STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45F414	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Health Care Center	212 NW 10th St Seminole, TX 79360

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** 03896 Based on interviews and record reviews the facility failed to ensure the residents had the right to participate in, his or her treatment which included the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she preferred, for 3 of 13 residents (Residents #8, #72, #222) reviewed for resident rights. The facility failed to obtain a signed informed consent based on information of the benefits, risks, and options available for: Residents #8 prior to the administration of Lorazepam and Trazodone; Resident #72 prior to the administration of Trazodone; Resident #222 prior to the administration of Seroquel and Lorazepam. Lorazepam, Trazodone, and Seroquel are psychotropic medications (a psychoactive drug taken to exert an effect on the chemical make-up of the brain and nervous system); This failure could place residents at risk of receiving medications without their prior knowledge or consent, or that of their responsible party or being aware of the benefits and risks of the medications prescribed. Findings included: Resident #8 Record review of Resident #8's undated face sheet, revealed a [AGE] year-old-female was admitted to the facility on ,d+[DATE] with diagnoses to include Hypertension (force of the blood against the artery walls was too high), anxiety disorder (fears that are strong enough to interfere with daily life), insomnia (trouble sleeping), and Alzheimer's Disease (a progressive disease that destroys memory and other mental functions). Record review of the undated baseline care plan for Resident #8 revealed the following, Resident is prescribed High Risk/Black Medication Trazodone and Lorazepam. Record review of comprehensive MDS assessment dated [DATE] did not include information regarding Resident #8's communication abilities, in addition, the MDS did not include information regarding Resident #8's cognition or a BIMS score. Record Review of Resident #8's MDS did not include information regarding Resident #8's medications. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #8's order summary report dated 7/25/24 revealed the following orders: Buspirone 5mg 1 tablet by mouth twice a day as related to anxiety disorder dated 7/22/24. Lorazepam 2mg give by mouth every four hours related to anxiety dated 7/18/24. Trazodone 50mg give 1 tablet by mouth at bedtime related to insomnia. Record review of the Electronic Medical Record for Resident #8 revealed that she was administered Trazodone on 7/24/2024. Resident #8 was administered Lorazepam on 7/20/2024. Record review of Resident #8 's electronic medical record of scanned consents on 7/25/24 revealed a consent for Buspirone; however, there were no consents for Lorazepam and Trazodone. Resident #72 Record review of the face sheet for Resident #72 dated 7/23/24 revealed that the resident was admitted to the facility on [DATE] and was [AGE] years old. The resident had diagnoses that included, insomnia (sleep disorder), Alzheimer's disease, unspecified (cognitive disorder), COVID-19 acute respiratory disease, history of falling from heavy alcohol use, alcohol dependence, in remission, Wernicke's encephalopathy (neurological/cognitive disorder), and constipation (digestive disorder). Record review of the admission MDS assessment for Resident #72 dated 5/26/24 revealed the resident had a BIMS score of 7 indicating the resident was moderately cognitively impaired. She had an active diagnosis of insomnia unspecified. It was further documented that the resident was taking an antidepressant. Record review of the care plan for Resident #72, last revised on 5/24/24, revealed the following, Problem Start Date: 05/25/2024 Resident experiences insomnia. Goal Target Date: 08/22/2024 Resident's use of Trazadone to induce sleep will result in the improvement of the resident's functional status as evidenced by resident states feeling rested. Approaches included, Approach Start Date: 05/25/2024 Administer medications: trazadone. Monitor and record effectiveness. Monitor and report any adverse side effects . Record review of the physician orders for Resident #72 dated 7/23/24 revealed that the resident had an order stating, Order on hold from 7/11/24 to 7/17/24, trazodone tablet: 50 mg; amount; one tablet; oral, at bedtime - PRN. Give at least three hours after wine. Diagnosis: insomnia, unspecified. Start date 5/21/24, end date open ended. Record review of the MAR (May 2024 thru July 2024) for Resident #72 revealed that she was administered trazodone from 5/14/24 through 5/19/24 and that the order was open ended and PRN. There was a hold of the medication for the period of 7/11/24 through 7/ 17/24. The resident's PRN trazodone order was still active. Record review of the June 2024 pharmacy consultant report revealed there were no recommendations for Resident #72. Record Review of the consents for psychoactive medications revealed Resident #72 had no consent found for the trazodone. Resident #222 (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of resident #222 undated face sheet revealed, a [AGE] year-old female originally admitted on [DATE]. Resident #222 had a medical history of heart disease, insomnia (difficulty sleeping) and chronic pain. Record review of Resident #222 admission MDS Section C- Cognitive Patterns revealed a BIM's score of 05 which indicated the resident had severe cognitive impairment. Record review of Resident #222's physician orders revealed Start date 3/12/2024 zolpidem -Schedule IV (4) tablet; 10 mg, 1 tablet; oral At Bedtime. Record review of Resident #222's care plan last revised 4/3/2024 revealed Resident experiences insomnia. Goal Target Date: 07/03/2024 Resident's use of zolpidem to induce sleep will result in the improvement of the resident's functional status as evidenced by resident verbalizing adequate sleep and rest. Approach Start Date: 04/03/2024 Administer medications: zolpidem. Monitor and record effectiveness. Monitor and report any adverse side effects. Record review of document titled Consent for Psychotropic Medication Therapy revealed signature of the person obtaining permission was not signed. The document did not indicate who the consent was signed by. The document did not determine whether consent was given as no box was checked to determine if the resident or representative agreed with treatment or refused treatment. On 7/25/24 at 11:17 AM an interview was conducted with the DON regarding the psychoactive medication consent for trazodone for Resident #72. She stated, I don't know what could have happened. She stated nursing staff were responsible for ensuring that the consents were complete. She stated, The (consents) book is supposed to be audited. We try to do it quarterly. She added that she expected the staff to have completed the consents. Regarding the possible risk to residents, she stated, For us not much of an affect. We call the family first before giving any psychoactive meds. It is paperwork (issue). During an interview on 7/25/24 at 12:10PM with the DON, she verified the consents for Resident #8 for Trazodone and Lorazepam did not exist, the facility had not attempted to complete the consents. The DON verified with Surveyor the consent for Resident #222 was not complete; the consent was missing the signature of the staff who obtained the consent and whether the consent was provided for treatment by the resident or representative via a signature. The DON stated the nurse obtaining the medication order is responsible for obtaining the complete consent for psychotropic medications. She stated all staff had been trained on obtaining consents. She stated human error is the cause for the missing and incomplete consents. She stated the potential negative outcome was incomplete paperwork. During an interview on 7/25/24 at 12:28PM, the ADM stated the admitting nurse or the nurse receiving the order for the psychotropic medication is responsible for obtaining the consent for the psychotropic medication from the resident or their responsible party on the same day it is received from the physician. The ADM stated the consent should have been obtained prior to the residents being given psychotropic medications. The ADM stated the nurses have all been trained on medication consents. The ADM stated human error was the reason for the lack of consents and the incomplete consents. The ADM stated a potential negative outcome to the residents was the resident's family would not receive notification of the medication being administrated. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Interpretation and Implementation: Residents will not receive medications that are clinically indicted to treat a specific condition. Psychotropic medication is any medication that affects brain activity associated with mental processes. Psychotropic medications include anti-psychotics, anti-depressants, anti-anxiety, and hypnotics. Residents, families and/ or the representative are involved in the medication management process. Psychotropic medication management includes: Indications for use, dose, duration, adequate monitoring for efficacy, adverse consequences, preventing, identifying, and responding to adverse consequences. Residents and or their representative have the right to decline treatment with psychotropic medications. 46425

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 03896 Based on observation, interview and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as was possible in 2 of 3 common resident baths (Tan and Mauve Halls) in that: The facility failed to ensure chemicals were not stored with resident toiletries and personal items in 2 of 3 common resident baths (Tan and Mauve Halls). These failures could place residents at risk for accident hazards resulting in injuries. The findings include: On 7/24/24 at 9:02 AM an observation was made of the central bath on the Mauve Hall which included rooms 32 through 43. The door to the bath was not locked. There was a spray bottle of Disinfectant Cleaner and Deodorizer on an open shelf next to washcloths and towels. The Virex Plus One Step Disinfectant Cleaner and Deodorizer was labeled, Causes moderate eye irritation. Avoid contact with eyes or clothing. Wash thoroughly with soap and water after handling . The upper cabinets in the bath were locked. One of 2 cabinets had spray bottles of Virex Plus, a spray bottle of pink liquid, and an aerosol can of End [NAME] II spray disinfectant located on the upper shelf. The spray bottle of pink liquid was hand labeled Hand sanitizer MSD (Material Safety Data) sheet at nurse station. The aerosol can of End [NAME] II spray disinfectant was labeled, Causes substantial but temporary eye injury . These spray bottles of cleaners/disinfectants were stored on a shelf above an open container of razors, hand and body lotion, hair conditioner, shampoo, and deodorant. Two CNAs, A and C, entered and left the room but did not move the spray bottle of Virex Plus that was on the shelf that was in an open area. On 7/24/24 at 9:14 AM an observation was made of the central bath on the [NAME] Hall which included rooms 13 through 24. The door was not locked. One of 2 upper cabinets was unlocked and had three spray bottles of Virex Plus disinfectant on the upper shelf. The bottles were stored next to a container of shampoo and tubes of protective skin ointment and a bin of nail clippers. The shelf below these cleaners had containers of shampoo, conditioner, lotion, and body wash. On 7/24/24 at 9:23 AM an interview and observation were conducted with CNA A in the [NAME] Hall central bath. She stated she had worked in the facility previously and yesterday (7/23/24) was her first day back. CNA A was shown the unlocked cabinet containing the cleaners stored above and with resident toiletries. She stated, the cabinet may have been left unlocked by the night shift and staff were supposed to lock the cabinets. She added she felt the cleaners were stored in the cabinet, so they were convenient to clean the shower chairs. She also stated that she did not know why the shampoo was stored next to the cleaners. She then moved the bottle of shampoo away from the spray bottles of cleaners and put it with the other toiletries stored on the shelf beneath the cleaners. Regarding any training on storage of chemicals and baths, she stated there had been nothing mentioned about not storing chemicals above toiletries and with resident items. She further stated that if a (chemical) bottle had a hole, it could leak and get in the resident bottles. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/24/24 at 9:51 AM an interview was conducted with CNA C in the Mauve central bath. Regarding the pink substance in the spray bottle, she stated, It says hand sanitizer, but it is not hand sanitizer. I'm not sure what it is. She stated she had worked in the facility previously but returned on Monday (7/22/24). Regarding training related to bathing area chemical storage, she stated, They say to make sure that it (chemicals) is locked up. They did not mention about not storing chemicals above resident items. She stated, chemicals could get on residents and their skin as a result of chemicals stored with and above resident items. On 7/24/24 at 10:02 AM an interview was conducted with the DON regarding chemical storage in the baths. She stated she had trained staff on chemical storage in baths. She added that chemicals and resident items could not be stored together and the doors on the cabinets should be locked. She stated chemicals should not be stored above resident items and razors. She stated this issue occurred due to people not being careful. She stated, We (Nursing staff) do rounds. We look for these types of things (unsafe chemical storage). We have a checklist; I do not know if it is always used. She stated chemicals could spill on resident items and these items could not be used as a result of unsafe chemical storage. She also stated she expected staff to keep chemicals stored safely. On 7/24/24 at 10:10 AM an interview was conducted with the Administrator regarding chemical storage in the baths. She stated she did not know why this situation occurred. She added, Staff failed to report this chemical storage issue and staff had been trained how to store chemicals. She stated, she expected staff to have questioned the storage of the chemicals and reported the issue. She added, staff should have conducted walking rounds to ensure that chemicals were stored safely in bathing areas. She stated the unsafe storage of chemicals could have a negative effect on residents. The negative effect could be anything. It depends on the resident. It could cause harm. On 7/24/24 at 3:33 PM an interview was conducted with the DON regarding chemical storage in bathing areas. She stated that she was ultimately responsible to ensure that chemicals were stored safely in bathing areas. On 7/24/24 at 3:34 PM an interview was conducted with the Administrator regarding chemical storage in bathing areas. She stated that the CNA supervisor was responsible for ensuring that chemicals were stored in a safe manner in bathing areas. On 7/25/24 at 8:35 AM an observation was made in the Mauve central bath. There were spray bottles of Virex Plus and End [NAME] II (aerosol can) disinfectants stored in a locked cabinet on a shelf that was directly above disposable briefs and open boxes of gloves. The shelf was adjustable and there were gaps along the bottom edge of the shelf that the disinfectants were on. On 7/25/24 at 8:41 AM an interview was conducted with CNA B in the Mauve Hall central bath. She stated she knew chemicals were stored on one side of the cabinetry and resident toiletries on the other. She stated, due to the condition of the shelf, if the chemicals leaked, it could burn or cause infection for the residents. She then moved the disposable briefs and gloves from under the chemical storage shelf. On 7/25/24 at 8:42 AM an observation was made in the [NAME] Hall central bath. There were three spray bottles of Virex Plus disinfectant on the shelf in a locked cabinet. The shelf was adjustable and had gaps along bottom edge of the shelf. This cabinet was located above an open box of gloves. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/25/24 at 8:43 AM an observation and interview were conducted with CNA A, in the [NAME] Hall bath. The CNA was shown the issue with the placement of the spray bottles of disinfectant and condition of the shelf. She stated she understood the issue and moved the box of disposable gloves from under the chemical storage shelf. Record review of the SDS documentation for Virex Plus One Step Disinfectant Cleaner and Deodorant, Revision: 2021 - 10- 19, revealed the following documentation, . 4. First Aid Measures. Diluted product. Eyes: rinse with plenty of water. Indigestion: if swallowed: call a poison center . or Dr./physician if you feel unwell. 7. Handling and Storage. Storage: store in a well-ventilated place. Keep cool. Store locked up. Store in corrosive resistant container with a resistant inner liner . Record review of the Safety Data Sheet for End [NAME] II Spray Disinfectant, revision: 2021-09-28, revealed the following documentation, . 2. Hazardous Identification. Classification for the undiluted product. Signal word: DANGER. Hazard Statements. Extremely flammable aerosol. Contains gas under pressure; may explode if heated. Causes eye irritation. Precautionary Statements. Keep away from heat, hot surfaces, sparks, open flames, and other ignition sources . Avoid contact with eyes, skin and clothing. Wash affected areas thoroughly after handling. If in eyes: rinse cautiously with water for several minutes. Remove contact lenses, if present and easy to do. Continue resting for at least 15 minutes. If eye irritation persist: get medical advice or attention. Protect from sunlight. Store in a well-ventilated place. Dispose in accordance with all federal, state and local applicable regulations . 4. First Aid Measures. Undiluted product: Eyes: In eyes: rinse cautiously with water for several minutes. Remove contact lenses, if present and easy to do. Continue rinsing for at least 15 minutes. If eye irritation persist: get medical advice/attention. Indigestion: If swallowed: Call a poison center . or doctor/physician if you feel unwell . 7. Handling and Storage . Storage . Protect from sunlight. Store in well-ventilated place. Record review of the Resident Roster provided by the facility on 7/23/24 revealed that the DON documented on 7/24/24 that 10 residents in the facility were independently ambulatory. Of those 10 residents there were two residents that were cognitively impaired/confused. Both residents resided on the Mauve Hall. Record review of the in-service documentation dated 4/24/24 revealed that the DON provided an in-service with Topics that included . using chemicals . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's current document titled Quality Indicator Survey Round sheet revealed the following documentation, . Hazards/Personal Care. 9. AM, 1 PM, 4 PM. J. Items keep out of reach out and open . Bathroom/Shower. 9 AM, 1 PM, 4 PM. J. Hazardous items out and open . Record review of the facility policy titled Quality of Life - Safe and Sanitary Environment, Storage Areas, Environmental Services, Revised December 2009, revealed the following documentation, Policy Statement. Housekeeping and laundry department storage areas shall be maintained in a clean and safe manner. Policy Interpretation and Implementation 3. Cleaning supplies, etc., shall be stored in areas separate from food storage rooms, and shall be stored as instructed on the labels of such products .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03896 Based on observation, interview, and record review, the facility failed to offer, based on a resident's comprehensive assessment, a therapeutic diet when there was a nutritional problem, and the health care provider ordered a therapeutic diet for 3 of 3 residents (Residents #18, 72 and 73) reviewed for nutrition status. The facility failed to provide Residents #18, 72 and 73 with their physician ordered therapeutic diets that included fortified foods for the noon meals on 7/23/24, 7/24/24 and 7/25/24. This failure could place residents at risk for hunger, weight loss and chemical imbalances. The findings included: Resident #18 Record review of the current undated face sheet for male Resident #18 revealed that the resident was admitted to the facility on [DATE] and readmitted on [DATE]. The resident was [AGE] years old and had diagnoses of moderate protein calorie malnutrition (nutritional deficiency), urinary tract infection, site not specified, (history of) (infection of urinary tract), Constipation, unspecified (digestive disorder), type two diabetes mellitus without complications (blood sugar disorder), other retention of urine, and dementia, and other diseases, classified elsewhere, unspecified, severity, with other behavioral disturbance (cognitive disorder). Record review of the annual MDS assessment for Resident #18 dated 5/6/24 revealed the resident was on a therapeutic diet as a resident. The resident had a BIMS score of eight indicating moderate cognitive impairment. The resident had an active diagnosis of moderate protein calorie malnutrition. Record review of the care plan for Resident #18 last reviewed 2/09/24 revealed there was no care plan specific for nutrition. Record review of the vitals for Resident #18 revealed a weight range was from January 2024 (150lbs) to July 2024 (142.9 lbs). In June 2024 the resident was 148.4lbs and in July 2024 was 142.9 lbs. The weight loss was 3.71% in one month. Record review of the Dietician notes for Resident #18 revealed the following, 05/14/2024 14:01 ANNUAL NUTRITION ASSESSMENT: . Diet order: fortified food with all meals, regular diet, thin liquids. Snacks/supplements: snacks TID. PO intake: 50-100%, showing adequate to good appetite. Wt: 148.1 lb, BMI 20.6, ht 69 in, IBW 160 lb. Wt is lower than desired for age. Pt appetite is noted to fluctuate and pt receives snacks and family provides snacks as well . Current diet order meets adequate needs at this time. Recommend continue current diet order Goal of wt stable x 3%, PO intake >65% skin remain intact. RD will continue to monitor PRN. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician orders for Resident #18 dated 7/23/24 revealed that the resident had an order that stated, Fortified foods to all meals with meals. 7 AM, 12 PM and 5 PM. The start date was 5/22/23 and the end date was open ended. The resident also had an additional diet order that stated, regular diet within liquids. Start date 5/17/23, end date, open ended. On 7/23/24 at 12:19 PM, Resident #18 was observed in the dining room, feeding himself. He was served tea, Mexican vegetables, Chicken enchilada casserole, water, and chocolate chip cookie. The resident consumed 83% of his meal. No foods were identified as fortified. On 7/24/24 at 12:20 PM Resident #18 was observed in the dining room, feeding himself. He was served water, coffee, cut up sliced ham, sliced potatoes, cream corn and apple crisp. Observation of the tray card for Resident #18 revealed no documentation that the resident was on a fortified diet. Resident #18 completed his meal at 12:46 PM and left the dining room. On 7/24/24 at 4:18 PM an interview was conducted with the DON regarding therapeutic diets for residents. Regarding Resident #18, she stated, the resident's eating would come and go and he was on the thin side. Resident #72 Record review of the face sheet for female Resident #72 dated 7/23/24 revealed that the resident was admitted to the facility on [DATE] and was [AGE] years old. The resident had diagnoses that included, Alzheimer's disease, unspecified (cognitive disorder), COVID-19 acute respiratory disease, history of falling from heavy alcohol use, alcohol dependence, in remission, Wernicke's encephalopathy (neurological/cognitive disorder), insomnia (sleep disorder), Essential (primary) hypertension (high blood pressure), and constipation (digestive disorder). Record review of the admission MDS assessment dated [DATE] for Resident #72 revealed that the resident had a BIMS score of 7 indicating the resident was moderately cognitively impaired. She had a diagnosis of Wernicke's encephalopathy and hypertension. There were no documented nutrition issues on the MDS. Record review of the care plan for Resident #72, last revised 5/25/24, revealed the following, Problem Start Date: 05/24/2024 Resident has experienced weight loss R/T ETOH (alcohol) abuse at home and is at risk for weight loss currently. Goal Target Date: 08/22/2024 Resident will maintain current body weight of 99 pounds. Approaches included, .Approach Start Date: 05/24/2024 Diet: Regular . Approach Start Date: 05/24/2024 Provide supplements: Chocolate Ensure with breakfast. Fortified diet with all meals . Record review of the weights for Resident #72 revealed her weight range was 99.5lbs (May 2024) to 103. 2lbs (July 2024) between 5/16/24 and 7/01/24. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Dietician notes for Resident #72 revealed the following, 06/25/2024 11:17 INITIAL NUTRITIONAL ASSESSMENT: . Diet order: fortified diet, regular texture, regular liquids. Snacks/supplements: one banana to Lunch tray daily, chocolate ensure with breakfast, may have 5 oz of wine every evening . PO intake: 26-50%, showing fair to adequate appetite on average. Wt: 99 lb, BMI 18, ht 62 in, IBW 110 lb. Pt wt is stable since admit, pt is underweight, wt gain would be beneficial at this time . Nutrition dx: Underweight r/t decrease appetite as evidenced by BMI of 18 and PO intake of 26-50%. Pt requires supervision during meal times, set up only. Skin intact. Current diet order/supplements/snacks meets adequate needs at this time. Recommend continue current diet order Goal of wt stable x 3%, PO intake >50%, skin remain intact RD will continue to monitor PRN. Record review of the lab report for Resident #72, Complete Metabolic Panel 14 dated 5/28/24 revealed the resident had a potassium level of 3.2 mmol/liter, which was indicated as low on a scale of 3.5 to 5.1. Record review of the current physician orders for Resident #72 dated 7/23/24 revealed the following orders, One scoop of chocolate ice cream with lunch and supper. Start date 7/15/24, end date open ended. Add one banana to lunch tray daily, order start date 5/30/24, and end date open ended. Chocolate Ensure with breakfast once a day 8 AM, start date 5/14/24, end date open ended. Fortified diet, regular texture, regular liquids, start date 5/14/24, end date open ended . Record review of the website Drugs.com (https://www.drugs.com/cg/potassium-content-of-foods-list.html) revealed the following, Potassium Content of Foods List, 7/07/24, What is potassium? Potassium is a mineral that is found in most foods. Potassium helps to balance fluids and minerals in your body. It also helps your body maintain a normal blood pressure. Potassium helps your muscles contract and your nerves function normally How much potassium does fruit contain? The amount of potassium in milligrams (mg) contained in each fruit or serving of fruit is listed beside the item. High-potassium foods (more than 200 mg per serving): 1 medium banana (425) . On 7/24/24 at 12:09 PM observation in the dining room, there was a dietary staff member with three bananas and handed them out to random residents. Resident #72 did not receive a banana (high potassium food). On 7/23/24 at 12:12 PM a dining room observation was made of Resident #72. She was feeding herself independently. She received Mexican vegetables, chocolate chip cookie, tea, coffee, water, and chicken enchilada casserole. The resident consumed 50% of her meal. No ice cream or banana was served. No foods were identified as fortified. On 7/24/24 at 12:21 PM observation in the dining room revealed Resident #72 was served water, coffee, tea, cut ham slice, sliced potatoes, cream corn, and apple crisp. Resident #72 left the dining room at 12:54 PM and the resident consumed 37.5% of her meal. The resident did not receive a banana or scoop of chocolate ice cream as ordered. The tray card for Resident #72 had no documentation that the resident was on a fortified meal diet. No foods were identified as fortified. On 7/25/24 at 12:40 PM observation and interview with Resident #72 in the dining room after completing the noon meal revealed she was served chocolate ice cream but no banana. No evidence f a banana was observed on the dining table. The resident stated that she did not receive a banana for lunch. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/25/24 at 12:42 PM during an interview with CNA B, she stated, staff had asked for bananas that morning (7/25/24) and they (dietary staff) said they had none. Staff were told the food truck was due to come today (7/25/24). On 7/24/24 at 4:18 PM an interview was conducted with the DON regarding therapeutic diets for residents. Regarding why residents were on fortified diets, she stated Resident #72's weight was very low, and she recently had COVID. She added the resident was a lifelong alcoholic and drank her calories. The DON further stated staff found she liked sweets. She stated the resident came to them with malnutrition. She also stated they were trying to get pounds on her. Resident #73 Record review of the current undated face sheet revealed that Resident #73 was readmitted to the facility on [DATE]. Her original admission was 11/18/15 and she was [AGE] years old. The resident had diagnoses listed as obsessive-compulsive disorder, unspecified (mental disorder), unspecified, glaucoma (vision disorder), history of pressure ulcer of other site/stage one (skin integrity damage), and constipation (digestion disorder). Record review of the quarterly MDS assessment for Resident #73 dated 5/24/24 revealed that the resident had a BIMS score of 3 which indicated that she was severely cognitively impaired. She also had an active diagnosis documented of OCD. The MDS did not document any nutritional issues. Record review of the current care plan for Resident #73, last reviewed on 6/8/24, revealed the following, Problem Start Date: 05/13/2023 Category: Nutritional Status Resident has concerns about not gaining weight and limits her intake if she feels her weight is increasing . Goal Target Date: 08/30/2024 Resident will not exhibit signs of malnutrition or dehydration. Approaches included . Approach Start Date: 05/30/2024 Offer available substitutes if resident has problems with the food being served. An Additional Problem stated, Problem Start Date: 04/14/2022 Category: Pressure Ulcer/Injury Resident is at risk for pressure ulcers R/T age, skin, and general condition. Approaches included, .Approach Start Date: 05/30/2024 Diet: regular with snacks, super cereal with breakfast . Record review of the current vitals for Resident #73 revealed that the resident had a weight of 124 lbs on 6/3/24 and on 7/01/24 the resident had a weight of 122.8 lbs. Record review of the Dietician notes for Resident #73 dated 05/14/2024 11:44 revealed the following, QUARTERLY NUTRITION ASSESSMENT . Diet order: regular diet. Snacks/supplements: fortified soup with lunch, super cereal with breakfast, snacks BID. PO (oral) intake: 0-50% on average, showing poor appetite. Wt 121.7 lb, BMI 21.5, ht 63 in, IBW 100-120 lb. Wt is WNL for age. Wt stable No new labs. Skin intact. Pt needs set up tray help only. Current diet order meets adequate needs at this time. Recommend continue current diet order Goal of wt stable x 3%, PO intake >65%, skin remain intact RD will continue to monitor PRN. Record review of the current physician orders dated 7/23/24 for Resident #73 revealed that the resident had an order for Fortified soup with lunch with the start date of 4/01/22 and was open ended. She also had an order for Super cereal with breakfast, start date 4/1/22 and open ended. The resident had an additional dietary order stating, Regular diet, start date 6/1/20, end date open ended. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	He stated, he did not have access to the nursing home diet order document that was submitted to the survey team. He stated, I don't get this (document). The nursing home system does not come to us. We are on a different system. He added the Dietary department needed the paper diet communication form. He stated this issue with fortified diets occurred due to communication issues, nursing staff turnover and things fallen by the wayside. He stated, dietary staff work off a set of cards with the diet restriction; the diet tickets were placed on the trays and dietary staff had meetings to go over the changes. He stated, when dietary staff were made aware of issues, they made sure the correct diet was served quickly as possible. He added dietary staff were very flexible and things would get missed at times. He stated the dietary team (staff) was responsible for ensuring that residents received the diet ordered. He stated if residents failed to receive their ordered therapeutic diet, it could hurt them and result in continued weight loss and unhealthiness. On 7/24/24 at 4:18 PM an observation and interview were conducted with the DON regarding therapeutic diets for residents. She stated, nursing staff had a system where they fill out a dietary communication form. Observation revealed that there was a Nursing Dietary Communication Form that she presented. She was asked if there was any monitoring system to ensure that resident received the correct diet. She stated, Patient Services Coordinator and DON would get together, and we make sure our information matches on diets. The Patient Services Coordinator is the Dietary Manager's assistant. She added there was a Dietitian who came monthly that communicated with dietary department also. She stated it was hard to eyeball a fortified diet since it may have been mixed in the food. She added staff should have been matching the foods with the diet. She stated nursing and dietary staff were responsible for ensuring that residents received their ordered therapeutic diet. She stated, nutritional level would not improve as a result of residents not receiving their ordered therapeutic diet. On 7/24/24 at 4:47 PM an interview was conducted with Administrator regarding therapeutic diets. She stated, Staff dropped the ball regarding the therapeutic diets. She stated she expected staff to have written the diet on the (dietary communication) form and given it to the dietary department. She stated the Dietary Manager was responsible for ensuring that residents received their order therapeutic diet. She stated the risk associated with residents not receiving their ordered therapeutic diet depended on the resident's condition and depended on their diagnosis. On 7/25/24 at 9:21 AM an interview was conducted with the Dietary Manager regarding the diet for Resident #18, he stated that the fortified foods order had not been picked up by the dietary department. Regarding Resident #73's diet, he stated his department needed an order for the fortified soup. Regarding Resident #72's diet, he stated that the therapeutic items such as ice cream and bananas and being on fortified diet had been mixed up with the orders for Resident #19. Record review of the in-service documentation dated 04/24/24 revealed that the DON provided an in-service with Topics that included .therapeutic diets . Record review of the facility's Nursing-Dietary Communication Form revealed the following documentation, . Physician Ordered Supplements .Supercereal____Fortified Eggs____ Fortified Mashed Potatoes ____Fortified Pudding ____Fortified Cream Soup ___Milkshakes____ . (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the current undated facility dietary guidelines document titled Therapeutic Diets and Food Service. Facility: (Facility), revealed the following documentation, Introduction. The CMS definition of therapeutic diet for long-term care facilities is: a diet ordered by a physician or other delegated provider that is part of the treatment for a disease or clinical condition, to eliminate, decrease, or increase certain substances in the diet (e.g., Sodium or potassium), or to provide mechanically altered food when indicated. Other delegated providers may include a nurse practitioner, clinical nurse specialist, or physician assistant, or a qualified dietitian, or other clinically qualified nutrition professional. However, the medical professional retains responsibility for the order. The delegated provider criteria is also applicable to the ordering of nutritional supplements, such as TwoCal HN (supplement), boost, Ensure, Glucerna, and ProSource Liquid Protein . Good nutrition is necessary for all residents in the healthcare facility and is an important part of their medical treatment. Our residents have various medical conditions, such as high blood pressure, diabetes, heart problems, or kidney disease to name a few; that is why it is important to follow the guidelines that have been ordered for them .

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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** 03896 49279 Based on interview and record review, the facility failed to ensure PRN orders for psychotropic drugs are limited to 14 days unless the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, for 2 of 16 residents (Resident #3 and Resident #72) reviewed for unnecessary medications. - The facility failed to ensure Resident #3 had a stop date or duration for PRN alprazolam (a medication used to treat anxiety). - The facility failed to ensure Resident #72 had a stop date or duration for PRN Trazadone (a medication use to treat insomnia). These failures could put residents at risk of possible psychotropic medication side effects, adverse consequences, decreased quality of life, and dependence on unnecessary medications. Findings included: Resident #3 Record review of Resident #3's undated face sheet revealed a [AGE] year-old female originally admitted on [DATE]. Resident #3 had a medical history of congestive heart failure (compromised blood supply to the body), hypertension (high blood pressure), and generalized anxiety disorder. Record review of Resident #3's quarterly MDS dated [DATE], Section C. Cognitive Patterns revealed resident had a BIMS score of 12, which indicated Resident #3 had moderate cognitive impairment. Section I - Active Diagnoses section revealed resident had a psychiatric/Mood disorder of anxiety disorder. Section N - Medications section of the MDS revealed resident was taking antianxiety medication. Record review of Resident #3's care plan last revised on 5/2/2024 revealed, Resident receives antianxiety medication: Alprazolam R/T anxiety disorder. Long Term Goal Target Date: 10/31/2023. Resident will not exhibit drowsiness/oversedation, delayed reaction, cognition/behavior, disturbed balance/gait/positioning ability, slurred speech, little/no act. invol., drug dependence, sleep disturb., rash, blurred vision, anticholinergic symptoms. Approach Start Date: 05/02/2024 Monitor for drug use effectiveness and adverse consequences. Approach Start Date: 05/02/2024 Monitor resident's mood and response to medication. Approach Start Date: 05/02/2024 Pharmacy consultant review. Record review of Resident #3's physician orders revealed Start date 7/27/2023 alprazolam - Schedule IV tablet; 0.25 mg; amt: one tablet; oral Twice a day - PRN, open ended. Diagnosis: F41.1: Generalized anxiety disorder. (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 #3's Emar for July 2024 revealed Resident #3 had received alprazolam PRN on 7/1-7/3, 7/5-712, 7/15-7/17, 7/20, and 7/24. Record review of Resident #3's Emar for June 2024 revealed Resident #3 had received alprazolam PRN on 6/1-6/3, 6/5-6/15, 6/19, 6/21, 6/23, and 6/25-6/30. Record review of Resident #3's Emar for May 2024 revealed Resident #3 had received alprazolam PRN on 5/1-5/16, and 5/18- 5/23. Record review of document titled Psychotropic and Sedative/Hypnotic Utilization by Resident dated 6/29/2024 revealed Resident #3 had Alprazolam tab 0.25mg bid PRN ordered 7/27/2024. Last GDR did not have a date and next evaluation did not have a date. Record review of documents titled Consultant Pharmacist Medication Regimen Review dated 6/1/2024-6/26/2024 revealed no recommendations for Resident #3's alprazolam. Record review of documents titled Consultant Pharmacist Medication Regimen Review dated 5/1/2024-5/29/2024 revealed no recommendations for Resident #3's alprazolam. Record review of documents titled Consultant Pharmacist Medication Regimen Review dated 4/1/2024-4/24/2024 revealed no recommendations for Resident #3's alprazolam. Record review of documents titled Consultant Pharmacist Medication Regimen Review dated 3/1/2024-3/27/2024 revealed no recommendations for Resident #3's alprazolam. Resident #72 Record review of Resident #72 face sheet dated 7/23/24 revealed a [AGE] year-old female originally admitted to the facility on [DATE]. Resident #72 had a medical history of insomnia (sleep disorder), Alzheimer's disease, unspecified (cognitive disorder), COVID-19 acute respiratory disease, history of falling from heavy alcohol, use, alcohol dependence, in remission, Wernicke's encephalopathy (neurological/cognitive disorder), and constipation (digestive disorder). Record review of Resident #72 admission MDS dated [DATE] revealed the resident had a BIMS score of 07 which indicated the resident had moderate cognitive impairment. Resident #72 had an active diagnosis of insomnia unspecified. It was further documented that the resident was taking an antidepressant. Record review of Resident #72's care plan, last revised on 5/24/24, revealed the following, Problem Start Date: 05/25/2024 Resident experiences insomnia. Goal Target Date: 08/22/2024 Resident's use of Trazadone to induce sleep will result in the improvement of the resident's functional status as evidenced by resident states feeling rested. Approaches included, Approach Start Date: 05/25/2024 Administer medications: trazadone. Monitor and record effectiveness. Monitor and report any adverse side effects. (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 #72 physician orders dated 7/23/24 revealed, Order on hold from 7/11/24 to 7/17/24, trazodone tablet: 50 mg; amount; one tablet; oral, at bedtime - PRN. Give at least three hours after wine. Diagnosis: insomnia, unspecified. Start date 5/21/24, end date, open ended. Record review of Resident #72's Emar (May 2024 thru July 2024) revealed that she was administered trazodone from 5/14/24 through 5/19/24 and that the order was open ended and PRN. There had been a hold of the medication for the period of 7/11/24 through 7/ 17/24. Resident #72's PRN trazodone order was still active on 7/23/24. Record review of the June 2024 pharmacy consultant report revealed there were no recommendations for Resident #72. During an interview with the DON, on 7/25/2024 at approximately 10:15AM, she stated she was going to have a meeting with the Nurse Practitioner about this issue because it had happened before. Regarding the PRN order, she stated, the Nurse Practitioner had not placed a stop date on the medication or made it scheduled. She stated that the Nurse Practitioner and pharmacy consultant, and others who saw the order, were responsible for this issue. She stated, We are getting ready to get rid of the PRN orders. We will start monitoring for the PRN orders. She stated, she had expected staff to have gotten a scheduled order or corrected the PRN order and placed a stop date on it. Regarding a possible risk to residents she stated, I'm confused. The solution is probably to schedule the medication. She added, the PRN trazadone order had gotten overlooked, and staff did not want to change Resident #72's routine. She stated she did not feel there was a risk of Resident #3 being on a PRN alprazolam as she takes it regularly every day for anxiety. The DON stated the alprazolam should have been scheduled as Resident #3 had been admitted with that order. She stated prior to today she did not realize the alprazolam had no end date. The DON stated she reviews all recommendations by the pharmacist and saw she was on Xanax (alprazolam) but no one had said anything about it. She stated her expectations is to make sure they are within the state guidelines for PRN usage. During an interview with the ADM on 7/25/2024 at 11:06 AM, she stated it is a team effort between staff, the NP, DON and physicians to ensure residents are not on any unnecessary medications. She stated during care plan meetings those medications are reviewed for you and during the quarterly MDS meetings. She stated the possible risk of unnecessary medications if unnecessary side effects for the residents. She stated the possible reason for having PRN medications with no end date was human error and not checking. Record review of facility policy titled Medication Utilization and Prescribing- Clinical Protocol, revealed, Assessment and recognition . 1. When a medication is prescribed in response to an identified problem, condition, or risk, the physician and staff will identify the indications (condition or problem for which it is being given, or what the medication is supposed to do or prevent), considering the resident's age, conditions, risks, health status, and existing medication regimen . 2. The physician and staff will review the rationale for existing medications that lack a clear indication or are being used intermittently on a PRN (as needed) basis . (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. The consultant pharmacist should use the monthly and interim drug regimen review to help identify potentially problematic medications, including medication regimens that are not supported based on clinical signs or symptoms . Monitoring . 1. The staff and physician will periodically re-evaluate the conditions and symptoms for which each resident is receiving medications to ensure that the medication and dosage are still relevant and are not causing undesired complications. 2. The staff and physician will monitor the progress of anyone with a probable adverse drug reaction and anyone for whom medications have been adjusted because of the possibility of an adverse drug reaction.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 42515 Based on interview and record review, the facility failed to electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS for 1 of 1 facility reviewed for administration (Fiscal year 2024 for the second quarter January 1, 2024, to March 31, 2024). The facility failed to submit PBJ (Payroll Based Journal) staffing information to CMS for the 2nd quarter of the fiscal year 2024. This failure could place residents at risk for personal needs not being identified and met due to staffing. Findings included: Record review of the CMS PBJ Staffing Data Report (payroll-based staffing), CASPER Report (Certification and Survey Provider Enhanced Report)1705 D FY Quarter 2 2024 (January 1- March 31), dated 07/18/24, indicated the following entry: Failed to Submit Data for the Quarter Triggered .Triggered=No Data Submitted for the Quarter. During an interview on 07/25/24 at 11:15 AM, the DON stated the MDS nurse was responsible for the data submission for PBJ staffing. The DON stated she did not monitor to ensure data was submitted and she did not know why the information was not submitted for the second quarter. During an interview on 07/25/24 at 11:39 AM, the MDS nurse said she was responsible for PBJ data submission. The MDS nurse stated she had been trained on PBJ data submission and was last trained about 3 years ago. The MDS nurse stated she did not know why the PBJ data was not submitted for the second quarter of 2024. The MDS nurse stated she did not know a risk to the residents for not submitting PBJ data. During an interview on 07/25/24 at 11:44 AM, the ADM stated the MDS nurse was responsible for ensuring PBJ data information was submitted in a timely manner. The ADM stated she did not know why the PBJ data information was not submitted for the second quarter of 2024 as she was new to the facility. The ADM stated she did not work at the facility when the MDS nurse was trained on PBJ data submissions. The ADM stated she did not know a potential negative risk to the residents with the facility failing to submit the PBJ data information in a timely manner. Record review of the facility's policy, Reporting Direct-Care Staffing Information (Payroll-Based Journal), Revised August 2022, revealed: Policy Statement Direct care staffing information is reported electronically to CMS through the Payroll-Based Journal system. (continued on next page)

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	45F414	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Health Care Center	212 NW 10th St Seminole, TX 79360

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Policy Interpretation and Implementation 1. Complete and accurate direct care staffing information is reported electronically to CMS through the Payroll-Based Journal (PBJ) system in a uniform format specified by CMS. .9. Direct care staffing information is submitted on the schedule specified by CMS, but no less frequently than quarterly. 10. Staffing information is collected daily and reported for each fiscal quarter no later than 45 days after the end of the reporting quarter. Dates are as follows: Fiscal quarter #1: October I-December 31; Submission Deadline: February 14 Fiscal quarter #2: January 1- March 31; Submission Deadline: May 15 Fiscal quarter #3: April 1 - June 30; Submission Deadline: August 14 Fiscal quarter #4: July 1 - September 30; Submission Deadline: November 14. 46425

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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** 03896 49279 Based on observations, interviews, and record review, the facility failed to maintain an infection control program designed to provide a safe, comfortable, and sanitary environment to help prevent the development and transmission of diseases for 3 of 4 residents (Residents #3) reviewed for infection control. 1. CNA A failed to utilize proper hand hygiene during incontinence care for Resident # 3. 2. CNA C failed to utilize proper hand hygiene during incontinence care for Resident #172 3. The facility failed to implement enhanced barrier precautions for Resident #18. These failures could place residents at risk for infection and cross contamination. The findings include: Resident #3 Record review of Resident #3's undated face sheet revealed a [AGE] year-old female originally admitted on [DATE]. Resident #3 had medical history of congestive heart failure (compromised blood supply to the body), hypertension (high blood pressure), and generalized anxiety disorder. Record review of Resident #3's quarterly MDS dated [DATE], Section C. Cognitive Patterns revealed resident had a BIMs score of 12, which indicated Resident #3 had moderate cognitive impairment. Section H - Bladder and Bowel revealed Resident #3 did not utilize any appliances and was not on a urinary toileting program. Record review of Resident #3's Care Plan dated 7/27/23, revealed Resident #3 had a problem of urinary incontinence. The care plan revealed an approach of Provide incontinence care after each incontinent episode. During an observation of Resident #3's incontinence care on 7/23/2024 at 11:40AM, CNA A donned clean gloves, removed Resident #3'S soiled undergarments and cleaned residents front with wet wipes. CNA A doffed dirty gloves and donned clean gloves. No handwashing was utilized between the glove changes. CNA A assisted Resident #3 to roll onto her right side and cleaned Resident #3's buttocks. CNA A doffed dirty gloves and donned clean gloves; no handwashing was utilized between the glove changes. CNA A assisted resident with her clean undergarments and pants. CNA A doffed dirty gloves and assisted Resident #3 to her wheelchair without utilizing hand hygiene after removing her gloves. Resident #18 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #18's undated face sheet revealed an [AGE] year-old male originally admitted on [DATE]. Resident #18 had a medical history of dementia, depression, hypertension (high blood pressure), and type 2 diabetes. Record review of Resident #18's quarterly MDS dated [DATE], Section C- Cognitive Patterns revealed resident had a BIMs score of 08, which indicated Resident #18 had moderate cognitive impairment. Section H - Bladder and Bowel of the MDS revealed resident had an indwelling catheter (medical device used to drain urine from the bladder). Record review of Resident #18's care plan last revised 2/09/24, revealed the following, Problem Start Date: 06/27/2023 Category: Urinary Incontinence Resident requires an indwelling urinary catheter R/T urine retention. Long Term Goal Target Date: 08/10/2023 Resident will have catheter care managed appropriately as evidenced by not exhibiting signs of infection or urethral trauma. Approaches included, .Approach Start Date: 06/27/2023 Provide catheter care daily and as needed. Record review of Resident #18's physician orders revealed the following orders: Start date 4/27/2023, Foley Catheter care every shift. Start date 8/08/2023, CHANGE FOLEY CATHETER BAGEVERY WEEK ON TUESDAYS Start Date 3/27/2024, CHANGE FOLEY CATHETER #16 FRENCH EVERY MONTH ON NIGHTSHIFT Record review of Resident #18's EMR did not reveal Resident #18 had physician orders or a care plan for EBP for the indwelling catheter. During an observation on 7/23/24 at 10:34 AM, Resident #18 was in his room. The resident was in a wheelchair and had a catheter. There was no signage on his room indicating that he had enhanced barrier precautions. There was a box of gloves in the room on the sink. During an observation on 7/23/2024 at 12:25pm, Resident #18 was observed to have an indwelling catheter. No enhanced barrier precaution signs were noted on the resident's door or outside of the resident's room. No PPE was observed outside of Resident #18's room. Resident #172 Record review of Resident #172 undated face sheet revealed a [AGE] year-old female originally admitted on [DATE]. Resident #172 had a medical history of osteoarthritis (loss of bone density), asthma, seizure like activity, and muscle spasms. Record review of resident #172 quarterly MDS dated [DATE], Section C - Cognitive Patterns revealed a BIMS score 15 which indicated the resident was cognitively intact. Section H- bladder and bowel revealed resident #172 was occasionally incontinent. Record review of Resident #172's Care Plan with an approach start date of 9/10/2021 revealed Resident#172 had urinary incontinence. Resident #172's care plan revealed an approach Toileting and Bowel/Bladder Control: Continent of bowl and bladder. Has some incontinent episodes and wears green briefs for these episodes. (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 of Resident #172's incontinence care on 7/24/2024 at 1:26pm, CNA C donned clean gloves after handwashing and wiped Resident #172's buttocks with wet wipes. CNA C grabbed the clean brief with contaminated gloves and fastened the brief onto the resident. CNA C doffed dirty gloves and washed her hands with soap and water. CNA C failed to change gloves and utilize hand hygiene prior to grabbing the clean brief. During an interview on 7/24/24 at 2:15pm with CNA C, she stated she had been at the facility for two years. She stated her infection preventionist was the DON. CNA C stated she has been trained on handwashing between glove changes and her last training was March 2024. She stated the potential negative outcomes could be staff catching something from the residents, or the resident's getting germs or diseases from staff. She stated handwashing should be done before providing care to the resident, after wiping the resident, before putting their clothes back on and before exiting the room. She stated she was aware that she did not change gloves or wash her hands after wiping the resident's buttocks, but she thought it was too late to fix her mistake. During an interview on 7/24/24 at 2:28pm with CNA A, she stated she did not know who the infection preventionist was. CNA A stated she had handwashing training but not at this facility. She stated she had been at this facility for the past two day. CNA A stated she had been nervous during incontinence care and forgot to do hand washing between glove changes. She stated the risk of not washing your hands between glove changes could be risk of infection for the resident and herself. She stated she had been trained on EBP but only for residents with covid and open wounds. She stated she had not taken care of Resident #18 but was aware he had an indwelling catheter and required EBP. She stated EBP is for infection control and to prevent getting anything splashed. During an interview on 7/25/2024 at 09:58 AM, CNA B stated prior to today they were not utilizing enhanced barrier precautions for Resident #18. She stated they had been trained on EBP, but it was for residents who had Covid, not open wound or indwelling catheters. She stated the risk of not utilizing EBP could be risk of infection. She stated she had not read the facility policy on EBP. CNA B stated the infection preventionist was the DON. During an interview with the DON, on 7/25/2024 at 10:25 AM, she stated she is the infection preventionist. She stated she had trained her staff on handwashing and infection control within the last 3 months. The DON stated the risk of not washing your hands or using proper infection control could be the potential for infection. She stated her expectation of staff is to wash their hands when they go into the room, when they exit the room, and anytime they change gloves. She stated everything in the facility policy is what staff should be following. The DON stated the facility utilizes EBP for residents with indwelling catheter or wounds. She stated the staff has been trained on EBP, and it is an ongoing training. She stated she believes the last training was April 2024. The DON stated the risk of not utilizing EBP is infection. During an interview with the ADM on 7/25/2024 at 11:06 AM, she stated the DON was the infection preventionist. She stated the DON is responsible for training staff and does not know when the last training occurred. The ADM stated she was not sure if there had been training on EBP as she had only been at the facility since April 2024. The ADM stated they do random observation of staff for handwashing, and she will come in on the night shift to observe as well. She stated the risk of not handwashing is risk of transmitting contagions. She stated her expectation of staff is to wash their hands between glove changes. (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 facility policy titled Hand washing/ Hand hygiene revealed . Indications for hand hygiene . G. Immediately after glove removal . 5. the use of gloves does not replace hand washing/ hand hygiene. Record review of facility policy titled Enhanced Barrier Precautions last revised on August 2022 revealed, Policy statement Enhanced barrier precautions are utilized to prevent the spread of multidrug resistant organisms for residents. .5. EBP are indicated (when contact precautions do not otherwise apply) for residents with wound and/or indwelling medical devices regardless of MDRO colonization. .10. Signs are posted in the door or wall outside the resident's room indicating the type of precaution and PPE required #11 PPE is available outside of the residence room.