STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cass Valley Healthcare Center	103 Teakwood St Centerville, TX 75833

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on observation, interview, and record review, the facility failed to ensure the communication system which allows residents to call for staff assistance was within reach for 5 (Resident #4, Resident # 21, Resident # 31, Resident #26, and Resident #20) out of 17 residents reviewed for call system placement. The facility failed to ensure Resident #4, Resident #21, Resident #31, Resident #26 and Resident #20's call light was within reach. The failure could place residents at risk for being unable to call for assistance from staff. Findings include: Review of Resident #4's face sheet reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of hemiplegia (paralysis or severe weakness in one side of the body) and cerebral infarction (stroke). Review of Resident #4's Optional MDS, dated [DATE], reflected a BIMS score of 11 indicating moderate cognitive impairment. MDS further reflected resident required substantial assistance with sitting on side of bed and transferring to the toilet. Review of Resident #4's Care Plan, dated 05/13/2024, reflected resident requires staff assistance for meeting needs. Care plan reflected resident had an ADL self-care performance deficit and required extensive 2-person transfer and dependence for toileting needs. Interventions included to encourage resident to use call bell to call for assistance. Observation and interview on 08/20/2024 at 09:15 AM, revealed Resident #4 lying in bed by the window with the call bell hanging from the back wall out of the resident's reach. Resident #4 stated he did not know where the call bell was and shrugged his shoulders when asked further questions. 2. Review of Resident #21 face sheet reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), personal history of traumatic brain injury (brain dysfunction caused by an outside force, usually a violent blow to the head), an anxiety disorder (feelings of worry, anxiety or fear). (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: 675065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #21's MDS, dated [DATE], reflected a BIMS score of 13 indicating resident was cognitively intact. MDS further reflected resident required moderate assistance with eating and substantial assistance with toileting. Review of Resident #21's Care Plan, dated 05/13/2024, reflected resident had an ADL self-care performance deficit and required assistance with transfers, eating and toileting. Interventions included to encourage resident to use call bell to call for assistance. Observation and interview on 08/20/2024 at 09:45 AM, revealed Resident #21 sitting in wheelchair alone in his room with call bell hanging against back wall and behind furniture. Resident #21 stated he did not know where the call bell was and that he never uses it. He stated he goes out of the room to get someone if he needs something. 3. Review of Resident #31's face sheet reflected a [AGE] year-old male admitted to the facility on [DATE] with readmission on 05/01/2024 with diagnoses of nontraumatic intracerebral hemorrhage (bleeding in the brain that occurs without surgery or trauma), encephalopathy (brain disease that alters brain function), hemiplegia and hemiparesis (weakness and paralysis on one side of the body). Review of Resident #31's MDS, dated [DATE], reflected a BIMS score of 03 indicating severe cognitive impairment. MDS reflected resident was dependent on staff for toileting and hygiene needs. Review of Resident #31's care plan, dated 07/08/2024, reflected resident had an ADL self-care performance deficit and required assistance with transfers, eating and toileting. Interventions included to encourage resident to use call bell to call for assistance. Observation and interview on 08/20/2024 at 10:00 AM, revealed Resident #31 alone in the room, lying in bed with the call bell draped across the chair on the other side of the room. Resident # 31 was difficult to understand but stated he did not know about his call bell. 4. Review of Resident #26's face sheet reflected an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of metabolic encephalopathy (brain dysfunction caused by a chemical imbalance in the blood from an underlying condition that affects metabolism), Alzheimer's disease (progressive disease that destroys memory and other mental functions), and transient cerebral ischemic attack (mini stroke). Review of Resident #26's MDS, dated [DATE], reflected a BIMS of 10 indicating moderate cognitive impairment. MDS indicated resident required moderate assistance with toileting and showering. Review of Resident #26's Care Plan, dated 07/09/2024, reflected resident had an ADL self-care performance deficit and required assistance with transfers, eating and toileting. Interventions included to encourage resident to use call bell to call for assistance. Observation and interview on 08/20/2024 at 10:15 AM, revealed Resident # 26 alone in room lying in bed by the window with the call bell across the room out of reach. Resident #26 stated he never has a call bell where he can reach it. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Cass Valley Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 103 Teakwood St Centerville, TX 75833	

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of Resident #20's face sheet reflected an [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (progressive disease that destroys memory and other mental functions), Bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and Dementia (impairment of brain functions such as memory loss and judgement). Review of Resident #20's MDS, dated [DATE], reflected a BIMS of 04 indicating severe cognitive impairment. MDS reflected resident required supervision with toileting and shower. Review of Resident #20's Care Plan, dated 06/09/2024 reflected resident had an ADL self-care performance deficit and required assistance with toileting and supervision/setup with eating and transfers. Interventions included to encourage resident to use call bell to call for assistance. Observation on 08/2024 at 11:00 AM, revealed Resident #20 resting in bed with her call bell out of reach, hanging from back wall onto the floor. Resident was not interviewable. In an interview on 08/22/2024 at 3:51 PM, CNA C stated it was the nursing staff's responsibility to ensure the residents call bell was within reach or it could place the resident at risk for falls. She stated the nurses at the nurses station would only be able to hear some of the residents if they were to cry out for help. In an interview on 08/22/2024 at 4:10 PM, LVN A stated it was everyone's responsibility to ensure the call bells are within the residents reach and to tell the residents to call if they need anything. She stated a resident could fall while trying to get up and reach the call bell. She stated the nurses at the nurse station would only be able to hear some residents if they were to holler for help. In an interview on 08/22/2024 at 5:30 PM, Interim DON stated the call bells should be within reach at all times. She stated the staff have received in-services on call bells and she has started making rounds in the facility to monitor compliance. She stated when the call bell is not within reach it places the resident at risk for injury and not being able to get what they need. Review of in-service training, dated 03/27/2024, reflected call lights are everyone's responsibility and something anyone can help with. The training reflected the staff are to make sure call bells are within reach every time the staff enter and exit the room.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49851 Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for 1 (Resident #22) of 4 residents reviewed for abuse. The facility failed to prevent physical abuse against Resident #22 by CNA H as seen on video surveillance. The noncompliance was identified as PNC IJ. The IJ began on 07/04/2024 and ended on 07/05/2024. The facility had corrected the noncompliance before the survey began. This failure placed the resident at risk of physical and psychological harm. Findings include: Observation of Resident #22's video surveillance revealed CNA H assaulting the resident on three occasions during the 6:00 PM to 6:00 AM shift on 07/04/2024. The video captured CNA H striking Resident #22 with an open hand and the strikes were clearly heard on the audio. Due to the angle of the camera, it was difficult to identify where exactly on his body Resident #22 was slapped, but it appeared to be on the right arm and the backside. No observable reaction was noted by Resident #22 in the videos. Review of Resident #22's face sheet reflected a [AGE] year old male admitted to the facility on [DATE] and again on 12/22/2023 with diagnoses of Peripheral Vascular Disease (A circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), Cognitive Communication Deficit (may have trouble reasoning and making decision while communicating, have trouble responding in an appropriate manner), and Amnesia (memory loss). Review of Resident #22's comprehensive MDS, dated [DATE], reflected resident was rarely or never able to understand verbal communication, cognitive skills for daily decision making were severely impaired and the resident was always incontinent of bowel and bladder. Review of Resident #22's Care Plan, revised 06/12/2024, reflected resident had an electronic monitoring device in his room with consent signed, resident was moved to memory care wing, resident required staff assistance for meeting emotional, intellectual, physical and social needs related to dementia. Care Plan also reflected resident had potential to be physically aggressive with staff and would hit staff during incontinence brief change. Interventions included in-service staff on Abuse Prohibition Policy, analyze times of day, places, circumstances, triggers and what de-escalates behavior and document, and provide physical and verbal cues to alleviate anxiety. In an interview on 08/20/204 at 2:20 PM, the ADON stated the for Resident #22 came to the facility and showed the DON the video of CNA H abusing Resident #22. She stated CNA H was employed by the Staffing agency. She stated the facility agreed it was abuse and law enforcement put out a warrant for CNA H's arrest. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 08/21/2024 at 10:45 AM, Resident #22's RP (FM 1) stated that himself or FM 2 monitored the video surveillance camera in Resident #22's room daily. FM 1 stated the evening of the incident 07/04/2024 FM 2 reviewed the video and observed CNA H being rough and slapping the resident. FM 2 went to the facility and showed the DON the video. FM1 stated the DON at the time called in the incident to the state and FM 2 met with the sheriff's office and filed a report. FM 1 stated he believed the suspect had been arrested. He stated there was a lot of turnover with the administrator and DON but he felt the facility handled the investigation well. FM 1 stated he did not notice a change in Resident #22's behavior follwing the incident. Observations and interviews with Resident #4, Resident #6, and Resident #21 revealed none had concerns with abuse and all felt safe at the facility. Interviews with direct care staff revealed all were knowledgeable of abuse prohibition policy. In an interview 08/22/2024 at 3:51 PM, CNA C stated she received abuse training several times a year. She stated if she witnessed abuse she would report it to the administrator. In an interview on 08/22/2024 at 4:10 PM, LVN A stated she was trained on abuse in July. She stated if she witnessed abuse she would report it to the administrator immediately. In an interview on 08/22/2024 at 5:30 PM, the interim DON stated the staff are trained on Abuse Prohibition Policy annually and as needed. She stated that staff are screened for history of abuse before hire. In an interview on 08/22/2024 at 5:50 PM, the Administrator stated staff are trained on Abuse Prohibition Policy annually and after every reportable event. She stated they run abuse/neglect registry checks before hire for all new staff. Attempted interview with CNA H with no return communication. The Administrator and DON at the time of the incident are no longer employed at the facility. Review of reports received from the Staffing Agency reflected a background check was completed for CNA H on 03/13/2024, with clear status. Records also reflected CNA H was deactivated from the Staffing Agency platform as of 07/06/2024 and her account had been permanently disabled. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility investigation, dated 07/12/2024, reflected the Administrator at the time took the appropriate actions to ensure the safety of the residents after the incident and provided education for the staff. Behavior monitoring was conducted for all residents on the memory care unit for 72 hours, weekly random check-offs were implemented for staff members providing direct care, and Abuse/Neglect in-service and drills were conducted. The report further reflected CNA H was immediately, on 07/05/2024, reported to the Staffing Agency and taken off the facility schedule. A skin assessment was completed on Resident #22 and all other residents that received care from CNA H with no issues/injuries noted. Per facility report, Resident #22 continued same meal intake, sleep pattern and no increased behaviors following the incident. CNA H only worked that one shift at the facility and has been banned from working at any company facility. Facility investigation report reflected 5 direct care staff completed an abuse questionnaire on 07/11/2024, abuse drill evaluations were completed as well as an in-service on abuse policy. Review of the questionnaire reflected staff were aware of how and when to report abuse to the Abuse Prohibition Coordinator (Administrator). The abuse policy in-service, dated 07/05/2024, was signed by 49 employees. Review of the police report, dated 07/08/2024, reflected CNA H intentionally and knowingly caused physical contact with Resident #22, by striking the resident several times with an open hand and should have believed that the resident would regard the contact as offensive or provocative. Review of facility Abuse Prohibition Policy, dated 05/17/2024, reflected physical abuse defined as . slapping . and controlling behavior through corporal punishment. The policy reflected the facility would investigate alleged abuse and provide notification of information to the proper authorities according to state and federal regulations. It also reflected employees will receive training and reinforcement on all aspects of abuse program at the time of initial orientation, annually and through ongoing in -services. The noncompliance was identified as PNC IJ. The IJ began on 07/04/2024 and ended on 07/05/2024. The facility had corrected the noncompliance before the survey began.

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	675065	A. Building B. Wing	08/22/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on observation, interviews, and record review the facility failed to ensure residents unable to conduct activities of daily living (ADLs) received the necessary services to maintain good grooming and personal hygiene for 4 of 8 (Resident #12, Resident #18, Resident #25, and Resident #28) residents reviewed for ADL care. 1. The facility failed to ensure Resident # 12, Resident #18, Resident #25, and Resident #28 nails were cleaned and did not have any rough edges. These failures placed residents at risk of a decline in their hygiene, loss of dignity and decreased quality of life. Findings included: 1. Record review of Resident # 12's Face Sheet dated, 08/22/2024, reflected a [AGE] year-old male admitted on [DATE] with diagnoses of type 2 diabetes mellitus without complications (high levels of blood glucose can damage the blood vessels and nerves that control the heart), lack of coordination (a problem with movement that can manifest in a variety of ways, such as difficulty with fine motor skills), anxiety disorder (worry endlessly over everyday issues such as health, money, family problems-even if the person realizes there's little cause for concern). Record review of Resident #12's Quarterly MDS Assessment, dated 07/19/2024, reflected the resident had a BIMS score of 07 indicated his cognition was severely impaired. Resident #12 required assistance with personal hygiene, dressing, transfers, and showers/bathing. Resident #12 had a behavior problem of picking at skin on his hand. Record review of Resident #12's Comprehensive Care Plan, dated 08/14/2024 reflected Resident #12 had an ADL self-care performance deficit. Intervention: Resident required assistance with personal hygiene, dressing, transfers, bed mobility, and toileting. Observation on 08/20/2023 at 10:50 AM, Resident # 12's nails was rough around the edges on his right hand. He also had blackish substance underneath his nails on his middle and ring fingers on his right hand. Resident was sitting in wheelchair in his room. There was an odor of feces on residents' fingers. In an interview on 08/20/3034 at 10:53 AM, Resident #12 stated he sometimes scratched his bottom at night and he got poop (a word for feces) on my fingers. He stated he asked someone to clean it last night and the lady said she would come back and clean his fingers. Resident #12 said no one came back to his room. He did not respond to questions about his fingernails being rough around the edges. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident # 18's Face Sheet dated, 08/22/2024, reflected a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] diagnoses of : type two diabetes mellitus without complications (high levels of blood glucose can damage the blood vessels and nerves that control the heart), muscle weakness- generalized (loss of muscle strength), combined forms of age-related cataract, bilateral (when the lens in both eyes becomes cloudy from age, injury or disease), other lack of coordination (a problem with movement that can manifest in a variety of ways, such as difficulty with fine motor skills), hemiplegia , unspecified affecting left non dominant side (left side paralysis- the loss ability to move). Record review of Resident #18's Quarterly MDS Assessment, dated 07/18/2024, reflected Resident #18 had a BIMS score of 10 indicated her cognition was moderately impaired. She required assistance from staff with personal hygiene, dressing, transfers, eating and bathing. Record review of Resident #18's Comprehensive Care Plan, dated 07/31/2024, reflected Resident #18 wished to have long fingernails. Intervention: keep fingernails smooth and clean. Monitor for any skin impairments related to long fingernails. Resident #18 makes poor safety choices. Intervention: Attempt to monitor Resident #18 in regard to safety choices that place resident at risk. Educate Resident #18 on risks associated with poor safety choices. Resident #18 had an ADL self-care performance deficit. Intervention: Resident #18 was dependent on staff for personal hygiene. Observation on 08/20/2024 at 11:15 AM, Resident #18 was in her room sitting in wheelchair. Resident #18 nails were approximately 1-2 inches long on both hands. Resident #18's left hand had nails on her ring finger, middle finger, and fore finger rough around the edges. In an interview on 08/202/2024 at 11:17 AM, Resident #18 stated she preferred her nails long but wanted her nails to be filed so they would not be so uneven and rough. She stated she always had a lot of pride in her fingernails and loved them long but did not prefer them to be unkept with not being filed. Resident #18 stated she was not able to file her nails any longer. She stated she asked someone on Saturday and on Sunday to file her nails and both of the ladies that worked at this facility told her that was not their job she would need to speak to the person who does activities she was the only staff that filed nails. Resident #18 stated she scratched her arm a little with one of her nails as she pointed to her right arm. Observed on 08/20/2024 at 11:19 AM, Resident #18's right arm and there was a small scratch, however, it was not a skin tear. 3. Record review of Resident #25's Face Sheet, dated 06/17/2024, reflected a [AGE] year-old male admitted on [DATE] with a diagnoses of lack of coordination (a problem with movement that can manifest in a variety of ways, such as difficulty with fine motor skills), age-related physical debility (frail patients often present with symptoms including weakness, fatigue, medical complexity, and reduced tolerance to medical and surgical interventions), muscle weakness (loss of muscle strength), muscle wasting and atrophy, not elsewhere classified, other site (muscle atrophy - the wasting or thinning of muscle mass, muscle wasting- weakening, shrinking, and loss of muscle caused by disease or lack of use), and anxiety disorder due to known physiological condition (when anxiety symptoms (startle easily and can't relax) are a direct result of a physical health problem). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #25's Admission MDS Assessment, dated 06/21/2024, reflected Resident #25 had a BIMS score of 9 indicated Resident cognition was moderately impaired. He required assistance with personal hygiene, showers, dressing and toileting hygiene. Record review of Resident #25's Comprehensive Care Plan, dated 07/12/2024, reflected Resident #25 had an ADL self-care performance deficit. Intervention: Resident #25 required assistance with personal hygiene, toileting hygiene, showers, and dressing. Resident #25 was resistive to care related to anxiety (startle easily and can't relax) he will refuse turning and repositioning and repositioning to offload areas and therapy participation sometimes. Intervention: Allow Resident #25 to make decisions about treatment regimen, to provide sense of control. Resident #25 had a communication problem related to aphasia (a language disorder that affects a person's ability to understand and express language, including reading and writing). Resident #25 had a mood problem anxiety related to disease process of CVA (a medical conditions that occurs when blood flow to the brain is suddenly cut off - this diagnosis was not listed on the face sheet) Intervention: Monitor/record/ report to medical doctor as needed acute episode feelings or sadness; feelings of worthlessness or guilt or change in psychomotor (movement-oriented activities that require practice and involved characteristics such as coordination, strength, speed and flexibility). Observation on 08/20/2024 at 11:30 AM, Resident #25 was lying in bed. His nails were approximately three inches long on all fingers on both hands. All of his fingernails on the left hand were rough around the edges. His right hand had blackish substance of a bowel movement (the process of moving waste through the intestines after eating or drinking) odor. There was a blackish substance on the tips of his middle and forefinger on his right hand. Resident #25 had a blackish substance underneath his nails on his fore finger, middle finger, and ring finger of the right hand. Attempted interview on 08/20/2024 at 11:34 AM, Resident #25 did not want to be interviewed. Attempted interview on 08/20/2024 at 3:05 PM, Resident #25 did not want to be interviewed. 4. Record review of Resident # 28's Face Sheet, dated, 08/22/2024, reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of type 2 diabetes mellitus without complications (high levels of blood glucose can damage the blood vessels and nerves that control the heart), lack of coordination (a problem with movement that can manifest in a variety of ways, such as difficulty with fine motor skills), muscle weakness (loss of muscle strength), muscle wasting and atrophy, not elsewhere classified, other site (muscle atrophy - the wasting or thinning of muscle mass, muscle wasting-weakening, shrinking, and loss of muscle caused by disease or lack of use), unspecified dementia, unspecified severity, with anxiety (a condition in which a person loses the ability to think and solve problems. Unspecified severity- a medical classification for dementia that does not have a specific diagnosis and does not have a specified severity. Anxiety with dementia- often related directly to worries about coping with the condition and what the future holds). Record review of Resident #28's Admission MDS Assessment, dated 07/27/2024, reflected Resident #28 had a BIMS score of 6 indicated his cognitive status is severely impaired. He required assistance with bathing, dressing, personal hygiene, and transfers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #28's Comprehensive Care Plan, dated 08/14/2024, reflected Resident #28 needed had an ADL self-care performance deficit. Intervention: Resident #25 required assistance with personal hygiene, toileting hygiene, showers, and dressing. Observation on 8/20/2024 at 1:03 PM, reflected Resident # 28 was sitting in his wheelchair in his room. He had approximately 2-3 inches of long nails on his right and left hand. Resident #28's forefinger nail had a sharp nail only in the corner of the finger on his left hand. Resident #28's ring finger, thumb, small finger, and middle fingernails on his left hand was rough around the edges. Resident #28 had a very long nail approximately 4 inches long on his right hand. Resident #28 right hand had a sharp nail and rough around the edges in the corner of his ring finger. His right-hand fingernails on his middle finger and fore finger had a blackish substance underneath these nails. There was an odor of bowel movement (the process of moving waste through the intestines after eating or drinking) odor. In an interview on 08/20/2024 at 1:06 PM Resident #28 stated when he nails gets long and he can not find anyone to cut his nails, he will bend his nails until they break. He stated that is why you see that sharp nails in the corners. Resident #28 also stated when he bends his nails they don't break smoothly and causes a sharp point on some of his nails. He stated if someone does not want to cut his nails he will do it himself. Resident #28 stated he was a diabetic (high levels of blood glucose can damage the blood vessels and nerves that control the heart), and he knew his nails may become infected if his nails was not cut properly. Resident #28 stated he did have to use the bathroom last night and did have poop (a slang word for feces- waste matter from the bowels after food had been digested) to come out his bottom. Resident #28 stated he did scratch his bottom and got poop on his hands and he tried to get most of it off his hand (he raised his right hand when he was discussing where the poop was located). In an interview on 08/22/2024 at 1:30 PM, ADON G stated if a resident had rough edges around the nail there was a possibility the resident may scratch themselves or someone else and develop a skin tear. She stated if a resident ingested blackish substance on their fingers or underneath their fingernails, there was a possibility the substance may be some type of bacteria. She stated a resident may develop a stomach illness with symptoms of diarrhea and vomiting. ADON G stated it was according to what the bacteria was to determine if a resident would become ill. ADON G stated the nurses completed all nail care for residents with a diagnosis of diabetes (high levels of blood glucose can damage the blood vessels and nerves that control the heart). She stated if a staff was not certain if they were to file someone nails the staff was expected to ask their nurse supervisor. ADON G stated all residents was expected to receive nail care during showers and as needed. She stated it was the nurse supervisor responsibility to monitor nail care. ADON G stated she would need to review the electronic medical record to determine if any residents refused nail care. (continued on next page)

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	675065	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cass Valley Healthcare Center	103 Teakwood St Centerville, TX 75833

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/22/2024 at 4:45 PM, CNA K stated the nurses completed all diabetic (high levels of blood glucose can damage the blood vessels and nerves that control the heart) fingernails and the CNAs were responsible for all other residents' nails. CNA K stated the CNAs were responsible to complete nail care such as trimming, filing, and cleaning the nails during showers and as needed. CNA K stated if a resident had blackish substance underneath their nails, it was probably some type of bacteria such as bowel movements (the process of moving waste through the intestines after eating or drinking). She stated if a resident swallowed bacteria it was a potential the resident may become ill and may develop major stomach problems such as diarrhea or vomiting. CNA K stated if a resident became severely ill the resident may need to be transferred to emergency room for more care. She stated she worked with Resident #12, Resident #18, Resident #25, and Resident #28. CNA K stated the only resident she knew resisted care was Resident #25. CNA K stated Resident #25 resisted being turned or repositioned she was not aware of him refusing nail care. and Resident #31, and she was not aware of them refusing nail care. She stated if a resident's nails were rough around the edges there was a possibility the resident may scratch themselves and develop a skin tear, or possibly scratch their eye and cause a tear on their eyeball. CNA K stated she had been in-service on nail care but did not remember the date of the in-service. In an interview on 08/22/2024 at 5:05 PM, CNA C stated the CNAs was responsible for cleaning, trimming, and filing all residents' nails except for the residents with diagnosis of diabetes (high levels of blood glucose can damage the blood vessels and nerves that control the heart) and the nurses was responsible for residents with diabetes. CNA C stated the nurses was responsible for all residents' nails with diagnosis of diabetes. CNA C stated if a resident had a rough nails or their nails were dirty, nail care was expected to be completed as needed. CNA C stated if a resident nails was rough around the edges there was a possibility a resident may scratch themselves or another resident. CNA C stated the scratch may develop into a skin tear. CNA C stated if there was a blackish substance on the residents' fingertips or underneath their nails and the resident swallowed the blackish substance there was a possibility a resident may become ill with stomach issues such as vomiting. She stated she worked at this facility as needed. CNA C also stated she had given care to Resident # 28, Resident #12, Resident #18, and Resident #25. She stated she was not aware of any of these residents refusing nail care. She stated she had been in-serviced on nail care but did not recall the date. In an interview on 08/22/2024 at 5:35 PM, LVN A stated the nurses and the CNAs were responsible for nail care. She stated the nurses were responsible to trim and clean all resident's nails with a diagnosis of diabetes (high levels of blood glucose can damage the blood vessels and nerves that control the heart). LVN A stated it was the CNAs responsibility to clean and trim all other residents' nails. She stated she was not aware of Resident #10, Resident #28, Resident #12 or Resident #25 refused nail care. She stated Resident # 25 would refuse to be turned or off load his heels but not nail care. LVN A stated if there was a blackish substance underneath the residents' nails, there was a possibility the substance had bacteria underneath the residents' nails. She stated if a resident swallowed the bacteria there was a possibility a resident may become extremely ill with stomach issues such as diarrhea and vomiting. LVN A stated if a resident scratched themselves with rough nails there was a potential a resident may develop a skin tear and there was a possibility the resident may scratch another resident and cause a skin tear on another resident. She stated she had been in-serviced on nail care but did not recall the date of the in-service.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on observation, interview and record review, the facility failed, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility sponsored, individual activities, independent activities, designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident , encouraging both independence and interaction in the community for 3 of 8 residents (Resident #10, Resident #19, and Resident #25) reviewed for activities. The facility failed to develop an activity program based on preferences of Resident #10, Resident #19, Resident #25 during the months of July to August 2024. These failures placed residents at risk of boredom, depression, increased behaviors, and diminished quality of life. Findings include: 1. Record review of Resident #10's Face Sheet, dated 08/22/2024, reflected an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with the diagnosis depression unspecified (used when a person's symptoms do not clearly align with a specific mental disorder or where there is insufficient information for a more definitive diagnosis), other secondary parkinsonism (caused by brain injuries or brain disorders), and cognitive communication deficit (can effect both verbal and nonverbal communication, such as speaking, listening, reading, writing, and social interaction skills). Record review of Resident #10's Annual MDS Assessment, dated 01/30/2024, reflected Resident #10 was rarely/never understood. She had poor short (unable to recall after 5 minutes and long (unable to recall long past memories) term memory recall. Resident #10 does not have speech (absence of spoken words). Resident #10 activity preferences was listening to music and participating in religious activities or practices. Record review of Resident #10s Quarterly MDS Assessment, dated 07/30/2024, reflected Resident #10 had poor short (unable to recall events after 5 minutes) and long-term memory recall (unable to recall past events). Resident #10 was rarely/ never understood or rarely/never understands others. Record review of Resident 10's Comprehensive Care Plan, dated 08/14/2024, reflected Resident #10 required staff assistance for meeting emotional, intellectual, physical, and social needs related to disease process and immobility. Intervention: Resident #10 needed in-room visits and activities. Record review of Resident #10's in room activity participation record in the electronic medical record reflected Resident #10 did not have any documentation of receiving in room activities or attending group activities. The record review was completed with the Activity Director M. She stated she did not have any participation records on Resident #10. Observation on 8/20/2024 at 10:31 AM. Resident #10 was sitting in the lobby asleep. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/20/2024 at 4:00 PM, Resident #10 was in bed. Her door to her room was slightly opened. Resident #10 was awake there was no lights on in her room. Television was not on and did not observe any radio in her room which music was her favorite activity. Resident #10's room was dark and she was moving her eyes side to side. Resident had sad expression (forehead wrinkled and eyebrows were brought together -signs of sad expression). In an interview on 8/20/2024 at 4:05 AM, Resident #10 was not interview able. Observation on 08/21/2024 at 7:45 AM, Resident #10 was in bed. Her door to her room was slightly opened. Resident #10 was awake and there were no lights on in her room and no stimulation such as a radio in her room which is her favorite activity listening to music. Resident #10 did not have television on in room. In an interview on 8/21/2024 at 8:15 AM, Activity Director M stated she did not have any in room or group participation records for the month of July 2024 and August 2024 for Resident #10. She stated she would print all of the in-room participation records for the months of July 2024 and August 2024 In an interview on 08/21/2024 at 8:45 AM, Activity Director M stated after the activity in room participation records were printed Resident #10 did not have any in room or group participation records for the months of July 2024 or August 2024. She stated she did not know if she received in room activities or attended group activities during the months of July 2024 and August 2024. Activity Director M stated if a resident had a diagnosis of depression and was not physically able to do activities without assist from another person, there was a possibility Resident # 10 may become more depressed and may become very lonely. She stated Resident #10 quality of life may decrease. She stated Resident #10 does sit in the lobby but sleeps most of the time and she was not receiving any activities in the lobby. She stated it was her responsibility to ensure all residents received activities according to their past and current interest. 2. Record review of Resident #19's Face Sheet, dated 08/22/2024, reflected a 94- year-old female admitted to the facility on [DATE] with diagnosis of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a condition in which a person loses the ability to think and solve problems. Unspecified severity- a medical classification for dementia that does not have a specific diagnosis and does not have a specified severity), major depressive disorder (feelings of guilt or worthlessness, lack of energy, agitation (unable to stay calm) and /or sleep disturbances), and unspecified glaucoma (a group of eye diseases that cause increased pressure in the eye, which can damage vision). Record review of Resident #19's Admission MDS Assessment, dated 10/18/2024, reflected Resident #19 had a BIMS score of a 15 indicated her cognition was intact. Resident #19's activity preferences were the following: go outside and get fresh air when weather permitted, participate in religious services or practices, listen to music, reading such as: books, newspapers, and magazines. Participating in groups activities was not very important to Resident #19. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #19's Quarterly MDS Assessment, dated 07/17/2024, reflected Resident #19 had a BIMS score of 15 indicated her cognition was intact. Resident #19 had moderately impaired vision- not able to see newspaper headlines but can identify objects. She was assessed to feel down, depressed, or hopeless. Resident #19 also felt tired and bad about herself, had difficulty concentrating on things such as: reading or watching television. Record review of Resident #19's Comprehensive Care Plan, dated 07/31/2024, reflected Resident #19 required staff assistance for meeting emotional, intellectual, physical, and social needs related to immobility. Intervention Resident #19 needed in room visits and activities if unable to attend out of room events. Resident was resistive to care related to adjustment to nursing home and dementia (a condition in which a person loses the ability to think and solve problems). Resident #19 refused to get out of bed. Intervention: All Resident #10 to make decisions about treatment regime, to provide sense of control. Resident #19 had impaired cognitive function/dementia (a condition in which a person loses the ability to think and solve problems). Intervention: Reminisce with Resident #19 using photos of family and friends. Observation on 8/20/2024 at 11:30 AM, Resident #19 was in her room lying in bed. The door to her room was barely opened and she did not have television on and did not see a radio or other stimulation in her room. Resident #19 had sad expression on her face such as (forehead wrinkled, and eyebrows were brought together -signs of sad expression). Resident #19 was staring toward the ceiling. In an interview on 08/202/2024 at 11:33 AM, Resident #19 stated she was lonely and there was not anything for her to do except watch television and she was tired of television. She stated she did not receive in room visits or activities from anyone and she did not know what in room visits or in room activities was until now. Resident #19 stated she never heard of in room activities. Resident #19 stated she did not prefer to attend group activities it made her feel uncomfortable being around others in a group. She stated if someone would just bring her a radio or something for her to listen to music. Resident #19 stated she loved Gospel music and liked country music. She stated if there was gospel or country music on television she never knew about it or ever saw it on television. Resident #19 stated music was her favorite thing to do. She stated she never liked to read very much due to her vision. Resident #19 stated her neighbor had books on tape and her neighbor would listen to different types of books. Resident #19 stated she might enjoy listening to books but she would need to try it before she made decision if she liked to listen to books. Resident #19 stated no one had ever offered her anything to read and with her poor vision it would need to be very large print. Resident #19 stated she did like to go outside in the spring and fall sometimes. She stated she did not recall anyone assisting her to sit outside. Resident #19 stated that would be nice sometimes not every day or every week but maybe once or twice a month when weather was cooler. She stated she did like to listen to devotionals. She stated it would be nice if someone read the bible to her or a devotional to her once a week. Resident #19 stated there is never anything to do and no one comes by and will sit and talk to me. She stated do you think you can talk to someone and ask them if they would visit with me sometimes and bring me something to do instead of watching television all the time. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/21/2024 at 8:15 AM, Activity Director M stated Resident #19 was not on the in-room activity program. She stated she did not realize Resident #19 was not getting out of bed very often. The Activity Director M stated she did not have any participation records for Resident #19 during months of July 2024 and August 2024. She stated she had not been reminiscing using photos of Resident #19's family and friends. Activity Director M stated if Resident #19 did not want to attend group activities she needed to be receiving in room activities. Activity Director M stated she did not realize it was on Resident #19's care plan she was to receive in room activities reminiscing about family or friends' photos. She stated Resident #19 had a potential of becoming bored and depressed if she was not doing the activities she preferred or not doing any type of activities in her room. Activity Director M stated she had not been offering her large print books to read, books on tape or a radios. She stated if music, religious activities and going outside was her favorite activities these type of activities was expected to be provide to Resident #19. She stated it was her responsibility to ensure all residents received activities according to their past and current interest. 3. Record review of Resident #25's Face Sheet, dated 06/17/2024, reflected a [AGE] year-old male admitted on [DATE] with a diagnoses of lack of coordination (a problem with movement that can manifest in a variety of ways, such as difficulty with fine motor skills), age-related physical debility (frail patients often present with symptoms including weakness, fatigue, medical complexity, and reduced tolerance to medical and surgical interventions), muscle weakness (loss of muscle strength), muscle wasting and atrophy, not elsewhere classified, other site (muscle atrophy - the wasting or thinning of muscle mass, muscle wasting- weakening, shrinking, and loss of muscle caused by disease or lack of use), and anxiety disorder due to known physiological condition (when anxiety symptoms (startle easily and can't relax) are a direct result of a physical health problem). Record review of Resident #25's Admission MDS Assessment, dated 06/21/2024, reflected Resident #25 had a BIMS score of 9 indicated Resident cognition was moderately impaired. Resident#25's activity preference was the following: have books, newspaper, and magazines to read, listen to music, watching news, go outside to get fresh air when the weather was good, and participating in religious services or practices. Record review of Resident #25's Comprehensive Care Plan, dated 07/12/2024, reflected Resident #25 had a mood problem anxiety related to disease process of CVA (a medical conditions that occurs when blood flow to the brain is suddenly cut off - this diagnosis was not listed on the face sheet) Intervention: Monitor/record/ report to medical doctor as needed acute episode feelings or sadness; feelings of worthlessness or guilt or change in psychomotor (movement-oriented activities that require practice and involved characteristics such as coordination, strength, speed and flexibility). Resident # 25 had impaired cognitive function/dementia or impaired thought process (a condition in which a person loses the ability to think and solve problems). Intervention Reminisce with Resident #25 using photos of family and friends. Observation on 08/20/2024 at 11:30 AM, Resident #25 was lying in bed. The lights were off in his room and the door was slightly open leading into his room. He did not want to discuss anything about his nails. He made eye contact with Surveyor O when mentioned in room activities or in room visits. Resident #25 also clinched his mouth / jaw (sign of stress) when surveyor O mentioned if he received in room visits talking about pictures of his family and friends. Resident #25 did not have any stimulation in his room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/20/2024 at 11:34 AM, Resident #25 stated no when asked if he received activities or visits in his room showing him pictures of his family and friends. Resident #25 stated no when asked if he liked to do anything with a group of people. In an interview on 08/21/2024 at 8:15 AM, Activity Director M stated Resident #25 was on the in-room activity program due to Resident #25 did not attend group activities. She stated her schedule was to visit all in room residents Monday to Friday in the morning. Activity Director M stated according to Resident #25's participation records he only received two in room activities during the month of July 2024 and did not receive any in room activities during month of August 2024. She stated Resident #25 had a potential of becoming depressed, lonely and may have a decrease of quality of life. She stated she had not reminisced with Resident #25 with photos of his family and friends. She stated Resident #25 was expected to receive in room visits/ activities Monday thru Friday. Activity Director M stated she did not have any excuse why she did not visit Resident #25 to provide in room activities/ visits. She stated it was her responsibility to ensure all residents received activities according to their past and current interest. In an interview on 08/22/2024 at 2:05 PM, the Administrator stated all activities including in room visits was expected to be documented on the date the activity occurred with the residents. She stated if the Activity Director M did not document any activities, the activity did not occur with the resident or residents. The Administrator stated a resident may become depressed, lonely and have a diminish quality of life if they were not receiving activities of their preferences on a daily or weekly basis. She stated she had been in this facility approximately two weeks and would definitely be making observations of the activity programming. Record review of the Facility's Policy on Activity Programs, revised on 06/2018, reflected activity programs are designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident. Activities offered are based on the comprehensive resident -centered assessment and the preferences of each resident. All activities are documented in the resident's medical record.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40884 Based on observations, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with profession standards for food safety for 1 of 1 kitchen reviewed for food and safety and sanitation. 1. The facility failed to appropriately thaw frozen meant defrost on 08/20/2024. 2. The facility failed to store boxes of food off the floor, ensure the floor of the refrigerator was free of debris in the walk- in refrigerator on 08/20/2024. 3. The facility failed to ensure Dietary Aide P washed or sanitized her hands prior to placing new gloves on her hands when she was giving a resident some zip lock bags on 08/21/2024. These failures placed residents at risk for health complications and foodborne illness. Findings included: Observation on 08/20/2024 at 9:05 AM, there was approximately 10 pound of frozen hamburger meat in a clear plastic round tube shape located in a pot sitting in the kitchen sink. The hamburger meat was not thawed and more than half was frozen. There was not any running water over the frozen hamburger meat. There was approximately half of the frozen hamburger meat not submerge in the water. Only half of the hamburger meat was submerged in the water. In an interview on 08/20/2024 at 9:08 AM, Dietary Aide P stated all the hamburger meat was required to be in the water to be defrosted. She stated running water was also expected to be running over the hamburger meat while it was being defrosted. Dietary Aide P stated she forgot to run the water over the hamburger meat and place the hamburger meat in a larger pot. Dietary Aide P stated she was in a hurry and forgot. She stated if the hamburger meat was not defrosted properly there was a possibility the hamburger meat may be ruined from being defrosted at room temperature. She stated it was a possibility a resident may become ill with stomach issues if the resident ate ruined meat. 2. Observation on 08/20/2204 at 9:13 AM, there were four boxes of food stacked on top of one another located in the walk-in refrigerator floor. There were also some paper napkins on the floor and one was stuck to the surveyors shoe. In the corner of the walk-in refrigerator was some type of crumbled food. 3. Observation on 08/22/2024 at 11: 15 AM, Dietary Aide P removed gloves from her hand and placed them in garbage can. She did not wash or sanitize hands after removing the gloves. Dietary Aide P touched her clothes and picked up 2 new gloves from the glove container. She touched the outside of the gloves such as fourchettes (slender pieces of fabric or rubber that forms the sides of the finger). Dietary Aide P placed the gloves on her hands and picked up approximately 3 zip plastic bags and placed her fingers inside two of the plastic bags and gave it to a resident. (continued on next page)

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Interview on 08/22/2024 at 11:20 AM, Dietary P stated she did touch her shirt after she removed her gloves. She stated she did not sanitize or wash her hands prior to placing new gloves on her hands. Dietary aide stated she did pick up the gloves where the fingers go inside the gloves. She stated she was expected to wash her hands prior to placing new gloves on her hands. Dietary Aide P stated she had been in-serviced on hand hygiene and wearing gloves when changing tasks or touching anything not sanitary.

Interview on 08/22/2024 at 2:05 PM, the Administrator stated all boxes located in the walk-in refrigerator was expected to be on a crate or on the shelves. She stated no boxes was to be stored on the floor of the refrigerator. She stated the boxes may become damp and the food inside of the boxes had a potential of being wet or damp. She also stated it was a possibility of a safety hazard if the boxes were stacked on each other they could fall and injure a staff. The Administrator stated all frozen meat was required to be defrosted on a flat pan located in the refrigerator on the bottom shelf. She stated if the dietary staff was defrosting hamburger meat in the sink all of the hamburger meat was expected to be submerged in water with running water pouring over the frozen hamburger meat. She stated it was a possibility the meat may ruin if not defrosted correctly but there was a slight chance of this occurring when defrosting. The Administrator stated all staff was to wash and sanitize their hands when they removed gloves and prior to placing new gloves on their hands. She stated if the dietary aide P did not sanitize her hands and touched inside the zip plastic bags to give to a resident there was a possibility the bags could become cross contaminated. She stated there should not be any paper napkins on the floor in the walk-in refrigerator. The Administrator stated all areas of the kitchen including walk-in refrigerator was expected to be kept clean and organized.

In an interview on 08/22/2024 at 3:45 PM, Dietary Manager L stated all meat was required to be defrosted either in the refrigerator on a flat pan located on the bottom shelf of the refrigerator or in the sink in a container with running water pouring over the meat. She stated the hamburger meat was to be submerged in the pot and be defrosted with running water over the entire hamburger meat. Dietary Manger L stated there was a possibility the portion of the hamburger meat not submerged in the water would not be defrosted correctly and may cause illness with a resident if the hamburger meat was ruined. She stated any time dietary staff removes their gloves they were expected to wash their hands immediately before doing any other type of task including placing new gloves on their hands. Dietary Manger L stated if Dietary Aide P touched the outside of the new gloves with her contaminated hands there was a possibility bacteria could cross contaminated inside of the plastic bags. She stated if the resident was placing food inside of those bags there was a potential where bacteria touch the food. Dietary Manger L stated if a resident ate contaminated food the resident may become sick with any type of stomach issues such as vomiting and diarrhea. She stated the boxes located in the walk-in refrigerator was not to be stored on the floor. She stated they were expected to be stored on pallets or on the shelves in the refrigerator. Dietary Manager L stated this had a potential of becoming a safety hazard due to the boxes was stacked on top of each other and if they feel a staff may become injured. She stated there should never been any type of napkins or paper on the floor in the walk-in refrigerator or anywhere in the kitchen. Dietary Manager L stated this was not sanitary. She stated there should never be any type of food on the refrigerator floor. She stated this was also not sanitary.

Review of the facility policy on Food Preparation and Service, dated 10/2022, reflected Foods will not be thawed at room temperature. Thawing procedures include:

a. Thawing in the refrigerator in a drip-proof container.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cass Valley Healthcare Center	103 Teakwood St Centerville, TX 75833

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Completely submerging the item in cold running water (70 F or below) that is running fast enough to agitate and remove loose ice particles. c. Thawing in a microwave oven and then cooking and serving immediately; or d. Thawing as part of a continuous cooking process Facility policy of Refrigerators and Freezers, dated 10/2022, reflected This facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. Refrigerators and freezers will be kept clean, free of debris, and mopped with sanitizing solution on scheduled basis and more often as necessary. Facility policy on Preventing Foodborne Illness- Employee Hygiene and Sanitary Practices, reviewed 06/12/2024, reflected Food and nutrition services employees will follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. Employees must wash their hands during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; and/or after engaging in other activities that contaminate the hands.

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NAME OF PROVIDER OR SUPPLIER Cass Valley Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 103 Teakwood St Centerville, TX 75833	

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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** 40884 49851 Based on observation, interview, and record review, the facility failed to establish and maintain an infection and prevention 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 5 (Resident #1, Resident #11, Resident #28, Resident #4, and Resident #17) of 35 residents reviewed for infection control. 1. LVN B failed to clean the reusable blood pressure (BP) cuff between resident use. 2. LVN A failed to perform hand hygiene and clean the catheter tip before performing catheter irrigation for Resident #17's suprapubic catheter (a flexible tube that drains urine from the bladder through a small incision in the lower abdomen) 3. The facility failed to ensure LVN I sanitized or washed her hands after touching contaminated items when delivering meal trays to residents, when setting up Resident #1, Resident #11 and, Resident #28's meal trays and during feeding of Resident #11 on 08/20/2024. These failures could place residents at risk for cross contamination and infection. Findings include: 1. Review of Resident #4's face sheet reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of hemiplegia (paralysis or severe weakness in one side of the body) and cerebral infarction (stroke). Review of Resident #4's Optional MDS, dated [DATE], reflected a BIMS score of 11 indicating moderate cognitive impairment. Review of Resident #4's Care Plan reflected resident requires staff assistance for meeting needs and has hypertension requiring BP monitoring and medication. Observation during med pass on 08/21/2024 at 08:30 AM, revealed LVN B checked the vital signs for Resident #6 and placed the BP cuff back on the medication cart without cleaning it. She then used the BP cuff to take vital signs for Resident #4 without cleaning the cuff first. In an interview on 08/21/2024 at 08:36 AM, LVN B stated she should have cleaned the BP machine in between resident use but didn't. She stated it is policy to clean it before and after use because of the germs and risk for infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #17's face sheet reflected an [AGE] year old male admitted to the facility on [DATE] and again on 09/02/2022 with diagnoses of incomplete quadriplegia (paralysis that affects a person's limbs and body from the neck down), chronic obstructive pulmonary disease (a group of lung disease that blocks airflow and makes it difficult to breathe), and overactive bladder (a problem with bladder function that causes the sudden need to urinate). Review of Resident #17's care plan, dated 07/16/2024, reflected resident has a suprapubic catheter and foley care should be provided every shift and as needed. Review of Resident #17's orders, date 07/17/2024, reflected an order to flush the catheter with 120-180 milliliters of sterile water every other day. Observation on 08/21/2024 at 09:56 AM, during suprapubic catheter irrigation procedure for Resident #17 revealed LVN A sanitize her hands and don gloves and gown. She placed the irrigation tray and supplies on the bedside table, opened the kit and then disconnected the draining bag from Resident #17's catheter and handed it to the resident to hold. She then poured the sterile water into the container and drew up some in the syringe. She connected the syringe to the catheter without cleaning the catheter tip first. She then began attempting to flush the catheter. She was not able to flush the catheter and called for assistance. She then reconnected the old drainage bag to the catheter while waiting for assistance. In an interview on 08/21/2024 at 11:10 AM, LVN A stated she forgot to clean the catheter before and after she attempted irrigation and reconnected the old bag. She stated not cleaning her hands and the catheter before irrigation placed the resident at risk for bladder infection. In an interview on 08/22/2024 at 5:30 PM, the interim DON stated reusable medical equipment should be sanitized before every use to prevent the spread of infection. She stated she would expect staff to follow procedure for aseptic technique during catheter irrigation to prevent the spread of infection. In an interview on 08/22/2024 at 5:50 PM, the Administrator stated the BP cuff should be cleaned in between residents for infection control. She stated she is not a nurse but would expect staff to follow procedure for catheter flushing to prevent the resident from getting an infection. Review of facility policy for reusable medical equipment, dated 03/2023, reflected items that come in contact with intact skin but not mucous membranes, such as BP cuffs, should be cleaned and disinfected between residents. Review of facility policy for catheter care, dated March 2024, reflected staff should use aseptic technique when there is a break in the closed system and clean technique when handling the catheter, tubing, or drainage bag. The policy does not specifically address the procedure for catheter irrigation. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Cass Valley Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 103 Teakwood St Centerville, TX 75833	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Observation on 09/20/2024 at 12:13 PM to 12:35 PM, reflected LVN I entered the dining room from the hall. She touched her clothes and moved her hair away from her face. LVN I began to speak to residents and touched the residents' clothes and wheelchair handles. She began to look at the meal trays on the meal tray cart. LVN I picked up one lid of a meal tray and touched the tines (the pointed prongs that allow you to spear and pick up the food) of the fork of Resident #28's meal tray. LVN I delivered Resident #28's meal tray to him in the dining room and did not change his fork. LVN I returned to the meal tray cart and did not sanitize her hands. She had the meal tray and touched the dirty dishwasher doorknob to enter the dishwasher room and placed meal tray on top of dirty plates and the middle finger, forefinger and ring finger touched dirty dishes in the dishwasher room. She exited the dishwasher room and proceeded to the meal cart without sanitizing or washing her hands. She picked up a meal tray off the meal cart and delivered the meal tray to Resident #1. When LVN I sat the meal tray on the table in front of Resident #1 she opened the thickened liquid water and the top part of her middle finger and fore finger on her right hand touched inside the container and touched the thickened water. LVN J asked LVN I to go into the hall and sanitize her hands. LVN I did not go into the hall to sanitize her hands or attempt to wash her hands. LVN I continued to pass out meal trays. LVN I delivered Resident #11's meal tray to her. She touched resident's hand and her specialty chair. LVN I opened Resident #11's thickened liquid and her forefinger and middle finger touched the thickened liquid and when she removed the lid off of Resident #11's plate of food she touched the green beans. After setting up the meal tray LVN I sat in a chair to begin to feed Resident #11. LVN I was given hand sanitizer and did sanitize her hands prior to feeding Resident #11. During feeding Resident #11, LVN I touched with her fore finger, ring finger and middle finger on her right hand the following: the arms of the chair she was sitting in, touched her own clothes and touched Resident #11's Hoyer lift sling to reposition the sling in Resident #11's chair. She also touched Resident #11's right hand. LVN I did not re-sanitize or wash her hands. LVN I picked up Resident #11's napkin to wipe off Resident #11's mouth. When LVN I wiped Resident #11's mouth she touched the side of Resident #11's upper lip with her fore finger and middle finger on her right hand. LVN J was sanitizing her hands every time she touched the table, chair or any object may be considered contaminated. She was feeding Resident #3. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/20/2024 at 1:33 PM, LVN I stated she never sanitized her hands during the time she was passing out meal trays and setting up meal trays for the residents. LVN I stated she was expected to sanitize or wash her hands when passing out meal trays and when she was setting up meal trays for the residents. She stated she did not recall if she touched the tips of the fork, napkins, inside the thickened liquids container for Resident #1 and Resident #11. LVN I stated she did touch the door knob leading into the dishwashing room and she may have touched dirty dishes. She stated she did not recall touching her clothes, her hair, resident's wheelchair, or sling in Resident #11's specialty chair. She stated it was possible she did touch all of this but she was focused on delivering meal trays and feeding Resident #11 instead of what she was touching. LVN I stated it is impossible for staff to sanitize their hands if they touch anything may be contaminated. She stated the only time she sanitized her hands was when she sat on a chair to feed Resident #11. She stated she did touch arm of her chair; the sling Resident was sitting on in her specialty chair and possibly her own clothes. LVN I stated it is crazy to expect staff to sanitize their hands every time they touch an object that may be contaminated. She stated this was impossible. LVN I stated she did wipe Resident #11's mouth and she may have touched the side of her lip with her fingers. She stated if she had touched anything contaminated it was a possibility bacteria could cross contaminate onto the fluids, food, napkin, and Resident #11's mouth. LVN I stated she did not believe it was necessary to sanitize her hands every time she touched any type of object that may be contaminated. She stated staff would be sanitizing their hands every few seconds. LVN I stated she had been in-serviced on passing out meal trays and feeding the residents. She stated during in-service it was explained to wash or sanitize hands in between delivering meal trays to the residents and when feeding the residents. LVN I did not answer the question if a resident may become ill if they did ingest some type of bacteria that potentially transferred from her fingers or hands onto the resident's food or drink. In an interview on 08/20/2024 at 00:00, LVN J stated she did ask LVN I to sanitize her hands. She stated LVN I did not sanitize her hands when she was passing out meal trays and setting up meal trays for residents. LVN J stated all staff was expected to sanitize or wash hands during each meal tray delivered to a resident. LVN J stated all staff was to sanitize their hands when they touch their hair, clothes or any object that was considered contaminated. She stated they had been in-serviced on hand hygiene during dining room service. LVN J stated she did not recall the date of the in-service. She stated if a resident did swallow some type of bacteria the resident had a potential of becoming physically ill such as vomiting or diarrhea. In an interview on 08/22/2024 at 1:30 PM, ADON G stated all staff was expected to sanitize their hands prior to delivering meal trays and in between each meal tray delivered to a resident. She stated if staff touched any type of object such as doorknob, wheelchair, resident or staff clothes, hair, Hoyer sling, arms of a chair and/ or table, the staff was expected to sanitize or wash their hands after each contact with anything may be considered contaminated. ADON G stated if staff were not washing or sanitizing their hands during meal service and was touching residents' drinks, food or even plates it was a possibility bacteria may cross contaminate food, utensils such as fork and or the resident's plates. She stated if a resident ingested bacteria there was a possibility a resident may become sick with some type of food borne illness. She stated she had only been working at the facility about three weeks and she only knows about the in-services she had completed since she had been employed at this particular facility. (continued on next page)

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	675065	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cass Valley Healthcare Center	103 Teakwood St Centerville, TX 75833

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Administrator on 8/22/2024 at 2:05 PM, she stated all staff was expected to wash or sanitize hands prior and in between each meal tray delivered to the residents. She stated the staff was expected to sanitize or wash hands whenever they became in contact with anything considered contaminated such as: hair, clothes, dirty dishes, wheelchair, arms of a chair, etc. The Administrator stated there was a potential a resident may develop a food borne illness if a resident's food or drink was cross contaminated by bacteria on a staff fingers or hands. She stated she began working at this facility approximately two weeks ago and she was trying to look at a lot of things and the in-services been given in the past she had not looked at the in-services at this time and could not answer if an in-service had been given on dining room hand hygiene. Review of facility policy for reusable medical equipment, dated 03/2023, reflected items that come in contact with intact skin but not mucous membranes, such as BP cuffs, should be cleaned and disinfected between residents. Review of facility policy for catheter care, dated March 2024, reflected staff should use aseptic technique when there is a break in the closed system and clean technique when handling the catheter, tubing, or drainage bag. The policy does not specifically address the procedure for catheter irrigation. Review of the Facility Policy of Hand Hygiene, revised on 10-2020 reflected This facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall be trained on the importance of hand hygiene in preventing the transmission of healthcare- associated infections. Use and alcohol-based hand rub containing at least 62 % alcohol; or , alternatively, soap and water for the following situations: 1. Before and after direct contact with residents. 2. After direct contact with a resident's intact skin.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 49851 Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public for 5 residents (Resident #4, Resident #14, Resident #31, Resident # 9, and Resident #8) out of 10 resident rooms reviewed for environment. The facility failed to ensure walls and floors were clean and in good repair for Resident # 4, Resident #14, Resident #31, Resident #9, and Resident #8's room. This failure could affect all residents, staff, and the public by placing them at risk for diminished quality of life due to the lack of a well-kept environment. Findings include: Observation on 08/20/2024 at 03:10 PM in Resident # 4 and Resident # 14's room revealed large (approximately 2 ft) long holes in the wall behind Resident #14's bed. The bed was pushed up into the wall and there was a white powdery substance on the floor behind the bed. Observation in the room further revealed a cable outlet hanging from the wall next to the dresser. Behind Resident #4's bed there were holes in the wall, unable to see the size due to the bed. In an interview on 08/20/2024 at 03:10 PM, Resident # 4 stated he did not know about the holes behind the bed, but he knew about damaged wall where the cable outlet was. He stated it had been that way for a while. Resident #14 was not interview able. Observation on 08/20/2024 at 4:00 PM in Resident # 31's room revealed scratch marks and missing paint behind and next to the resident's bed. There was a brown substance on the floor and white debris on the floor. Observation on 08/20/2024 at 4:10 PM, in Resident # 8 and Resident #9's room revealed missing trim and paint under the windowsill with exposed drywall. Resident # 8's bed was up against the wall under the window with pillows and bedding by the damaged wall. Observation behind Resident #9's bed revealed the bed pushed up into the wall with damaged drywall and white debris/powder on the floor. In an interview on 08/20/2024 at 4:12 PM, Resident #9 stated she did not know about the holes behind her bed, but she knew they pushed the bed in the wall to get the door closed. In an interview on 08/22/2024 at 4:45 PM, Housekeeping supervisor D stated debris falls on the floor every time the bed hits the wall. She stated they do their best to keep the floors clean, but she needs assistance from the nursing staff to move the resident's bed out of the way because she cannot do it herself. She stated they clean the rooms and floors everyday and try to deep clean often. She stated they do not have a floor crew anymore and she does the best she can with the staff they do have. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/22/2024 at 5:00 PM, Maintenance supervisor E stated there have been damages to the walls since March of 2023. He stated he began working in the maintenance department in May of 2024 and started repairing the damaged walls using sheetrock that was previously ordered by someone else but realized it was the wrong material. He stated the administrator told him to hold off until they get the correct supplies. He stated the reason for the damaged walls was because there is no tolerance for door clearance if the bed is pulled away from the wall. He further stated the damaged walls were not homelike and could cause illness due to the drywall dust and could cause depression and make the residents feel unnoticed. He was not aware of the cable wire hanging from the wall and said he would take care of that immediately. In an interview on 08/22/2024 at 5:50 PM, the Administrator stated they were working on fixing the holes in the walls. She stated she contacted a maintenance person from another building to assist. She stated they plan to replace the drywall and place some type of bumper on the walls to prevent further damage. She stated she is unsure how long the holes have been there and did not realize how big they were. She stated maintenance was scheduled to come back this week but delayed due to the survey. She further stated the damaged walls could cause potential harm or risk to the resident from the drywall dust and possible pest problem from the holes. She stated the damages are not homelike. Regarding the dirty floors she stated she has spoken with housekeeping already and expects the floors to be cleaned every day. Review of facility Homelike Environment policy, dated February 2021, reflected residents are provided with a safe, clean, comfortable and homelike environment . the staff and management maximizes the characteristics of a homelike setting . including a clean, sanitary and orderly environment.