STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455986	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Henderson Health & Rehabilitation Center	1010 W Main St Henderson, TX 75652

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019 Based on observation, interview and record review the facility failed to treat each resident with respect and dignity and care in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 2 of 18 residents (Resident # 28 and Resident # 42) reviewed for resident rights. 1. The facility failed to ensure Resident #28's dignity when dining while the Nurse Practitioner assessed the resident's foot callous at the dining room table while the resident was eating with other residents eating . 2. The facility failed to ensure Resident #42 had toilet paper, paper towels and soap in dispenser for personal hygiene use. These failures could place residents at risk for a decreased quality of life, decreased self-esteem and increase anxiety. Findings include: 1. Record review of Resident #28's face sheet, dated 04/17/2024, indicated an [AGE] year-old female who was admitted on [DATE]. Resident #28 had diagnoses which included Dementia with other behavioral disturbances (general term for loss of memory, language, problem solving and thinking was severe enough to interfere with daily life), Cognitive communication deficit (problems with communicating), Depression (loss of pleasure or interest in activities for long periods of time) and Anxiety (feeling of fear, dread, and uneasiness). Record review of the MDS Quarterly Assessment, dated 2/22/2024, indicated Resident #28 was sometimes understood and sometimes understood others. Resident #28 had a BIMS score of 3, which indicated severe cognitive impairment. Resident #28 required supervision for most ADL's. Record review of Resident #28's care plan, revised on 11/6/2023, indicated Resident #28 was at risk for behavioral problems. There was an intervention to intervene as necessary to protect the rights and safety of others by removing resident to an alternative location when needed to protect the rights and safety of others. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/16/2024 at 12:18 p.m. revealed, Resident #28 was sitting at a table with all memory care residents in the dining area. The Nurse Practicioner was knelt beside Resident #28 assessing her right foot at the dinner table while other residents looked on. The Nurse Practitioner was spreading each toe out inspecting Resident #28 right foot and said she did not have a wound but a large callous. A resident to the right of Resident #28 was observing during the assessment while eating lunch. During an interview on 4/16/2024 at 12:30 p.m., the Nurse Practitioner said it was not usual practice for her to assess her residents while they were eating. She stated she usually had the resident return to their room, and it depended on the situation. The Nurse Practitioner said she was going to make a referral for the resident to see the podiatrist . There were approximately 10-12 residents in the dining room at the time of the assessment. During an interview on 4/17/2024 at 11:13 a.m., LVN D said it was not appropriate for a nurse, Nurse Practitioner or Physician to remove a resident's socks or shoes to assess their feet while at the dinner table. The resident could feel embarrassed. LVN D said he had not observed any staff assessing residents at mealtimes . During an interview on 4/17/2024 at 11:26 a.m., LVN E said it would be a dignity issue to assess a resident's feet while eating at the table with other residents. LVN E said she would offer to take the residents to their room to be assessed privately even on the memory unit. LVN E said if she observed a clinician such as a doctor or Nurse Practitioner performing an assessment in a public area, she would report to management. LVN E said a resident could feel humiliated . During an interview on 4/17/2024 at 11:34 a.m., the ADON said she would wait after the meal was completed to assess a resident. The ADON said she could see where assessing a resident while they were eating would make them feel uncomfortable. The ADON said she would check the resident's cognitive level. The ADON said it could make another resident wonder why they were performing an assessment at the table and may not want to observe. The ADON said she expected staff to perform assessments and care in a more private room area where other residents were not around. During an interview on 4/17/2024, the DON said it depended on where you were and if the resident wore shoes. The DON said the resident initiated the encounter with the Nurse Practitioner and allowed the Nurse Practitioner to observe her foot at the dining table while she was eating. The DON said she did not have an issue due to the resident having a mentation that allowed her to know what was going on. The DON said there was 100% confusion on the memory care unit. The DON said she would assume the Nurse Practitioner would explain to the family what was going on if the family came in the facility. The DON said Resident #28 was willing to allow the Nurse Practitioner to observe her at the time and stuck her foot up. The DON said all residents with memory issues should be treated with dignity and respect but that was not what happened, and she did not feel it was a dignity issue with Resident #28. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/2024, the ADM said resident's care was based on the resident's particular need. The ADM said the Nurse Practitioner making rounds should not have assessed the resident's feet during a meal. The ADM said the resident should have privacy when assessing a resident's skin or foot would not need to take place during their meal. The ADM said she would offer the resident go to another room, attempt to move resident to another area, or come back at another time if a resident offered to be assessed at the dining table. The ADM said she would redirect the resident and wait till after meal. The ADM said she would want to base care on the resident's memory needs. 2. Record review of Resident #42's face sheet, dated 4/17/2024, indicated Resident #42 was a [AGE] year-old female who was admitted on [DATE]. Resident #42 had diagnoses which included Hyperlipidemia (a condition in which there are high levels of fat particles in the blood), Dementia (general term for loss of memory, language, problem solving and thinking was severe enough to interfere with daily life), anxiety ((feeling of fear, dread, and uneasiness) and ulcerative (chronic) pancolitis with other complications (form of inflammatory bowel disease characterized by widespread inflammation affecting the entire colon). Record review of the MDS Optional State Assessment, dated 1/11/2024, indicated Resident #42 was usually understood and sometimes understood others. Resident #42 had a BIMS score of 3, which indicated severe cognitive impairment. Resident #42 required limited assistance with toileting. Record review of Resident #42's care plan, revised on 2/26/2024, indicated Resident #42 was at risk for behavioral problems and incontinence of bowel and bladder. There was an intervention to assess and anticipate resident's needs such as food, thirst, toileting needs, comfort level, body positioning and pain. During an observation on 4/15/2024 at 9:47 a.m., Resident #42 bathroom had a brown residue in the sink, no paper towels, no soap in the dispenser and no toilet paper. Resident #42 said when she urinated, she would drip dry and she said if she had a bowel movement, she would use paper towels from the dining room she collected during meals from her tray. Resident #42 pulled open her top drawer of her dresser cabinet and she showed napkins from her dining room tray she had stacked in her dresser drawer. Resident #42 said she ran her hands under water in her bathroom sink and did not use soap. Resident #42 said the facility never had soap in her bathroom . During an interview on 4/17/2024 at 9:25 a.m., CNA B said when she came in the morning, she would get the residents up for the day. CNA B said she would gather the resident's clothes and take them to the shower room for the residents with a scheduled shower. CNA B said she would get the residents ready for their day by changing their briefs if they were wet, performed perineal -care to freshen them up, brush hair, brush teeth, and wash their face. CNA B said there were residents who could go to the bathroom on their own. CNA B said the facility did not keep toilet paper in the resident's room because residents would wipe and clog the toilets. CNA B could not identify what the residents used to get clean after toileting. CNA B could not identify residents who washed their hands after leaving their bathroom. CNA B said residents who did not have proper hand hygiene would be at risk for infection if they got feces on their hands and then in their mouth. CNA B said she did touch doors and other objects the residents touched which could cause staff to become sick and affect others around her. CNA B said the staff checked the rooms to see if they needed to be cleaned and CNA B said she would take care of it if she could. CNA B said the residents did not use hand sanitizer while on the memory unit. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/2024 at 9:40 a.m., CNA A said she would get the residents up before breakfast and took them down to the shower room to get them cleaned up and dressed by brushing their teeth, washing their face and hands. CNA A said the residents did not have wash cloths or soap in their rooms. CNA A said everyone should have soap, but residents would put it in their hair. CNA A said the housekeeper supplied the toilet paper. CNA A said the housekeeper knew which resident rooms to put toilet paper in. CNA A said she checked the residents every 2 hours to ensure they were clean. CNA A said she was not sure how the residents were wiping because the residents must ask staff, and staff brought them wipes. CNA A said if a resident did not have access to toilet paper, soap and paper towels, it would be nasty, and they could get an infection. CNA A said not being cleaned properly could place the residents at risk for skin issues or cause their bottom to get red. CNA A said staff were at risk for infection if objects were touched by residents who had not washed their hands, then staff touched objects the residents touched. CNA A said the majority of the residents did need supplies in their room. During an interview on 4/17/2024 at 9:56 a.m., LVN E said residents started their day getting up and sitting in the main room or going to the shower room. LVN E said residents were scheduled for a shower, they would go to the shower room. LVN E said the staff performed morning care for all residents. LVN E said the evening shift would get up 6 residents to receive morning care. LVN E said there were certain residents who received paper towels and toilet paper. LVN E said she was not sure how the residents washed their hands. LVN E said she was unaware residents did not have soap in their dispenser and there was no way to determine who had washed their hands. LVN E said residents and other staff could get contaminated and become sick. LVN E said she expected resident's hands to be washed prior to meals and between meals as needed. During an interview on 4/17/2024 at 10:11 a.m., Hospitality Aid F said she was the housekeeper for Hall 3 and the Memory care unit. Hospitality Aid F said she went in the morning and emptied the trash out of the rooms and checked the paper towels, toilet paper and soap dispensers. Hospitality Aid F said she was instructed by her supervisor not to place paper towels and toilet paper on the memory unit due to residents clogging the toilets. Hospitality Aid F said Aides told her not to put soap in the dispenser in the resident's rooms. She said residents not washing their hands could contaminate other surfaces other residents and staff touched placing them at risk for infection. Hospitality Aide F said this was the resident's home and they should have access to toilet paper, paper towels and soap. During an interview on 4/17/2024 at 10:39 a.m., Hospitality Aide G said she was the supervisor for housekeeping. She said toilet paper and paper towels were not being placed in the resident's room. Hospitality Aid G said the residents were to use the dining room bathroom and shower room bathroom to wash their hands and use the bathroom. Hospitality Aide G said residents would put paper towels and toilet paper in their toilet. Hospitality Aide G said she was not sure which residents were independent with toileting. She said the facility was no longer putting soap in the dispensers in the resident's rooms on the memory hall due to residents putting soap on their face and hands. Hospitality Aide G said upper department heads made the decision not to put paper products in the resident's bathrooms and was told the staff would be responsible for washing and tending to the resident hygiene. Hospitality Aide G said handwashing was important for all residents and staff. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/2024 at 11:34 a.m., ADON P said residents on the memory care unit did not have toilet paper in their rooms due to residents stopping up toilets, sinks and stuffing paper towels in the sinks which caused water to overflow. ADON P said the staff on the unit were responsible for washing all the resident's hands in the morning before breakfast and changed residents to prepare them for the day. ADON P said the staff kept rounding and identified residents who needed to be changed. ADON P said she was not aware of who was washing and getting personal care completed after residents toileted. ADON P said she would not want residents using a sock or drip dry after toileting. During an interview on 4/17/2024 at 11:45 a.m., the DON said the facility staff talked about the toilet paper, paper towels in the past due to plumbing issues from resident's stuffing things in the toilet. The DON said the facility was going to take another look at the issue. The DON said she observed staff, and they made sure the residents had hand sanitizer. The DON said she discussed with staff to make more frequent rounds to make sure the residents were not taking off their brief and placing them in drawers or under the mattress. The DON said the facility needed to do a case-by-case evaluation. During an interview on 4/17/2024 at 1:14 PM, the ADM said the residents on the memory unit were taking paper towels and toilet paper and sticking them in their own orifices. The ADM said paper towels, toilet paper and soap were not in the rooms on the memory hall. The ADM said there was not a policy just concern for the well-being of the residents. The ADM said the facility had plumbing issues related to the residents on the memory unit stuffing paper towels and toilet paper down the sink. The ADM said the unit staff had access to the main bathroom on the hall and the shower room they could take residents to use during the day. The ADM said the hand sanitizers and soap were removed due to resident putting it in their drinks. The ADM said the facility was re-evaluating and seeking alternative options for residents to ensure proper hygiene was achieved. Record review of the facility policy, dated 2/16/2020, titled Promoting/Maintaining Resident Dignity, reflected . It is practice of the facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect . What is dignity .innate quality of being a human .a person's self-esteem .Process: 1. All staff members are involved in providing care to residents to promote and maintain resident dignity .2. During interactions with residents, staff must report, document and act upon information regarding a resident preference .6. Respond to request for assistance in a timely manner which include but not limited to responding to call lights, toileting/incontinence, and personal needs .12. Maintain resident privacy Record review of the facility's, undated and untitled, policy reflected Standard Bathroom Cleaning indicated . daily cleaning of the bathrooms, restrooms and tub-shower rooms help provide a sanitary environment, prevent odors, control infectious material, and prolong the useful life of the equipment .Procedure .empty and sanitize toilet, using bowl brush daily .add bowl cleaner one time per week, more if necessary

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on observation, interview and record review the facility failed to ensure residents had the right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely for 1 of 6 (Resident #33) residents reviewed for environment. 1. The facility failed to ensure Resident #33's bathroom sink was free of brown substances. 2. The facility failed to ensure soiled briefs were removed from Resident #33's trash can. These failures could place residents at risk of an unsafe or uncomfortable environment and a decrease in quality of life and self-worth. Findings include: Record review of Resident #33's, undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #33 had diagnoses which included CVA (damage to the brain from interruption of its blood supply), hypertension (high blood pressure) and Alzheimer's disease (progressive disease that destroys memory and other important mental functions). Record review Resident #33's quarterly MDS assessment, dated 02/14/2024, reflected Resident #33 had a BIMS of 02, which indicated severe cognitive impairment. Resident #33 had no behaviors, was frequently incontinent of bowel and bladder and was dependent on staff for personal hygiene and toileting. Record review of Resident #33's care plan indicated no care plans for behaviors. The care plan, dated 02/14/2024, indicated Resident #33 was frequently incontinent of bowel and bladder and required assistance of 1 staff member for incontinent care. During an observation on 04/15/2024 at 9:30 a.m. revealed the bathroom of Resident #33 was noted to have a brown foul-smelling substance smeared throughout the sink. There were no paper towels and no soap in the bathroom. There was a soiled brief in the trash can next to the toilet. The mirror was covered in a white film. During an observation on 04/16/2024 at 10:20 a.m. revealed the bathroom of Resident #33 continued to have a brown foul-smelling substance smeared throughout the sink. There were still no paper towels or soap in the bathroom. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/15/2024 at 10:00 a.m., the family member of Resident #33 stated the only complaint they had about Resident #33's care was the bathroom was always dirty and looked like a rundown truck stop bathroom. The family member stated there was rarely any soap or paper towels and she liked to wash Resident #33's hands prior to her eating meals. The family member of Resident #33 stated she was unsure if it was Resident #33 or the resident next door who shared the bathroom with her who was smearing what appeared to be feces on the lavatory and mirror. She stated she felt like housekeeping should be cleaning those areas more frequently for sanitation reasons. She also stated Resident #33 would have been devastated prior to her illness to have a bathroom in the state of filth her bathroom was currently in. During an interview on 04/17/2024 at 11:00 a.m., CNA A stated there were several resident rooms and bathrooms that needed to be deep cleaned. CNA A stated the housekeepers were supposed to come and clean all the rooms and bathrooms each day. She stated the housekeepers were supposed to come back multiple times per day and clean, but they usually only came once a day. CNA A stated over the last 7 days she worked, today was the first day staff ensured all the soap dispenses and toilet paper holders were full for all residents. CNA A stated she alerted housekeeping when she saw them when a room was in need of cleaning. During an interview on 04/17/2024 at 11:30 a.m., Housekeeper Y stated it was her job when she was assigned to the memory care unit to ensure all the rooms and bathrooms were cleaned daily. She stated she came back to the memory care after each meal and cleaned the dining rooms. She stated she was unaware of why no one had cleaned Resident #33's bathroom on 04/15/2024 and 04/16/2024. She stated it was the responsibility of the housekeeper working the memory care unit to make sure it was done. She stated the Housekeeping Supervisor had their own area to clean and was not always available to check behind the housekeeping staff. During an interview on 04/17/2024 at 12:45 p.m., the ADM stated she expected the housekeeping policy to be followed by all housekeepers in each area of the building. The ADM stated there were a few residents on the memory care unit that were not provided soap in their rooms but were encouraged by the staff to wash their hands in the shower room for safety of the residents. The ADM viewed Resident #33's bathroom and stated the condition of the Resident #33's bathroom was unacceptable. The ADM stated the IDT would brainstorm as a team on a way to ensure all residents had access to a clean restroom and ways to wash their hands after using the bathroom and before meals. Record review of the facility's, undated, policy titled Resident Room Cleaning indicated, Daily cleaning of the bathrooms, restrooms and tub-shower rooms helps to provide a sanitary environment, prevent odors, control infectious material, and prolong the useful life of the equipment, paint, and floor finish . Clean and dust all fixtures, use high duster on any hard-to-reach areas. Use cleanser on sink for any stains. Shine chrome with damp cloth and mild cleaning solution. Use glass cleaner on mirrors.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on interview and record review the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality care within 48 hours of a resident's admission and included the minimum healthcare information necessary to properly care for a resident for 2 of 7 residents (Resident #181 and Resident #182) reviewed for care plans. The facility failed to develop and implement a baseline care plan within 48 hours of admission for Residents #181 and #182. This failure could place residents at risk of not receiving care and services to meet their needs. Findings include: 1. Record review of Resident #181's, undated, face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #181 had diagnoses which included traumatic subdural hematoma (bleeding fills the brain area very rapidly, compressing brain tissue), dementia (progressive disease that destroys memory and other important mental functions) and anxiety. Record review of an incomplete admission MDS assessment, dated 04/15/2024, reflected Resident #181 had a BIMS of 02, which indicated severe cognitive impairment. The discharge plan for Resident #181 was to remain in the facility long-term. Record review of the baseline care for Resident #181 reflected no baseline care plan was initiated prior to survey intervention. 2. Record review of Resident #182's, undated, face sheet reflected Resident #182 was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #182had diagnoses which included dementia (progressive disease that destroys memory and other important mental functions), hypertension (high-blood pressure) and hypothyroidism (progressive disease that destroys memory and other important mental functions). Record review of an incomplete admission MDS assessment, dated 04/22/2024, reflected an incomplete MDS in progress. Record review of the baseline care plan for Resident #182 reflected no baseline care plan was initiated prior to survey intervention. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/2024 at 12:30 p.m., the DON stated the baseline care plan was an interdisciplinary team responsibility. The interdisciplinary team consisted of the Social Worker, Activities Department, the nurse, therapy and dietary department. The DON stated a meeting was to be scheduled by the Social Worker with the resident and their family and each department had a section to complete. The DON was not aware the baseline care plan was to be completed within 48 hours of admission. The DON stated the baseline care plans for Residents #181 and #182 were not completed until 04/16/2024 after surveyor intervention. The DON stated the facility completed an in-service about timeliness of the completion of baseline care plans on 04/12/2024 with all IDT members that included the timeline for completion of the baseline care plan. The DON stated the baseline care plan acted as a set of instructions to follow for the resident's care. The DON stated not having a baseline care plan would make it hard for staff to give accurate care to the individual needs of each resident. During an interview on 04/17/2024 at 12:45 p.m., the Administrator stated she expected the staff members to do their part to complete the baseline care plans. She felt baseline care plans were important information to help the staff care for each resident. The ADM stated it was hard to care for new residents without having an outline and the baseline care plan gave the staff an outline until the MDS was completed and the comprehensive care plan was created to guide resident care. Record review of an in-service, dated 04/12/2024, signed by the Dietary Manager, Activities Director, Social Worker, and therapy department indicated the facility must have a baseline care plan meeting within 48 hours of the admission of the resident and implement a baseline care plan for all newly admitted residents. Record review of the facility policy, dated 11/08/2026, titled Baseline Care Plan, indicated the baseline care plans are developed and implemented within 48 hours of a resident's new admission Baseline care plans are developed by the Registered Nurses and other healthcare team members.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35295 Based on interview and record review the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for 1 of 20 residents (Resident #20) reviewed for care plans. The facility failed to revise Resident #20's care plan to reflect his choice to be a DNR. This failure could place residents at risk for not receiving appropriate care and interventions to meet their current choices and needs. Findings include: Record review of Resident #20's, undated, face sheet indicated an [AGE] year-old male who was admitted to the facility on [DATE]. Record review of Resident #20's physician's orders, dated [DATE] , indicated Resident #20 had diagnoses which included: Parkinson's Disease (a disorder of the nervous system that affects movement, often including tremors), Cerebrovascular Disease (affects blood flow to the brain) and dementia (persistent loss of intellectual functioning). Record review of Resident #20's physician's order, dated [DATE], indicated Resident #20 was a DNR. Record review of Resident #20's OOH-DNR indicated it was signed on [DATE] by Resident #20's family member. Record review of the care plan, dated [DATE], indicated Resident #20 had impaired cognition with a risk for further decline and indicated he was a full code. Resident has physician's orders that include a status of full code. The goal indicated staff would administer CPR if resident had an arrest. The interventions were to ensure the full code order was on the chart and begin CPR after absence of vital signs, call 911, notify physician, and notify family/responsible party. Record review of the admission MDS, dated [DATE], indicated Resident #20 had clear speech, was sometimes understood by others, and sometimes understood others. Resident #20 had a BIMS score of 6, which indicated severe cognitive impairment. He had inattention that was continuously present. Record review of the care plan on [DATE] at 11:05 AM indicated Resident #20 was full code. Record review of the physician's orders, dated [DATE], indicated Resident #20 was a DNR. The DNR was ordered by the physician on [DATE]. Record review of an OOH-DNR for Resident #20 was dated [DATE] . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Henderson Health & Rehabilitation Center	1010 W Main St Henderson, TX 75652

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:39 AM, MDS Q said the care plan was an IDT approach. She said different staff were responsible for the care plan in the different disciplines put different things in the care plan. She said the person responsible for the code status of a resident was the SW . During an interview and record review on [DATE] at 11:41 AM, the DON and the State Surveyor looked at Resident #20's care plan. The DON agreed the care plan indicated the resident was full code. She and she looked at his DNR, dated [DATE], and she stated she knew he was a DNR. She said his care plan should have been changed and updated to indicate he was a DNR, and it was not. She said his most recent care plan meeting was Wednesday [DATE] and the next day, [DATE] his family member came in and signed a DNR with the SW. She said the SW should have updated the care plan when she got the DNR paperwork. The SW and the DON reviewed the resident's physician's orders for a DNR, dated [DATE] and an OOH-DNR also dated [DATE]. She said the process was, whoever received the DNR paperwork should change the care plan. She said the SW did not change the care plan and it was her responsibility. She said ultimately, she was responsible for the care plan being updated to reflect the current status of Resident #20 because she was the DON. During an interview on [DATE] at 12:34 PM, the DON said the advance directive policy indicated the SW should document all DNR's. She said the SW knew it was her responsibility, and it was she who met with the family to discuss and complete the DNR. During an interview on [DATE] at 2:39 PM, the SW said she met with Resident #20's family to do the DNR on [DATE]. She said she was supposed to update the care plan but got busy and did not do it. She said it was her responsibility to update the care plan and she should have done it . During an interview on [DATE] at 12:07 PM, LVN R said the importance of code status on the care plan was for nurses to know whether or not to perform CPR on a resident. She said she would not want to do CPR if a resident was a DNR because it could cause a poor quality of life. She said you would certainly want to do CPR on a resident who had chosen a full code status. She said nurses had to know whether a resident was a full code or a DNR and their information had to be documented correctly. She said if staff did CPR on a resident who chose a DNR, that resident could end up on a tracheostomy (surgically created hole in the neck to allow air into the lungs) or life support. She said a DNR or a full code was the resident/family's choice to make. She said resident choices were very important. She said the SW was responsible for making sure the code status was documented correctly on the care plan. During an interview on [DATE] at 12:14 PM, LVN S said code status was important. She said if a resident was a DNR and they gave that resident CPR and revived them, they could be in a lot of trouble. She said if a resident was a full code and they thought the resident was a DNR, and did not try to revive them the resident could die. She said they had to be sure all information was in the care plan correctly. She said the residents choice was very important. She said the SW was responsible for making sure a resident's code status was correct in the care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:23 PM, ADON P said the resident's code status on the care plan was how they determined whether or not to initiate CPR for a resident. She said it was very important for the information to be correct regarding the resident's choices. She said if a resident was a DNR and they did CPR, it could cause harm to the resident because they could have broken bones during CPR, caused a poor quality of life, caused the resident's family to be upset, not acknowledged the resident's wishes or their right to choose. ADON P said if it was the other way around, and a resident was a full code and did not get CPR, they could die. She said the family would be very upset if the facility did not try to save them. During an interview on [DATE] at 1:11 PM, the DON said she expected the SW or the licensed staff who received DNR paperwork to update the care plan. She said she thought Resident #20's care plan not being updated with the new DNR order was an oversite on the part of the SW. She said she expected the care plan to be updated with the resident's wishes regarding a full code or a DNR. The DON said it would be a big problem if a resident who was a DNR was given CPR because that was a dignity issue and not the resident's wishes. She said that could cause the resident depression and a poor quality of life. She said giving a DNR resident CPR would be the worst scenario ever. She said if you did not give CPR to a resident who was a full code it could cause a resident to die before they should and not attempting to save their life. She said that was playing with someone's life. She said if the wishes of the resident were not followed it could also cause the family to be grievous. During an interview on [DATE] at 1:41 PM, the ADM said she expected the care plan to be correct regarding a resident's code status. She said the SW was responsible for making sure the care plan was updated to reflect the correct code status. She said the SW's responsibility for the care plan was the code status. She said regarding Resident #20's incorrect care plan (which indicated he was a full code when he was a DNR) that could have caused him to get CPR when that was against his wishes and it could be a dignity issue. She said they had a code book that ADON P updated with new information and staff could look in the book to see who was a DNR and who was a full code. She said she did not know if Resident #20's code status was updated in the Code Book . She said if a resident was a full code and incorrectly marked as a DNR the resident could die when they should not have, and that could cause legal issues. She said resident choices were important. During an interview and record review on [DATE] at 1:46 PM, ADON P showed the State Surveyor the Code Book which included a DNR for Resident #20 and a copy of his OOH-DNR dated [DATE]. She said she put the information for Resident #20's code status in the Code Book but did not remember when. Record review of an Advance Directives/Advance Care Planning Policy, dated ,d+[DATE], revised , d+[DATE], and ,d+[DATE], indicated: Policy It is the policy of this facility to recognize two fundamental rights of a person; the right to live and to continue treatment and the right to refuse or terminate unwanted treatment. This facility will honor a resident's wished and advanced directives pertaining to his/her own medical treatment, including wishes to withhold treatment . In the absence of the Social Worker the Administrator appoints a staff member to assume the responsibility for advance directives and advanced care planning. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.8.Social Service communicates to a nursing a residents advanced directive/code status implementation or changes. Record review of the Comprehensive Care Plans Policy, dated [DATE], indicated: Policy It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. .3.The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. b. Any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment .

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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** 48958 Based on observation, interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as was possible and residents received adequate supervision and assistance devices to prevent accidents for 2 of 6 residents (Residents #39 and #9) reviewed for accident hazards. 1. The facility failed to ensure Resident #39's shoulder seat belt was buckled prior to transport. Resident #39 slid out of the wheelchair to the floor when the facility transportation van stopped at a stop sign. 2. The facility failed to ensure CNA H and LVN I transferred Resident #9 safely when they tilted Resident #9's wheelchair back onto the anti-tip bars with all 4 wheelchair wheels not touching the floor and lowered Resident #9 into the wheelchair via mechanical lift. 3. The facility failed to ensure CNA H and LVN I ensured the mechanical lift legs were in the widest position while transferring Resident #9 from bed to her wheelchair. These failures could place residents at risk of falls which could result in injury and hospitalization . Findings include: 1. Record review of Resident #39's face sheet, dated 04/15/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #39 had diagnoses which included: end stage renal disease (kidney failure), pressure ulcer of sacral region stage 4 (full-thickness skin loss extends through the fascia with considerable tissue loss) and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Record review of Resident #39's quarterly MDS assessment, dated 3/25/24, reflected Resident #39 was usually understood and usually understood others. Resident #39 had a BIMS score 12, which indicated moderate cognitive impairment. Resident #39 required x2 assistance for bed mobility, transfer, toilet use and x1 assistance for personal hygiene and bathing. Record review of Resident #39 care plan, dated 4/16/24, reflected he required pressure relieving/reducing devices on bed/chair. Resident #39 has an air mattress bed. Resident #39 required reposition frequently or more often as needed or requested. Interventions included to approach Resident #39 in a calm manner. Resident #39 requested to called by name, spoken to slowly, maintain eye contact, talked while care provided, allow time for a response and do not rush. (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 and observation on 04/16/24 at 08:27 AM revealed Resident #39 was sitting in his bedroom in wheelchair. Resident #39 said, the day I slipped out of the seat, [Driver X] did not hook me up right. Resident #39 said [Driver X] was going 80 miles per hour down the highway, then he got on the brake and I slipped out of the wheelchair. Resident #39 said when he slipped out of his wheelchair, he hurt his wounds: on his knee, right arm and buttock. Resident #39 said after Driver X realized he had slipped out of his wheelchair, Driver X pulled over to a gas station to place him back in his wheelchair. Resident #39 said Driver X asked him if he was hurt, if he wanted to go to the emergency room or did he want to go back to the facility. Resident #39 said he told Driver X he was fine and he still wanted to go to his appointment. Resident #39 said Driver X did not drive fast he just got to where he was going. Resident #39 said Driver X strapped down his wheelchair, but he forgot to put his seat belt on. During an interview on 04/16/24 at 02:16 PM Resident #14 said she remembered the incident when Resident #39 slipped out of his wheelchair. Resident #14 said Driver X did not check Resident #39 before they left the facility. Resident #14 said Driver X put Resident #39 on the van and probably thought he had secured Resident #39, but evidently Resident #39 was not secured in the van. Resident #14 said Resident #39 was not in his chair good. Resident #14 said Driver X secured her and her wheelchair like he always did. Resident #14 said Driver X usually checked everyone before he left the facility. Resident #14 said it scared her when Resident #39 got out of his wheelchair. Resident #14 said Driver X did not drive fast. Resident #14 said she thought this was an accident and Resident #39 just was not in his wheelchair good. Resident #14 said she thought Resident #39 slid out of the chair and hit her wheelchair. Resident #14 said as soon as Driver X realized Resident #39 came out of his wheelchair, he immediately got off the highway and pulled over to the gas station. Resident #14 said Driver X checked on Resident #39 and got him back into his wheelchair. Resident #14 said she remembered Resident #39 said he was not hurt and he wanted to go to his appointment; after the incident. Resident #14 said after Driver X checked on Resident #39 and got him back in his chair they went to the doctor appointments, then back to the facility safely. During an interview on 04/17/24 at 08:52 AM, Driver Z said she was in-serviced and checked off on the transportation van on 4/08/24. Driver Z said, the process of loading a resident was, let the emergency brake down on the van. Secure the resident on the lift with a seat belt and lock the wheelchair before going up with the lift. Driver Z said there were 4 straps that went around the wheelchair and locked the wheelchair to secure. Driver Z said place the over the body seat belt over the resident prior to leaving the facility. Driver Z said she felt confident to transport the residents safely. During an interview on 04/17/24 at 09:53 AM, Driver X said he had two transports the morning of 4/1/24. Driver X said he secured Resident #14 in van first. Driver X said he thought he secured Resident #39's wheelchair and seat belt prior to departure from the facility. Driver X said, it does not make sense, why would I secure one resident and not the other one. Driver X said he felt like Resident #39 took the shoulder seat belt off his self. Driver X said they got to the four-way stop at the highway, then Resident #39 slid out of his wheelchair. Driver X said there were times when Resident #39 refused to wear his seat belt and said it made his stomach hurt and did not put it on tight, but Driver X would encourage Resident #39 he had to wear the seat belt. Driver X said in the past Resident #39 had refused to wear a seat belt and had taken off the seat belt during a previous transport. Driver X said he was terminated from the facility due to the incident. (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 4/17/24 at 2:42 PM, the DON said Resident #39 went to an appointment and Driver X forgot to put the shoulder strap across Resident #39. The DON said Resident #39 and Driver X were on their way to an appointment and Driver X got on the brake at a stop sign and Resident #39 slid out of his wheelchair to the floor. The DON said Resident #39 denied injuries due to the fall and denied hitting his head. The DON said Resident #39 said he just fell on the floor. The DON said Driver X did not notify the facility or Police and left the scene. The DON said there were no residents in the van at the time of the accident. The DON said after the accident with the hit and run Driver X and other van drivers were in-serviced. The DON said the staff was in-serviced over if an incident or accident happened while out on transport staff were expected to call the facility to notify management and Police, if necessary. The DON said after the accident with Resident #39 the van drivers were in-serviced on safety precautions, following policy and procedures. The DON said Driver X was terminated after the incident with Resident #39. The DON said there was a failure because Driver X forgot or got distracted and did not place the seat belt on Resident #39. The DON said, the bottom-line Resident #39 should have had a seat belt on prior to leaving the facility. (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 4/17/24 at 2:57 PM, the Administrator said Driver X returned to the facility from a transport with Resident #14 and Resident #39. The Administrator said Driver X notified management, he forgot to put Resident #39's shoulder strap on and the resident slid out of his wheelchair onto the floor of the van, due to Driver X stopped at a stop sign. The Administrator said Resident #39 had a lift pad between him and the seat and there was not a grip. The Administrator said Driver X pulled over to the gas station and checked to see if Resident #39 was injured, after Resident #39 denied injuries Driver X replaced Resident #39 back into his wheelchair. The Administrator said Driver X said he asked Resident #39 if he wanted to go back to the facility or emergency room . The Administrator said Driver X said Resident #39 refused and said he wanted to go to his appointment. The Administrator said Driver X assured the shoulder strap was secured and they went to appointments. The Administrator said when Resident #39 returned to the facility a nurse assessed him for injuries and Resident #39 said he was not injured. The Administrator said the nurse notified Resident #39's Physician and family of incident. The Administrator said x-rays were ordered and performed, no abnormal findings were noted. The Administrator said Resident #39 told staff his back hurt, but he had a history of back pain. The Administrator said Resident #39 had pain medication for back pain and the facility kept the pain controlled. The Administrator said staff checked on Resident #14 and got her statement of the incident. The Administrator said Resident #14's statement collaborated with Driver X's statement on the incident. The Administrator said the facility suspended Driver X while the investigation was pending. The Administrator said Driver X and three other staff members were certified to drive the facility van were in serviced on if an incident or accident happened while on a transport, they were to notify the facility as soon as possible or local police if necessary. The Administrator said the facility terminated Driver X, because the incident with Resident #39 and Driver X had incident in November 2023. The Administrator said Driver X was in facility van and was hit from behind. The Administrator said the driver of the car that hit the facility van ran and Driver X did not notify the facility or local police and left the scene to return to the facility. The Administrator said the facility in-serviced Driver X after an incident or accident to notify the facility, but he did not. The Administrator said her expectation was for Driver X to stop and notify the facility or 911 for assistance to ensure Resident #39 was able to be moved. The Administrator said Driver X did not have the credentials to make the decision to move Resident #39. The Administrator said Driver X admitted he felt rushed, Resident #39 was hard to deal with and he should have notified the facility of the incident when it happened. The Administrator said Driver X's defense for no notification to the facility was he was tried to make Resident #14 and Resident #39 to their appointments on time. The Administrator said the incident occurred and Driver X's failure could have caused more than potential harm to Resident #39. Record review of in-services and staff signatures dated 4/1/24, on Properly securing passenger for transport, loading and unloading passenger. Record review of van Orientation Checklists, dated on 4/1/24, for Driver X. These 3 record reviews moved up and documented in section 1 with the info about the van driver incident. (That is a quote of what they said.) Record review of the Maintenance Policy & Procedure Manual, dated 03/11/13, reflected . In order for our Residents to maintain the highest practical, physical, mental and psychological wellbeing it is the policy of this facility vehicle (Van) for residents who because of medical or special needs, require transportation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the, undated, Van driver job Description reflected .The overall purpose of the Van Driver position is to transport Facility Residents to prearranged physician and/ or dialysis appointments and/or to transport Residents on scheduled outings arranged by the Facility. Record review of Transportation Policy and Procedure for Center-Based Vehicle, dated 11/16/2023, reflected for our Residents to maintain the highest practical, physical, mental and psychological wellbeing it is the policy of this facility vehicle (Van) for residents who because of medical or special needs, require transportation. 2. Record review of Resident #9's face sheet, dated 4/16/2024, indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #9 had diagnoses which included: type 2 diabetes mellitus with hyperglycemia (high blood sugar), unspecified fall and morbid obesity (severely overweight). Record review of Resident #9's quarterly MDS, dated [DATE], indicated Resident #9 had clear speech, sometimes made self-understood, and sometimes had the ability to understand others. Resident #9's BIMS was 10, which indicated mild cognitive impairment. Resident #9 was totally dependent with bed mobility, and transfers. Record review of Resident #9's care plan, dated 11/10/2021, indicated Resident #9 had an ADL self-care deficit with an intervention: Transfers: staff x 2 hoyer lift. Resident #9 had the potential for falls with interventions that included: Anticipate and meet the resident's needs .Follow facility fall protocol. During an observation on 4/15/2024 at 11:07 AM, CNA H and LVN I placed a lift sling under Resident #9 while she was lying in bed. CNA H pushed the Hoyer lift under the bed and CNA H and LVN I attached the straps of the sling onto the Hoyer lift bar. CNA H raised the Hoyer lift until Resident #9 was lifted off the bed. CNA H and LVN I turned the Hoyer lift without opening the Hoyer lift legs to the widest position until the Hoyer lift was facing the resident's wheelchair. LVN I then opened the Hoyer lift legs to the widest position and CNA H placed the wheelchair between the opened Hoyer lift legs. CNA H then braced her body against the wall in Resident #9's room and tilted the resident's wheelchair all the way back where it was on the anti-tip bars, all 4 wheels were off the floor and the back of the wheelchair was resting on CNA H's thighs. LVN I began lowering the Hoyer lift as CNA H was pulling the sling and Resident #9 to guide her placement in the wheel chair. Once Resident #9 was in the wheelchair CNA H then grabbed the wheelchair handles that were resting on her thighs and slowly pulled the wheelchair back into an upright position. CNA H and LVN I removed the sling straps from the Hoyer lift bar. During an attempted interview on 4/15/2024 at 11:35 AM revealed Resident #9 was not able to answer questions due to cognitive impairment. During an interview on 4/15/2024 at 11:22 AM, CNA H said she did not feel the transfer was a safe transfer. She said it was probably not the safest way to do the transfer. She said she should have gone and asked therapy to help with a safe transfer for the resident. She said the resident could have fallen out of the w/c on top of her on the floor and got hurt. (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 4/15/2024 at 11:28 AM, LVN I said she did not feel like the transfer was a safe transfer. She said the legs on the Hoyer lift should have been opened when the resident was raised in the Hoyer lift. She said it was not safe when CNA H tipped the wheelchair all the way back on the anti-tip bars and braced herself against the wall with the wheelchair in her lap. She said she thought maybe the staff were trained in a new way that she was not aware of to transfer Resident #9. She said she should have stopped the transfer at that time. She said Resident #9 could have fallen on the floor or on top of the CNA H and either one of them could have been hurt. During an interview on 4/17/2024 at 10:51 AM, OT O said was is okay for the chair to be pulled back a little bit but once the anti-tip bars touch the floor that's where it should stop. She said the lift legs should have been opened earlier as soon as it was safe. She said if transfers were not performed correctly the resident was at risk of flipping back in the wheelchair and falling. During an interview on 4/17/2024 at 11:04 AM, PTA N said she had worked at the facility for 1 1/2 years. She said in this facility therapy did not usually do Hoyer lift transfers due to it not being a skilled task. She said in her opinion the lift legs should be open before the resident was connected to the Hoyer lift. She said the legs being opened stabilized the Hoyer lift and was safer for the resident. She said the anti-tippers on the back of wheelchairs were to keep the resident from tipping the chair backwards. She said the anti-tippers were not made to support the weight of a resident. She said the anti-tippers could break and cause harm or injury to the resident. During an interview on 4/17/2024 at 11:25 AM, ADON P said typically the Hoyer lift legs were closed while the Hoyer lift was under the bed, and prior to the resident being moved in the Hoyer lift, the Hoyer lift legs should be opened. She said no CNA should ever pull a resident back in the wheelchair to where only the anti-tipping bars were touching the floor. She said using Hoyer lifts or wheelchairs incorrectly could cause injury to the resident or staff. During an interview on 4/17/2024 at 11:32 AM, the DON said it depended on the space in a resident's room as to when the Hoyer lift legs were opened. She said if there was space, they should be opened as soon as the lift was pulled out from under the bed. She said it was not possible to open the legs of the lift while the lift was still under the bed. She said a resident's wheelchair should never be pulled back on the anti-tip bars while transferring a resident into the wheelchair. She said incorrectly done transfers could cause staff and residents to get hurt. During an interview on 04/17/24 at 11:48 AM, the Administrator said the lift legs should be opened as soon as there was enough space to open the legs. She said she did not see how it was possible for a wheelchair to be tipped back on the anti-tipping bars while transferring a resident. She said the anti-tip bars could break, and the resident could fall and get hurt. Record review of the facility's, undated, policy titled Hydraulic Lift (Hoyer Lift) reflected the purpose: to enable one individual to lift and move a resident safely, with as little effort as possible .open lift to the widest point and set brakes . 13. Position wheelchair and lock brakes. Swing resident's feet off bed. When resident has been lifted clear of bed, grasp bar and move to chair . 14. Push gently on knees as resident is being lowered into chair to correct position and maintain balance. Lower resident slowly. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the, undated, manufacturer's instructions for the Span F600B mechanical lift reflected: The F600B is intended to be used for transfers of the patient in and out of bed, their wheelchair, to and from the commode, or any other type of surface. Page 13 of the manufacturer's instructions indicated: Operating Instructions .Preparation Before Lifting .Widen the base and disengage the [NAME] brakes.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019 Based on observation, interview and record review the facility failed to ensure, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for 2 of 4 medication carts (Medication cart on hall 1 and medication cart hall 2) reviewed for pharmacy services. The facility failed to lock the medication carts for hall 1 and hall 2. This failure could place residents at risk of not having their medications available as prescribed, a drug diversion, and an adverse reaction if accessed. Findings include: During an observation on 4/17/2024 at 7:21 a.m., LVN D was observed preparing insulin during morning medication pass. LVN D had his medication cart pulled in front of the resident door and turned his back away from his medication cart to administer insulin to the Resident #25. LVN D did not to lock his medication cart LVN D returned to the cart and locked his medication cart and went to the resident's beside to administer the insulin as scheduled . There were no staff or residents observed in hallway while cart was unlocked. During an observation and interview on 4/17/2024 at 7:50 a.m., CMA C's medication cart was located outside room [ROOM NUMBER] and was unlocked as CMA C was in the resident's room. CMA C came out of room and realized her medication cart was unlocked and locked her cart. There were no residents, staff or visitors passing through the hall during the identified unlocked cart. CMA C said she switched carts and grabbed the blood pressure cuff and went in another room. CMA C said the medication carts should always be locked when not in use and she failed to lock the cart while checking on another resident. During an observation on 4/17/2024 at 7:50 a.m., the medication cart for hall 1 had the following medications: 1. Drawer 1: Vitamins such as Vitamin D (supplement for Vitamin deficiency), Multiple Vitamins (supplements); Aspirin (medication used for pain or inflammation), stool softener, Fiber (supplement used for constipation) and eye drops (lubricant). 2. Drawer 2: Liquid Levetiracetam 100 mg/ml (medication used to treat seizures) 3. Drawer 3: Overflow with extra scheduled medications for resident room [ROOM NUMBER]-28 B. Metformin 1000 mg capsules (medication used to lower blood sugar), Gabapentin 300 mg capsules (medication used for neuropathy pain), MiraLAX (stool softener), Sani wipes (product used to disinfect equipment) 4. Drawer 4: Cups, straws (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 observation on 4/17/2024 at 11:10 a.m., medication cart for hall 2 observed to have following: 1. Drawer 1: eye drops (eye lubricant), insulin pens (decrease blood sugar), nitroglycerin (used to treat chest pains) 2. Drawer 2: Amlodipine 5 mg (blood pressure medication), Sertraline 50 mg (antidepressant), OTC Melatonin (sleep aid), Pepcid (stomach acid reducer), Colace (stool softener) 3. Drawer 3 Breathing treatments Bromide/Albuterol (breathing treatment), Nyamyc (medication used to treat fungal infections) 4. Drawer 4: Overflow, cups, feeding, gloves, gowns and overflow and a prescription drug Cyclobenzaprine (muscle relaxer). During an interview on 4/17/2024 at 9:00 a.m., CMA C said she was responsible for her medication cart. CMA C said anyone passing by could get in an unlocked medication cart. CMA C said she was concerned there was an emergency with a resident and went in the room. CMA C said the resident had a question about her medications and her voice did not sound like an emergency. CMA C said if a resident went to an unlocked medication cart, they could take medications not prescribed. CMA C said medications could cause nausea, vomiting, increased sickness, or their blood pressure could drop. During an interview on 4/17/2024 at 10:05 a.m., LVN E said medication carts should always be locked when not in use. LVN E said there were medications and things residents, visitors or other staff members could get out of the medication cart and could cause a drug diversion. The LVN said the nurse or CMA who was scheduled to the cart was responsible for the medication cart and should lock the medication cart when not being used. During an interview on 4/17/2024 at 11:13 a.m., LVN D said the medication cart should always be locked while not in use. LVN D said it could put the residents and visitors at risk if they get into the medication cart. LVN D said a resident could have an adverse reaction to a medication if it was not prescribed to them. LVN D said the medication cart should be locked even if your back was turned against the medication cart. During an interview on 4/17/2024 at 11:45 a.m., ADON P said she expected the medication carts to be always locked while not in use. ADON P said a resident passing, staff or visitors could get in the medication cart and take something they did not need without staff aware and have an adverse reaction to a medication not prescribed to them. ADON P said it could include death if resulted in a reaction or insulin not prescribed. During an interview on 4/17/2024 at 12:08 p.m., the DON said she expected the nurses and CMA assigned to the cart to keep them locked when not in use. The DON said if the cart was within eye site, it could be unlocked, and she said it was acceptable for the cart to be unlocked if the cart was facing inside the resident room even if they turned their back. The DON said no one could get past the medication to get in the drawer if the cart was turned inside the doorway of the resident's room and said it was acceptable. (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 4/17/2024 at 1:12 p.m., the ADM said the medication carts were to be locked and the CMA or nurse assigned were responsible for the medication carts. The ADM said if the cart was within the nurse's eye site, it was okay for the cart to be unlocked if they had eye site on the cart. The ADM said if it was out of eye site, the cart should be locked. The ADM stated she expected the carts to be locked if unattended on the hall. Record review of the facility's policy, dated 1/20/2021, titled Medication Storage indicated it was the policy of this facility to ensure all medications housed on our premises will be stored, dated, and labeled according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light ventilation, moisture control, segregation, and security . General guidelines . All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) . Only authorized personnel will have access to the keys to locked compartments .during medication pass, medications must be under the direct observation of the person administering the medications or locked in the medication storage area/cart

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35295 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 2 of 4 residents (Residents # 20 and #52) reviewed for infection control practices. 1.LVN T failed to change her gloves after performing foley care on Resident #20 and touched clean surfaces. 2.CNA K failed to wash or sanitize her hands when changing gloves while performing foley catheter care for Resident #52. 3. CNA J and CNA K failed to wash or sanitize their hands after performing foley catheter care for Resident #52. These failures could place residents at risk of exposure to communicable diseases, cross-contamination and infections. 1. Record review of Resident #20's, undated, face sheet indicated an [AGE] year-old male who was admitted to the facility on 3/15/24. Record review of Resident #20's physician's orders, dated 4/16/24 , indicated Resident #20 had diagnoses which included: Parkinson's Disease (a disorder of the nervous system that affects movement, often including tremors), Cerebrovascular Disease (affects blood flow to the brain), flaccid neuropathic bladder (hyperstimulation of the nerves and muscles leading to urinary retention and the inability to fully empty the bladder) and Stage 3 pressure ulcer to the sacrum (an injury that breaks down the skin and underlying tissue). Record review of Resident #20's physician's order, dated 3/18/24, indicated: Urinary catheter 16 FR, 10cc, bulb to gravity. Record review of the admission MDS, dated [DATE], indicated Resident #20 had clear speech, was sometimes understood by others, and sometimes understood others. Resident #20 had a BIMS score of 6, which indicated severe cognitive impairment. The MDS indicated under H0300, Urinary Continence 9. Not rated, resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days. Record review of the care plan, dated 3/21/24, indicated Resident #20 had impaired cognition with a risk for further decline. Resident #20 had a urinary catheter and was at risk for urinary tract infections and injury. Urinary catheter care was to be provided per facility practice. (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 observation on 4/16/24 at 1:28 PM, LVN T and CNA V donned gowns and after washing their hands, donned gloves. LVN T performed foley care for Resident #20. CNA V assisted LVN T. LVN T performed foley care and did not change her gloves. She touched Resident #20's brief, blanket and bed side table with the same gloves. After covering Resident #20 and adjusting the bed side table she took off her gloves and washed her hands. During an interview on 04/16/24 01:38 PM, LVN T said she should have changed her gloves after the foley care when her gloves were dirty and before touching the resident's brief, blanket and bed side table. She said she was trained to change her gloves and clean her hands after foley care, and she did not because she was nervous. She said what she did was an infection control issue and could spread infection. During an interview on 4/17/24 at 12:02 PM, CNA W said it was important to take dirty gloves off before touching anything clean to prevent spreading germs. She said staff had to take off their dirty gloves, wash their hands and re-glove, if needed. She said it was an infection control issue to touch items or residents with dirty gloves. She said she was trained to remove her dirty gloves before touching anything clean and washing her hands to prevent infection. During an interview on 04/17/24 at 12:07 PM, LVN R said when doing foley or incontinent care it was an infection control issue to touch clean items when gloves were dirty. She said dirty gloves should be taken off immediately and hands washed before touching anything clean. She said anything could be spread by contact and could make the resident sick or sicker. During an interview on 4/17/24 at 12:14 PM, LVN S said dirty gloves should not touch clean items because that would be cross-contamination and could cause infection to the resident. She said dirty gloves should be swapped out for clean gloves, after hand washing during foley care. During an interview on 4/17/24 at 12:23 PM, ADON P said touching clean surfaces with dirty gloves could cause cross contamination of the clean area especially if someone else touched the dirty area with clean gloves or hands. She said the danger to the resident was infection, weight loss and an infection could require the resident to be on antibiotics. She said touching clean surfaces with dirty gloves was bad all the way around. During an interview on 4/17/24 at 1:11 PM, the DON said regarding foley care, a staff should never touch resident's items with dirty gloves. She said to do that was cross-contamination which could spread infection or cause infection. She said she expected staff to go by their training and change their gloves after a dirty procedure and perform hand hygiene. She said dirty gloves should be changed and hand hygiene performed before going to a clean area. During an interview on 4/17/24 at 1:41 PM, the ADM said she expected staff to follow best practices learned when obtaining their licensure. She said if a staff had dirty gloves on and touched a clean area it was cross-contamination and could cause infection. She said it was definitely an infection control issue and could cause a resident to become sick. Record review of a skills check off entitled Nursing Hand Hygiene, dated 10/16/23, indicated LVN T was competent in 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	Record review of a skills check off entitled Provides Catheter Care for Female, dated 8/8/23, indicated LVN T was competent in catheter care. 2. Record review of Resident #52's face sheet, dated 4/17/2024, indicated a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (unable to move the left side of his body), type 2 diabetes mellitus with hyperglycemia (high blood sugar) and obstructive and reflux uropathy (urine cannot drain through the urinary tract). Record review of Resident #52's care plan, dated 11/10/2021, indicated he had a urinary catheter related to obstructive uropathy with interventions to provide urinary catheter care per facility practice and to position the catheter bag and tubing below the level of the bladder. Record review of Resident #52's annual MDS, dated [DATE], indicated he was rarely/never understood, and a BIMS score that was not able to be obtained. He required total dependence with one-person physical assist with bed mobility, dressing, toilet use and personal hygiene. He was always incontinent of bowel. Bladder was not rated due to having a foley catheter in place. During an observation on 4/16/2024 at 3:12 PM in Resident #52's room revealed, CNA J and CNA K were present to provide foley catheter care. Both staff washed their hands in the assisted dining room before entering Resident #52's room. CNA J and CNA K stopped at linen cart in the hallway and applied gowns 2 doors down from Resident #52's room. CNA J and CNA K both knocked on the resident's door and entered the room. CNA J and CNA K sanitized their hands and donned gloves at the bedside. CNA J and CNA K positioned Resident #52 in supine position to perform his foley catheter care. CNA J doffed gloves and sanitized hands, CNA K doffed gloves and did not sanitize her hands and donned new gloves. CNA J removed the blanket from Resident #52 and placed the foley catheter bag and tubing on the bed next to his leg. CNA K placed a trash bag at the end of the bed. CNA J removed a wipe from the over the bed table and began cleaning around the foley catheter insertion site working in a downward motion. LVN E placed the wipes in the trash bag at the end of the bed. After CNA J completed the foley catheter care, CNA K repositioned Resident #52. CNA J, without changing gloves, took the foley catheter bag off the bed and positioned it under the mattress below bladder level. CNA J and CNA K pulled the resident up in bed without changing gloves, sanitizing or washing hands. CNA J and CNA K both doffed gloves and said skill complete without washing or sanitizing hands. CNA J then removed the trash bag at the end of the bed and placed it in the trash can in the resident's room. Both CNA J and CNA K stopped before exiting residents' room and doffed gowns then exited the room. Once in the hallway CNA J and CNA K said skill not complete we forgot to wash our hands and went over to the hand sanitizer station in the hallway and sanitized their hands. CNA J doffed clean gloves and re-entered residents' room and retrieved the trash bag from the trash can and walked down the hallway and disposed the trash bag in trash barrel. During an interview on 4/17/2024 at 3:31 PM, CNA K said she had been employed at the facility for about 1 year and 5 months., CAN K said she should have sanitized her hands when she doffed her gloves after positioning the resident. She said both CNA J and CNA K should have washed their hands after doffing gloves before they said, skill complete. She said residents could be at risk of an infection if they did not wash or sanitize their hands when changing their gloves. (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 4/17/2024 at 3:34 PM, CNA J said she had been employed at the facility for about 2 years. CNA J said she should not have gone back into the resident's room to retrieve the trash bag after she doffed her gown. She said CNA K should have sanitized her hands between glove changes after repositioning Resident #52. She said it was not the proper procedure for CNA K to have placed the trash bag on the end of the bed. She said residents could be at risk of an infection if they did not wash or sanitize their hands when changing their gloves. Record review of the Validation Checklist, dated 5/20/2023, for CNA K indicated she was trained and had demonstrated hand hygiene procedure in accordance with the facility's standard of practice. Record review of the Nursing Assistant Clinical Skills Checklist and Competency Evaluation, dated 8/16/2023, for CNA J indicated she was trained and had demonstrated hand hygiene procedure in accordance with the facility's standard of practice. Record review of the facility's policy titled Indwelling Foley Catheter Guidelines, dated 5/23/2014 and reviewed on 2/10/20, indicated: The facility shall identify and assess patients with an indwelling catheter or at risk for catheterization, provide appropriate treatment and services to prevent urinary tract infections and to achieve or maintain as much normal bladder function as possible, and ensure that indwelling catheters are medically necessary .Perform hand hygiene immediately before and after insertion or any manipulation of the catheter .Keep the collecting bag below the level of the bladder at all times. Record review of the facility's policy titled Hand Hygiene, dated 2/20/20, with a revised date of 2/11/2022, indicated: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility .The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Record review of the facility's policy titled Infection Control Guidelines dated 2/2007 with a revised date of 9/22/2015, indicated: The purpose for this policy is to reduce and prevent the spread of infections by the use of evidenced based techniques established infection control policies and procedures .Staff shall use hand hygiene when coming on duty, between patient contacts, after handling contaminated objects, after PPE removal, and before going off duty .Staff shall wash their hands with an antiseptic preparation before performing patient care procedures and when providing care to patients in isolation. Record Review of the facility's policy titled Infection Prevention and Control Program, dated 10/24/2022 and revised on 4/12/2023, indicated: This facility has established and maintains 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 as per accepted national standards and guidelines .Hand hygiene shall be performed in accordance with out facility's established hand hygiene procedures .All staff are expected to provide care consistent with infection control practices.