residents to have a medication they do not want or against the responsible party's wishes. He stated compliance was monitored monthly with the DON. Record review of facility policy titled Psychoactive Medications dated July 2024 revealed: Definition A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics . 3. Residents and/or representatives shall be educated on the risks and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions . (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9. Consent must be obtained from the resident or resident representative prior to administering a psychotropic medication (excluding an emergency).

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42515 49279 Based on interview and record reviews the facility failed to ensure PRN orders for psychotropic drugs were limited to 14 days for 2 of 24 residents reviewed for unnecessary medications (Resident #40 and #32). 1. The facility failed to ensure a PRN order for Lorazepam (medication used to treat anxiety disorders) dated 11/28/2024 and Lorazepam (medication used to treat anxiety disorders) dated 12/18/2024 had a stop date to ensure the medication did not extend beyond 14 days for Resident #40. 2. The facility failed to ensure a PRN order for Lorazepam (medication used to treat anxiety disorders) dated 12/16/2024 had a stop date to ensure the medication did not extend beyond 14 days for Resident #32. This failure placed residents with PRN psychotropic drugs at risk for side effects of psychotropic drugs and placed residents at risk for receiving unnecessary medications. Findings include: Record review of Resident #40's undated face sheet revealed a [AGE] year-old male originally admitted to the facility on [DATE]. Resident #40 had a medical history of paranoid schizophrenia (a chronic mental illness characterized by disruptions in thought, perception, emotion, and behavior), rhabdomyolysis (serious condition where damaged skeletal muscle breaks down rapidly), and generalized anxiety disorder. Resident #40 had a legal responsible party listed in the face sheet. Record review of Resident #40's quarterly MDS Section C- Cognitive Patterns dated 2/8/2025 revealed no BIMS score which indicates Resident #40 is rarely/never understood. Record review of Resident #40's physician orders revealed an order for lorazepam - Schedule IV tablet: 0.5 mg . Every 6 Hours - PRN, start date 12/18/2024 with no end date. Physician orders revealed an order for Lorazepam Intensol (lorazepam) - Schedule IV concentrate; 2 mg/mL; amt:0.25mL; oral Every 2 Hours - PRN, start date 1/03/2025 with no end date. Record review of Resident #40's care plan dated 2/13/2025 revealed resident had Problem start date: 10/28/2024, category psychotropic drug use, [Resident #40] is at risk for side effects related to taking an antianxiety medication (Lorazepam). Goal: I will exhibit no side effects related to taking an antianxiety medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #32's undated face sheet revealed an [AGE] year-old female originally admitted to the facility on [DATE]. Resident #32 had a medical history of unspecified dementia (a decline in cognitive function that cannot be attributed to a specific known cause), panic disorder (a mental and behavioral disorder, specifically an anxiety disorder characterized by reoccurring unexpected panic attacks), and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, eventually leading to the inability to perform simple daily tasks). Resident #32 had a legal responsible party listed in the face sheet. Record review of Resident #32's admission MDS Section C- Cognitive Patterns dated 12/24/2024 revealed a BIMs score of 00 which indicates Resident #32 had severe cognitive impairment. Record review of Resident #32's physician orders revealed an order for lorazepam - Schedule IV tablet; 0.5 mg; oral Every 6 Hours, start date 12/18/2024 with no end date. Physician orders revealed an order for Lorazepam Intensol (lorazepam) - Schedule IV concentrate; 2 mg/mL; amt:0.25mL; oral Every 2 Hours - PRN, start date 1/03/2025 with no end date. Record review of Resident #32's care plan dated 12/19/2024 revealed resident had Problem start date: 12/11/2024, category psychotropic drug use, Problem: Psychotropic Drug Use: I take medication to control my mood and at risk for adverse reaction. Goal: GDR (gradual dose reduction) and wean off. During an interview with the DON on 3/13/2025 at approximately 12:15pm, he stated the nurses are responsible for ensuring residents are free of unnecessary medications. He stated they monitor compliance with unnecessary medications by doing audits monthly and quarterly reviews. He stated the PRN orders are monitored at the same time consent forms are audited. He stated the potential negative outcome of unnecessary medications could be an increased risk of drowsiness, increase risk of falls and sedation. He stated he was not aware Resident #40 and Resident #32 had PRN psychotropic medications without a 14 day stop date. During an interview with the ADM on 3/13/2025 at 12:55pm, he stated nursing is responsible for ensuring resident are free from unnecessary or PRN medications. He stated the potential negative outcome of unnecessary medications could be Residents having an adverse medical reaction to the drug. He stated compliance is monitored with the DON along with monthly pharmacy consults. Record review of facility policy titled Psychoactive Medications dated July 2024 revealed: Definition A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics . 17. PRN orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration (i.e 14 days). a. If the attending physician or prescribing practitioner believes that it is appropriate for the prn order to be extended beyond 14 days, he or she shall document their rationale in the resident's medical record and indicate the duration for the pm order.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49305 Based on observation, interview, and record review the facility failed to ensure that its medication error rate was less than 5 percent. The facility had a medication error rate of 9.38% based on 3 errors out of 32 opportunities, which involved 2 of 7 residents (Resident #6 and Resident #10) reviewed for medication administration. 1. LVN A failed to administer Resident #6's Certizine medication according to physician orders, resulting in Resident #6 receiving the medication late. 2. LVN A failed to verify the dosage on Resident #6's Simethicone 125 mg medication order prior to administering the medication, resulting in Resident #6 being underdosed. 3. LVN A failed to verify the dosage on Resident #10's vitamin D3 125 mcg medication order prior to administering the medication, resulting in Resident #10 being underdosed. These failures could place residents at risk of incomplete therapeutic outcomes, increased negative side effects, and decline in health. Findings included: Resident #6 Record review of Resident #6's face sheet dated 03/12/25 revealed an [AGE] year-old female with an admitted [DATE] with the following diagnoses: neuropathy (nerve damage), congestive heart failure (condition where the heart does not pump adequately), and gastroparesis (digestive condition). Record review of Resident #6's current physicians orders revealed an order with a start date of 01/23/25 for Certizine 10 mg; amount: 1 tablet; oral; once a morning at 07:00 AM. Further record review revealed an order with a start date of 06/12/22 for Simethicone chewable tablet 125 mg; amount 1 tablet four times daily. During a medication administration observation on 03/12/25 at 8:59 AM for Resident #6, LVN A dispensed one Cirtizine 10 mg tablet and one Simethicone 80 mg tablet into a medication cup and administered the medications to Resident #6. Resident #10 Record review of Resident #10's face sheet dated 03/12/25 revealed an [AGE] year-old female with an admitted [DATE] with the following diagnoses: metabolic encephalopathy (a change in brain function due to an underlying condition), protein-calorie malnutrition (change in body composition due to reduced nutrients, and hypertension (high blood pressure). Record review of Resident #10's current physicians orders revealed an order with a start date of 08/16/23 for Cholecalciferol (vitamin D3) 125 mcg tablet (5,000 unit); amount: 1 tablet; oral once a morning 07:00 AM-10:00 AM. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a medication administration observation on 03/12/25 at 9:13 AM for Resident #10, LVN A dispensed one vitamin D3 25 mcg tablet into a medication cup and administered the medication to Resident #10. During an interview and observation on 03/12/25 at 12:32 PM, LVN A stated she was asked by nursing administration to take over medication pass for another staff member after 8:00 AM, which caused Resident #6's 7:00 AM medication to be administered late. LVN A pulled the bottle of Simethicone 80 mg from the top drawer of the medication cart and compared it to the physicians order for Resident #6. She stated, The order was for Simethicone 125 mg. The correct dosage was not given. LVN A pulled the bottle of vitamin D3 25 mcg from the top drawer of the medication cart and compared it to the physicians order for Resident #10. She stated, The order was for vitamin D3 125 mcg. I didn't read the order right. LVN A stated her protocol for a medication error was to report the error to her nurse manager and notify the physician. She stated she had been trained on accuracy of medication administration in her nursing education by verifying the right medication, right patient, right dosage, right time and right route. LVN A stated a potential negative outcome for failure to give medication at the right time was that it could interact with other medications. LVN A stated a potential negative outcome for failure to give the correct dosage of medication was that it could lower the therapeutic value and cause a resident to become sick. During an interview on 03/13/25 at 9:28 AM, ADON A stated she was notified by LVN A of the medication errors for Resident #6 and Resident #10. She stated the physicians were notified and orders were clarified in the electronic medical record for each resident. She stated staff were trained to verify dosage with medication orders prior to administration of medications and to report medication errors immediately to nursing administration. During an interview on 03/13/25 at 10:42 AM, the DON stated he was not aware that medication errors were made during the observation of medication pass. He stated staff were trained on accuracy of medication administration through competency checks conducted by the facility educator. He stated accuracy of medication administration was monitored through computer-based reconciliations of physicians orders and through periodic staff competency checks. The DON stated he was responsible to assure staff were properly trained on accurate medication administration. He stated a potential negative outcome for failure to administer medications according to physicians orders would be harm to the resident on multiple levels, such as death, depending on which medication is given. During an interview on 03/13/25 at 10:42 AM, the ADM stated he was not aware that medication errors were made during the observation of medication pass. He stated it was the DON's responsibility to assure staff were trained on accurate medication administration. He stated his expectation of staff for accurate medication administration was that medications were given on time and according to physician's orders. The ADM stated a potential negative outcome for medication errors was adverse reactions for residents. Record review of the facility-provided policy titled Specific Medication Administration Procedures, revised January 2018 revealed: Policy To administer medication in a safe and effective manner. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procedures . C. Review 5 Rights (3) times: 1) Prior to removing the medication package/container from the cart/drawer; a. Check MAR/TAR for order. 2) Prior to removing the medication from the container a. Check the label against the order on the MAR. 3) After the dose has been prepared and before returning the medication to storage.

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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. 49305 Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored properly for 2 of 4 medication carts (Station 1 medication cart and Station 2 medication cart), reviewed for medication storage. The medication cart assigned to Station 1 contained loose pills. The medication cart assigned to Station 2 contained loose pills. This failure could place residents at risk of not receiving prescribed medications as ordered and place the facility at risk of drug diversions. The findings included: On 03/12/25 at 9:23 AM, an observation of the medication cart for Station 1 was conducted with LVN A. Two loose pills were found in the bottom drawer of the medication cart. LVN A placed the pills in a dispensing cup and took them to ADON A for identification. ADON A identified the medication as Buspirone 10 mg (2 tablets). LVN A destroyed the loose pills by placing them in the sharps container on the medication cart. During an interview on 03/12/25 at 9:25 AM, LVN A stated there should not be loose pills on the medication cart. She stated she was not sure why the medication cart contained loose pills. She stated it was her responsibility to assure medications were properly stored on the medication cart. LVN A stated the medication cart should be checked for loose pills weekly and each time the cart was in use. She stated a potential negative outcome of loose medications on the cart would be a drug diversion or a resident receiving the wrong medication. On 03/12/25 at 9:56 AM, an observation of the medication cart for Station 2 was conducted with MA A. Four loose pills were found in the drawer of the medication cart. The DON identified the medications as: Protonix 40 mg (1 tablet), Eliquis 5 mg (1 tablet), Buspirone 10 mg (1 tablet) and Gabapentin 100 mg (1 capsule). The DON disposed of the pills in the sharps container on the medication cart. During an interview on 03/12/25 at 10:08 AM, MA A stated there should not be loose pills on the medication cart. She stated she was unsure why the medication cart contained loose pills. She stated it was her responsibility to assure medications on the cart were properly stored. MA A stated she usually checked the cart daily and cleaned it once per week. She stated she had been trained on proper medication storage approximately monthly through cart audits conducted by the ADON and the pharmacy consultant. MA A stated a potential negative outcome of loose pills on the cart would be a resident not having enough medication and missing a dose. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/13/25 at 10:42 AM, the DON stated he was not aware that there were loose pills on the medication cart. He stated the medication cart should not contain loose pills. He stated it was the responsibility of the medication aides and nurses to check the medication carts for loose pills. The DON stated staff were trained on proper storage of medications through quarterly in-services conducted by nursing administration. He stated the system to monitor the medication carts for proper storage was cart audits and medication administration audits conducted monthly by nursing administration. He stated the pharmacy consultant conducted cart audits approximately monthly to assure proper medication storage. The DON stated his expectation of staff for proper medication storage on the carts was to ensure there were no loose or expired medications on the carts and to keep carts clean. He stated a potential negative outcome for loose pills on the carts was cross contamination and residents receiving the wrong medication. During an interview on 03/13/25 at 11:12 AM, the ADM stated he was not aware that there were loose pills on the medication cart. He stated it was the responsibility of the nurses to check the carts for loose pills. He stated it was the responsibility of nursing administration to assure carts were monitored for proper medication storage. The ADM stated his expectation of staff for proper medication storage on the carts was that all medications were stored properly, and carts were clean and organized. He stated a potential negative outcome for loose pills on the cart was medication errors. Record review of the facility-provided policy titled, Medication Storage in the Facility, revised January 2018, revealed: Policy Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. . Procedures A. The provider pharmacy dispenses medications in containers that meet regulatory requirements, including standards set forth by the United States Pharmacopeia (USP). Medications are kept in these containers. . C. All medications dispensed by the pharmacy are stored in the container with the pharmacy label. .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48275 Based on observation, interview, and record review, the facility failed to provide food that was palatable, attractive and at a safe and appetizing temperature for 3 of 3 food forms (Regular, Mechanical Soft, and Pureed) for 1 of 1 meal reviewed for palatability. 1) The facility failed to provide food that was palatable, attractive and at appetizing temperatures for 3 of 3 food forms served (Regular, Mechanical Soft, and Pureed) at 1 of 1 meal observed (03/12/2025 lunch). These failures could place residents at risk of decreased food intake, hunger, and unwanted weight loss. The findings included: During confidential individual interviews, 3 of 5 residents voiced concerns related to food palatability and temperature. One Resident stated, this morning I didn't eat my breakfast because it had no taste. Another Resident stated, it's the lunch and the dinner that's not always good, the flavor, the food is cold sometimes. One other Resident stated that the other food was cold, the scrambled eggs, I just ate my oat meal and that was it. During the confidential Resident Council interviews held on 03/12/2025 at 09:57 AM, 4 of 10 residents voiced concerns related to food palatability, temperature and appearance. Residents stated some of the food, Mashed Potatoes had no taste. It was further stated the meals were cold, and bread was hard as a rock. Residents stated pork steak were hard to chew. It was also stated the food was very bland, lacked flavor and was cold, especially breakfast. Observation on 03/12/2025 at 12:01 PM the test trays arrived at the conference room and sampling began at 12:01 PM and were sampled by three surveyors with the following results. Pork steak 138 F Was hard and poor flavoring. Mashed Potato 133.2 F No taste. Baked Beans 119 F Cold. Bread Puree 86.3 F Poor appearance - flat on the plate. On 03/13/2025 at 10:39 AM an interview was conducted with CNA C, stated the cooks were responsible for making sure that the food was warm before served. She stated no in-service training had on food palatability till date. She also stated they have heard complaints from residents regarding cold food and on a regular basis, all I do was to warm up their food using the microwave. She added residents would easily get sick when served with cold food. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She stated some residents were vocal individually about the poor foods and she had not come across any food policy. On 03/13/2025 at 10:57 AM an interview was conducted with DM A, he stated, Once the food gets out of the kitchen, we have no control over it, because it takes time for it to get to the residents, but my cooks were responsible for making sure that the food was warm/hot before it leaves. He also added been trained on food handling. He further stated, received complaints from the residents, an ongoing issue, about cold food and taste. He stated food comes from the steamer to an insulated cart, remained hot till served by the nurses. He stated residents could start losing weight and not eat the food if foods were not palatable. He stated that he had the policy. On 3/13/2025 at 11:49 AM an interview was conducted with the ADM. Regarding food palatability, he stated, it was combination of both dietary and nursing, that food should not get cold in between. He stated No, I don't know why that happened, part of the things I would look at. He stated food was cold, due to the time interval the carts were left at the units before the meals were served and would get managerial staffs involved in meal services. He stated that the Dietary Manager was responsible for the food palatability. He added that he expected staff to serve nutritive food. He added that residents could experience a reduction in quality of life and experience weight loss if the food was not palatable. Record review of the Resident Advisory Council Agenda and Minutes dated 01/03/2025 revealed the following, . dietary still have some concerns Record review of the Resident Advisory Council Agenda and Minutes dated 03/07/2025 revealed the following, . dietary still have some concerns Record review of the facility's policy labeled Food Handling, revised June 2019, revealed the following documentation, Policy: to ensure that all food served by the facility is of good quality and safe for consumption

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	455940	A. Building B. Wing	03/13/2025

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Lubbock Hospitality Nursing and Rehabilitation Cen	4710 Slide Rd Lubbock, TX 79414

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41480 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services, in that: The facility failed to ensure foods were processed and pureed under sanitary conditions. These failures could place residents at risk for food contamination and foodborne illness. The findings included: The following observations were made on 03/11/25 at 11:00 AM during observation of puree meal preparation: After pureeing new potatoes, the DM took processor bowl, lid, and blade to 3 compartments sink and cleaned all 3 parts shaking liquid off all 3 parts. The DM took all 3 parts back to processor base and assembled. The bowl had liquid in bottom and lid was dripping liquid. The DM prepared puree bread then took processor bowl, lid, and blade to 3 compartments sink and cleaned all 3 parts shaking liquid off all 3 parts. The DM took all 3 parts back to processor base and assembled. The bowl had liquid in bottom and lid and blade was dripping liquid. The DM prepared puree carrots. During an interview on 03/13/25 at 10:39 AM, the DM stated he had been trained to allow the puree machine cannister to air dry before using. The DM stated the lunch tickets were late to the kitchen that day and he was running behind, that was why he did not allow the puree machine cannister to air dry between uses. The DM stated the facility only had 1 puree machine cannister to use at the facility. The DM stated a potential negative outcome to the residents was the food could have some kinds of bacteria from the water or soap residue. During an interview on 03/13/25 at 11:02 AM, the ADM stated he expected the dietary staff to follow the proper procedure for sanitization. The ADM stated the proper procedure for sanitization included sanitizing the puree machine cannister and allowing it to air dry between every use. The ADM stated the DM had been trained on pureeing food and allowing the puree machine cannister to air dry completely between uses. The ADM stated the DM did not allow the puree machine cannister to air dry between uses because he stated he was in a rush that day. The ADM stated a potential negative outcome to the residents was it could cause contaminated food and illness. Record review of the facility policy and procedure titled, Manual Cleaning and Sanitizing of Utensils and Portable Equipment, dated 2018 reflected the following: Policy: The facility will follow the cleaning and sanitizing requirements of the state and US Food Codes for manual cleaning in order to ensure that all utensils and equipment are thoroughly cleaned and sanitized to minimize the risk of food hazards. Procedure: (continued on next page)

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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. 49279 Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 7 of 12 residents (Residents #3, #28, #46, #40, #62, #6 and #10) reviewed for infection control. 1. MA A failed to sanitize the blood pressure cuff between resident use for Resident #3 and Resident #28. 2. LVN B failed to utilize hand hygiene between glove changes during wound care on Residents #46, #40, and #62. 3. LVN B failed to utilize enhanced barrier precautions during wound care for Residents #46, #40 and #62. 4. LVN A failed to utilize hand hygiene between residents during medication administration for Resident #6 and Resident #10. These failures could place residents at risk for cross contamination and infection. The findings include: During a medication administration observation on 3/12/2025 at 7:34 AM, MA A used the blood pressure cuff to take Resident #3's blood pressure. At 7:43 AM, MA A used the same blood pressure cuff to take Resident #28's blood pressure. No sanitation of equipment was conducted before or after using the blood pressure cuff on Resident #28 or Resident #3. Record review of Resident #62's care plan revealed Problem: I require enhanced barrier precautions due to the following: I am at increased risk of a MDRO acquisition due to having a wound . Approach Start Date: 11/05/2024 .Staff will wear PPE during high-contact activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, incontinent care, wound care of any type requiring a dressing. Record review of Resident #62's physician orders revealed a wound care order dated 1/28/2025 for LLE Vascular Ulceration Clean with Normal Saline/Wound Cleanser pat dry Calcium Alginate and cover with silicone superabsorbent dressing Daily and PRN in the event of dislodgement. During a wound care observation on 3/12/2025 at 8:47AM, LVN B failed to follow the enhanced barrier precaution signs outside Resident #62's door and did not don PPE gear prior to starting wound care. LVN B removed the dirty dressing to Resident #62s left leg and doffed dirty gloves. LVN B donned cleaned gloves without performing hand hygiene between the glove change. LVN B failed to change gloves after cleaning the wound on Resident #62's left leg and opened the wound supplies with dirty gloves. LVN B dressed Resident #62's left leg without changing gloves or performing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a medication administration observation on 3/12/25 at 8:59 AM, LVN A prepared morning medications for Resident #6. LVN A entered the resident room and administered the prepared medications to Resident #6. LVN A returned to the medication cart and prepared morning medications for Resident #10 without performing hand hygiene. LVN A entered the resident room and administered the prepared medications to Resident #10. Record review of Resident #46's care plan revealed Problem start date 03/09/2025: I require enhanced barrier precautions due to the following: I am at increased risk of a MDRO acquisition due to having a wound . Approach Start Date: 3/09/2025 .Staff will wear PPE during high-contact activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, incontinent care, wound care of any type requiring a dressing. Record review of Resident #46's physician orders revealed a wound care order dated 3/07/2025 for Wound Treatment Order: Location: coccyx Clean with Normal Saline/Wound Cleanser Place calcium alginate and cover daily and a physician order dated 2/26/2026 for Wound Treatment Order: Location: right ischium Clean with Normal Saline/Wound Cleanser Apply: petroleum gauze Cover with Primary Dressing: bordered gauze. During a wound care observation on 3/12/2025 at 9:00AM, LVN B failed to follow the enhanced barrier precaution signs outside Resident #46's door and did not don PPE gear prior to starting wound care. LVN B removed Resident #46's dirty dressing to right hip and coccyx. LVN B doffed dirty gloves and donned clean gloves without performing hand hygiene between the glove change. LVN B cleaned right hip wound and doffed dirty gloves, and donned clean gloves without performing hand hygiene between the glove change. LVN B dressed right hip and doffed dirty gloves. LVN B donned clean gloves without performing hand hygiene between the glove change. LVN B cleaned coccyx wound and doffed dirty gloves. LVN B donned clean gloves without preforming hand hygiene between the glove change. Record review of Resident #40's care plan revealed Problem start date 10/28/2024: I require enhanced barrier precautions due to the following: I am at increased risk of a MDRO acquisition due to having a wound . Approach Start Date: 10/28/2024 .Staff will wear PPE during high-contact activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, incontinent care, wound care of any type requiring a dressing. Record review of Resident #40's physician orders revealed a wound care order dated 12/20/2024 Wound Treatment Order Right hip Clean with Normal Saline/Wound Cleanser Apply calcium alginate Cover and a physician order dated 12/20/2024 Wound Treatment Order: Location: right thigh Clean with Normal Saline/Wound Cleanser Apply: calcium alginate Cover with Primary Dressing: foam dressing During a wound care observation on 3/12/2025 at 9:14 AM, LVN B failed to follow the enhanced barrier precaution signs outside Resident #40's door and did not don PPE gear prior to starting wound care. LVN B removed Resident #40's dirty dressings to right hip and right thigh. LVN B doffed dirty gloves and donned clean gloves without performing hand hygiene between the glove change. LVN B cleaned Resident #40's nonhealing surgical wound and doffed dirty gloves, and donned clean gloves without performing hand hygiene between the glove change. LVN B dressed Resident #40's right hip wound and doffed dirty gloves. LVN B donned clean gloves without performing hand hygiene between the glove change. LVN B cleaned Resident #40's right thigh wound and doffed dirty gloves. LVN B donned clean gloves without performing hand hygiene between the glove change and finished dressing Resident #40's right thigh wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/12/25 at 9:24 AM with LVN A, she stated she did not sanitize her hands between Resident #6 and Resident #10 while performing medication pass because she got in a hurry. She stated she had been trained in her nursing education to perform hand hygiene before and after contact with a resident and before handling medications. LVN A stated a potential negative outcome of failure to perform hand hygiene during medication pass was that a resident could get sick from cross-contamination. During an interview on 3/12/2025 at 9:45 AM with LVN B, she stated she had been at the facility for two weeks. She stated she had not received formal training on wound care, infection control or handwashing at this facility but she had training previously in her nursing career. She stated she was aware she needed to wash her hands between glove changes but was nervous and forgot. She stated she was not aware she needed to utilize EBP on residents with wounds. She stated she did see the signs outside of Resident #40, #46 and #62's rooms but did not see that it stated wound care as a reason for utilizing EBP. She stated handwashing is the most important part of infection control. She stated her infection preventionist was the DON. She stated she had infection control training in her nursing career. During an interview on 3/13/2025 at 11:08 AM with MA A, she stated she had been trained on infection control and her last training was sometime last year. She stated she had been trained to clean her equipment after each use and between residents. She stated she was aware she didn't do that after administering medication, but she had been nervous and had forgotten. She stated the potential negative outcome would be spreading infection between residents. During an interview on 3/13/25 at 10:42 AM with the DON, he stated staff had been trained on proper hand hygiene during medication pass. He stated hand hygiene should be performed prior to contact with a resident and after the administration of medications. He stated staff were trained on hand hygiene during medication pass through competency checks and rounds conducted by nursing administration. The DON stated his expectation of staff was to follow hand hygiene protocol during resident care. He stated a potential negative outcome for failure to properly sanitize hands during medication administration was the spread of infection. During a second interview on 3/13/2025 at approximately 12:15 PM with the DON, he stated he was the infection preventionist. He stated there was a hand hygiene training done about a month ago and the last infection control training had been the annual competencies. He stated staff had been trained on EBP and the last training would be in the competencies but was unsure of the date. The DON stated EBP was utilized for residents that have wounds, invasive tubes such as urinary catheters. He stated EBP is used to minimize the risk of infection between residents. He stated the potential negative outcome of staff not utilizing EBP could be the transfer of bacteria from one resident to the next. He stated his expectation of staff was for hand hygiene to occur between glove changes. He stated the potential negative outcome of not utilizing hand hygiene between glove changes could be transferring bacteria from one resident to the next. The DON stated staff had been trained to clean equipment between resident use. He stated the potential negative outcome of not cleaning the equipment could be spread of infection and germs. The DON stated compliance with infection control was monitored by doing walking rounds and ensure they are doing their handwashing. He stated he has done spot checks where he observed the staff perform incontinence care or wound care. He stated they also had a trainer and educator who would assist with the staff training. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/13/25 at 11:12 AM with the ADM, he stated was not aware that staff were not following protocol for hand hygiene during medication administration. He stated it was the responsibility of the DON to assure staff were trained on hand hygiene during medication administration. He stated his expectation of staff was to assure hand hygiene was performed at the correct times and according to policy. The ADM stated a potential negative outcome for failure to perform hand hygiene during medication administration was spreading infection. During a second interview on 3/13/2025 at approximately 12:55 PM with the ADM, he stated the DON was the infection preventionist. He stated staff have been trained on EBP. He stated EBP was used on residents who have wounds, dialysis ports, feeding tube or catheters. He stated they were used to prevent the spread of infection and the negative outcome of not following the EBP could be the spread of infection. The ADM stated staff should be utilizing hand hygiene after removing their gloves. He stated the potential negative outcome of not performing hand hygiene could be the spread of infection. He stated the wound care nurse had been trained on EBP and hand hygiene. The ADM stated staff had been trained to clean the equipment between resident use. He stated they needed to use the disinfecting wipes. He stated the potential negative outcome of not cleaning the equipment between resident use could be the spread of infection. The ADM stated the DON monitors compliance with infection control practices. Record review of facility policy titled Handwashing/Hand Hygiene last revised 1/20/2023 revealed: This facility considers hand hygiene the primary means to prevent the spread of infections. . 5. Hand hygiene must be performed prior to donning and after doffing gloves. 6. Hand hygiene is the final step after removing and disposing of personal protective equipment. Record review of facility policy titled Enhanced Barrier Precautions last revised 4-1-2024 revealed: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistance organisms . b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) . 4. High-contact resident care activities include .h. Wound care: any skin opening requiring a dressing. Record review of facility policy titled Cleaning and Disinfection of Resident-Care Equipment undated, revealed: Policy: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current CDC recommendations in order to break the chain of infection . Reusable multiple-resident items are items that may be used multiple times for multiple residents. Examples include stethoscopes, blood pressure cuffs, feeding tube pumps, and oxygen concentrators. b. Each user is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident. Record review of the facility policy titled Specific Medication Administration Procedures, last revised January 2018 revealed: Policy To administer medication in a safe and effective manner. Procedures F. Cleanse hands using antimicrobial soap and water or facility-approved hand sanitizer before beginning a med pass, before handling medication, and before contact with resident. . O. When finished with each resident, wash hands with antimicrobial soap and water or use facility-approved hand sanitizer. 49305