STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675067	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gainesville Convalescent Center	1900 O'Neal St Gainesville, TX 76240

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34399 Based on observation , interview and record review, the facility failed to promote and facilitate resident self-determination through support of resident choice for 1 of 7 residents (Resident #50) reviewed for resident rights. The facility failed to promote Resident #50's self-determination by not offering her an opportunity to smoke when smoke breaks occurred at the facility. This failure could place residents at risk of a decreased self-worth due to their preferences not being met. Findings include: Review of Resident #50's face sheet undated reflected Resident #50 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of stroke, cognitive communication deficit, diabetes, anxiety disorder, Alzheimer's disease and seizures. Review of Resident #50's Admission MDS assessment date 08/27/24 reflected Resident #50 had a BIMS of 14 indicating she was cognitively intact. Review of Resident #50's comprehensive care plan last revised on 08/23/24 reflected Resident #50 had the Potential for safety hazard, injury related to smoking. Resident assessed to be a supervised smoker and E-Cigarette. Intervention included Smoking allowed only in designated smoking areas. No smoking is allowed inside facility at any time. Review of Resident #50's Smoking assessment dated [DATE] reflected Resident #50 had smoking materials of cigarettes. It reflected smoking frequency of use was less than daily . Resident #50's assessment reflected she was a safe smoker. Observation and Interview on 09/10/24 at 2:25 PM with Resident #50 in her room revealed she was newer to the facility and was not aware of her rights. She could not recall any care plan meeting the facility had with her since admission. She stated she wanted to be involved in her care. She stated she was a current smoker but she was not aware the facility had smoking break times or even allowed her to smoke. She stated no one at the facility had offered to her the opportunity to smoke She stated she would like to smoke if she was allowed to while at the facility. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/10/24 at 2:28 PM with CNA N revealed she not aware Resident #50 was a smoker. She stated there was only 1 resident who was a current smoker on the secure unit. Interview on 09/11/24 at 12:50 PM with CNA I revealed she became aware on Sunday (09/08/24) about Resident #50 being a smoker because Resident #50 had asked her about it. She stated she would have to get with the AD to find out where her smoking items were since they were not on the secure unit. She stated she had not had a chance to check with the AD about Resident #50 yet. She stated Resident #50 had not been offered to smoke at smoking times and another resident had his smoking breaks. Interview on 09/11/24 at 3:20 PM with ADON revealed she did a smoking assessment on Resident #50 when staff found vapes and cigarettes in her possession. ADON stated Resident #50 should be allowed to smoke with supervision by staff during smoke break times. ADON stated she was unaware Resident #50 was not offered the opportunity to smoke during smoke break times. Observation and Interview on 09/11/24 at 4:09PM with CNA I revealed CNA I asked the AD about Resident #50's smoking items but AD did not have them. Observation of smoking items for the secure unit revealed no smoking items for Resident #50, only smoking items for another resident who smoked. CNA I stated Resident #50 did not get a smoking break since she was unable to find her smoking items. She stated she or the other CNA on the secure unit were the ones who took residents on the secure unit to the patio at smoking break times. Interview on 09/11/24 at 4:24 PM with LVN L revealed she was aware Resident #50 was a smoker when her vape and cigarettes were found in resident's possession. LVN L said they put them in the narcotic box in the medication cart for security. She stated Resident #50 had not asked her to smoke. She was unaware the CNAs on the secure unit were not aware Resident #50 was a current smoker. Interview on 09/12/24 at 9:28 AM with DON revealed she was unaware of Resident #50 not being offered the opportunity to smoke. She stated Resident #50 had a smoking assessment completed by ADON when smoking items were found in her possession. DON stated Resident #50's smoking items were located in the nurse's narcotic medication cart. She stated Resident #50 should be allowed the opportunity to smoke per her preference at smoking break times per the facility's smoking policy. Review of Facility's Smoking Resident List provided on 09/10/24 reflected Resident #50 was not a smoker. Review of Facility's Smoking Break Times provided on 09/10/24 reflected smoking schedule at 9:00 AM, 11:30 AM, 1:00 PM, 3:30 PM, 6:30 PM and 9:00 PM. Review of Smoking Policy - Residents dated October 2022 reflected This facility shall establish and maintain safe resident smoking practices. Prior to, and upon admission, resident shall be informed of the facility smoking policy, including designated smoking area, and the extent to which the facility can accommodate their smoking or non-smoking preferences.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49427 Based on observations, interviews, and record review, the facility failed to provide maintenance services necessary to maintain an orderly and comfortable homelike environment for 3 (Resident #9, #19, and #45) of 6 residents reviewed for resident rights. The facility failed to ensure the shared bathroom sink for Resident #9, Resident #19, and Resident #45 was in working order. This failure could place residents at risk for infection and living in an unsanitary and uncomfortable environment. Findings included: Record review of Resident #19's Quarterly MDS assessment, dated 08/19/2024, reflected she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. She had a BIMS score of 15 which indicated cognition was intact. Diagnoses included chronic obstructive pulmonary disease (a lung disease that limits airflow), dementia (loss of cognition) Parkinson's disease (brain disorder that causes uncontrollable movements), and stroke. Record review of Resident #19's care plan initiated on 03/19/2023 and updated on 07/19/2023 reflected the resident had impaired decision making due to dementia; interventions included encourage resident to verbalize her feelings, concerns, and fears and clarify misconceptions. Record review of Resident # 45's Quarterly MDS assessment, dated 08/21/2024, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. She had a BIMS score of 15 which indicated her cognition was intact. Diagnoses included dementia (loss of cognition), chronic pain syndrome, and muscle weakness. Record review of Resident #45's care plan initiated on 10/31/2023 and updated on 09/04/2024 reflected she had the potential for alteration in thought processes, impaired decision making, and memory loss due to dementia; interventions included provide reality orientation and validation as needed and promote dignity. Record review of Resident #9's Comprehensive MDS assessment, dated 08/02/2024, reflected she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. She had a BIMS score of 15 which indicated her cognition was intact. Diagnoses included schizoaffective disorder (mood disorder), bipolar disorder (mood disorder with unusual shifts in mood, activity level, and concentration), respiratory failure, and diabetes (chronic disease impacting sugar levels in the blood). Record review of Resident #9's care plan initiated on 10/06/2022 and revised 07/10/2024, reflected .resident is at risk for frequent infections .related to diabetes . She had a diagnosis of depression and was at risk for fluctuations in mood, little interest or pleasure in doing things .encourage resident to be an active participant in decision making . (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/10/2024 at 10:11 AM with Resident #19 she stated her bathroom sink had been clogged for over 2 weeks and she informed maintenance. She stated the Maintenance Director came and took some tools in there and told her there was a part he needed to order. She stated that since he worked on the sink the water pooled in the sink and slowly drained and she was not able to use the sink. She stated she had spoken with the DON about the issue as well and was told maintenance ordered some parts. She stated that she saw the Maintenance Director bring in a bucket and tools on several different occasions, but it still had issues. She stated the sink was shared between herself and the two residents next door (Resident #9 and Resident #45) and was not sure why the sink was clogged. In an observation on 09/10/2024 at 10:13 AM of the bathroom revealed there was one bathroom sink and it was over half full of water and a package of wipes was on the ledge of the sink. In an interview on 09/10/2024 at 10:29 AM with Resident #45 she stated that her sink was unusable and she had spoken with the Maintenance Director several times about the issue. She stated about a week ago he told her they had plunged it and that the cause was pencil shavings from the resident next door and he needed to get a new part for the sink. She stated staff were aware and told her they logged the concern in the maintenance book. She stated she likes to wash her face but was not able to with the sink being clogged so instead she used a wet rag to rinse her face. She stated she wished she could use the sink. In an observation on 09/11/2024 at 10:31 AM of Residents' (#9, #19, and #45) sink revealed it was a quarter full with water and was not draining. In an interview on 09/13/2024 at 12:12 PM with Resident #9 revealed she did not use her bathroom sink because it was not working and she did not want to cause problems with it. She stated that she uses wipes for her face and hand sanitizer for her hands after using the restroom. She stated she would like to use her sink and it bothered her to not be able to wash her face and hands. In an interview on 09/10/2024 at 10:40 AM interview with CNA G revealed she was aware of the clogged sink and sometimes it was drained and then would clog up again. She stated she informed maintenance and it was in the maintenance log. Record review of maintenance log reflected an entry that stated, sink isn't draining for Resident #9 and Resident #45's room, dated 05/31/2024. Section titled Work Performed reflected waiting on part 6-2, dated completed 6-14, and initialed by the Maintenance Director. In an interview on 09/11/2024 at 2:30 PM with the Maintenance Director revealed he was aware of the clogged sink at the end of May 2024 which was documented in his maintenance log and it was still an issue. He stated he was responsible for repairs in the building. He stated that he had taken apart the pipes and the pea trap had what looked like sediment. He stated he was able to run the snake through the pipe and it would drain slower, but it was still having issues and became clogged often. He stated he brought up the concern with the Previous Administrator in morning meetings and was not provided any direction other than buying a different snake and if it was still an issue then they needed to call a plumber. He stated the sink continued to clog into the end of June 2024. He stated he told the Previous Administrator they would need a plumber and he did not receive a response. He stated he did not document the subsequent clogs of the sink in the maintenance log. He stated residents having a working sink was important for infection control, so they could wash their hands, and for a homelike environment. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/12/2024 at 2:34 PM with the Housekeeping Manager revealed she was told by a housekeeper about a month ago that Resident #9, Resident #19, and Resident #45's shared bathroom sink was clogged and drained slowly. The Housekeeping Manager stated she thought it was because Resident #19 put her colored pencil shavings down the sink. She stated the Maintenance Director had attempted to fix the sink multiple times, but it became clogged again. In an interview on 09/12/2024 at 5:00 PM with the DON revealed she was aware of the sink concerns, and it was caused by Resident #9 putting pencil shavings down the drain and she had asked the resident not to dispose of the shavings in the sink in the past. She stated the Maintenance Director had worked on the sink multiple times. In an interview on 09/13/2024 at 11:00 AM with the Administrator revealed she was aware of the residents' (#9, #19, and #45) sink issue and was told it was due to Resident #19 putting pencil shavings down the sink. She stated they had a plumber coming today. She stated it was the responsibility of the Maintenance Director to address maintenance concerns. She stated the risk to residents was infection control and hygiene care because they would not be able to brush their teeth or wash their hands. Record review of the facility's homelike environment policy, titled Homelike Environment, dated 2001 and revised February 2021, reflected, .Residents are provided with a safe, clean, comfortable and homelike environment . 2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment; . Record review of the facility's maintenance policy, titled Maintenance Service, dated 2001 and revised December 2009, reflected, .The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times .10. Maintenance personnel shall follow established safety regulations to ensure the safety and well-being of all concerned . Record review of the facility's maintenance work order policy, titled Work Orders, Maintenance, dated 2001 and revised April 2010, reflected, .Maintenance work orders shall be completed in order to establish a priority of maintenance service . 5. Emergency requests will be given priority in making necessary repairs .

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49427 Based on interview and record review, the facility to ensure a new resident was not admitted with a mental disorder, unless the state mental health authority determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority prior to admission, that the individual requires the level of services provided by a nursing facility and if the resident requires such level of services, whether the resident requires specialized services for one (Resident #9) of six residents reviewed for PASARR screening. The facility failed to ensure Resident #9 received a PASARR level 2 evaluation. This failure could affect residents with mental illness and place them at risk of not being assessed to receive needed services. Findings included: Record review of Resident #9's Comprehensive MDS assessment, dated 08/02/2024, reflected she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. She had a BIMS score of 15 which indicated her cognition was intact. Diagnoses included schizoaffective disorder (mood disorder), bipolar disorder (mood disorder with unusual shifts in mood, activity level, and concentration), respiratory failure, and diabetes (chronic disease impacting sugar levels in the blood). Record review of Resident #9's care plan initiated on 10/06/2022 and revised 07/10/2024, reflected she received psychotropic medication for schizophrenia/schizoaffective disorder and bipolar disorder; interventions included .administer medications as ordered .monitor and document behaviors and signs of interactions and side effects. She had a diagnosis of depression and was at risk for fluctuations in mood, little interest or pleasure in doing things; interventions included .encourage resident to be an active participant in decision making .encourage to get out of bed as tolerated . provide psyche (psych) consult as ordered . Record review of Resident #9's Continuity of Care Document, undated, reflected the diagnoses of bipolar disorder, effective dated 08/30/2022 and schizoaffective disorder, effective dated of 09/29/2022. Record review of Resident #9's PASARR Level 1 Screening, Section C, dated 08/30/2022, reflected the question if there was evidence or an indicator the individual had a mental illness was marked NO. Record review of Resident #9's psychiatric visit summary titled, Psychiatric Periodic Evaluation, date of service 09/02/2024, reflected she was hospitalized in the past due to psychosis and had a .past psychiatric history significant for schizoaffective disorder, bipolar disorders with depression . and was seen for a follow up. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/11/2024 at 2:11 PM with the MDS Nurse revealed she was not familiar with PASARR and residents typically had the PASARR completed upon admission. She stated she was responsible to enter data into the system and update the MDS quarterly, annually, and upon a significant change in conjunction with the interdisciplinary team assessments. She stated she was not working at the facility when Resident #9 was admitted to the facility. The MDS Nurse reviewed Resident #9's diagnoses and stated she had schizoaffective disorder, bipolar disorder, and no dementia diagnosis. She stated that she was not sure if schizoaffective disorder or bipolar disorder qualified as a mental illness for the question in Section C of the PASARR Level 1 Screening and she would follow up with the Regional Reimbursement Specialist for clarification. She stated that the PASARR screening was to ensure a resident who qualified obtained extra help, activities, or therapy. In an interview on 09/11/2024 at 2:39 PM with the MDS Nurse, she stated she had reached out to the Regional Reimbursement Coordinator and stated Resident #9 should have had a positive PASRR screening and it should have been updated on subsequent MDS reviews. She stated that the local authority had been contacted and was going to come to reassess Resident #9 and they planned to audit all other residents with schizoaffective or bipolar disorder to ensure their PASRR screening was accurate. In an interview on 09/11/2024 at 3:06 PM with the Regional Reimbursement Coordinator revealed the MDS Nurse was responsible for the PASARR assessment, and it was completed upon admission. She stated based on Resident #9's diagnoses the resident should had been referred for a PASARR Level 2 evaluation and it should have been noticed during the quarterly MDS reviews. She stated the risk to residents by not having an accurate PASRR screening and not updated on subsequent MDS reviews was the resident might not receive services they needed. Record review of the facility's PASARR policy titled Resident Assessment - Coordination with PASARR Program, dated 2022, reflected: .1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening . a. PASARR Level I - initial pre-screening that is completed prior to admission i. Negative Level I Screen - permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later . 9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34399 Based on observations, interview and record review, the facility failed to develop and implement comprehensive person-centered care plans for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 6 of 24 (Residents #7, #28, #39, #43, #46, #50) of 24 residents reviewed for comprehensive care plans. 1. The facility failed to develop a comprehensive person-centered care plan for Resident #50. The comprehensive care plans failed to adress the specific psychotropic medications ordered by the physician, specific required ADL assistance and comfort measures and discharge goals. 2. The facility failed to develop a care plan for Resident #43 and #46's significant weight loss. The facility failed to develop ADL assistance comprehensive person-centered care plans for Resident #43 and #46. 3. The facility failed to include in the care plan last revised on 08/28/24 Resident #39's contractures to his right hand with interventions required to prevent further decline or injury. 4. The facility failed to care plan Resident #7's and Resident #28's preference to be showered by female staff. Resident #7 was showered on 09/13/2024, 09/06/2024, 09/02/2024, 08/28/2024, given a bed bath on 08/24/2024 by a male CNA, Agency CNA H, and refused a shower on 08/05/2024 and 07/31/2024. Resident #28 refused a shower on 09/02/2024, 08/05/2024, 07/31/2024 and was showered on 08/28/2024, signed by Agency CNA H. These failures could affect residents of the facility by not addressing their physical, mental, and psychosocial needs for each to attain or maintain their highest practicable physical, mental, and psychosocial outcome. Findings include: 1. Review of Resident #50's face sheet undated reflected Resident #50 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of stroke, cognitive communication deficit, diabetes, anxiety disorder, Alzheimer's disease and seizures. Review of Resident #50's Admission MDS assessment dated [DATE] reflected Resident #50 had a BIMS of 14 indicating she was cognitively intact. Resident #50 had inattention and disorganized thinking. Resident #50 had wandering behavior 1 to 3 days of the 7 day look back period. Resident #50 required partial/moderate assistance with oral hygiene and bathing/shower ADLs. Resident #50 required supervision with personal hygiene ADLs. It reflected in the activities section she liked music and to go outside. Resident #50 was taking antipsychotic and antidepressant medications. Care plan assessment summary reflected delirium, cognitive loss/dementia, communication, ADL functional/rehabilitation potential, mood state, behavioral symptoms, dental care and psychotropic drug use. Review of Resident #50's comprehensive care plan last revised on 09/02/24 reflected the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-start date 08/15/24, created date 09/02/24 Resident #50 had potential for drug related complications associated with use of psychotropic drug medications. It did not specify what psychotropic medications Resident #50 was ordered. -start date 08/15/24, created date 08/22/24 Resident #50's ADL functional state/rehabilitation potential [Resident #50] have a diagnosis of CVA (Stroke). It did not reflect specific ADL assistance Resident #50 required. Intervention reflected Assist with ADLs and comfort measures as needed. The care plan did not address Resident #50's discharge goals. Observation and Interview on 09/10/24 at 2:25 PM with Resident #50 in her room revealed she was newer to the facility. She stated she did not have a care plan meeting since admission. She stated she did not have any family to discharge with at this time, but she would like to be informed and provided her discharge plan options. She stated she wanted to be involved in her care. She stated she was a smoker but was not aware the facility had smoking break times. She stated she admitted from the hospital and was not aware of what to expect from the facility. Interview on 09/11/24 at 3:20 PM with ADON revealed she had not discussed discharge options with Resident #50. She stated Resident #50 had no safe place to discharge at this time but they should have had a care plan meeting for Resident #50 already. The ADON stated the resident's ADL assistance needs should be care planned by the MDS Coordinator. Follow-up interview on 09/13/24 at 1:30 PM with ADON revealed newly admitted residents including Resident #50 should have had a care plan meeting within 21 days of admitted . She stated Resident #50 was overdue for her care plan meeting and facility will schedule Resident #50's care plan meeting for next week. She stated she was responsible for giving the list to AD on which residents needed to be scheduled for care plan meetings and AD would then schedule the residents. 2. Review of Resident #46's face sheet undated reflected Resident #46 was a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Cerebral infarction (stroke), Depression, Hypertension, Chronic obstructive pulmonary disease (lung disease causing restricting airflow and breathing problems), asthma (chronic lung disease that causes inflammation in the airways making it difficult to breathe), protein-calorie malnutrition, Kidney Failure (condition that occurs when the kidneys are no longer able to filter waste from the bold or control fluid levels), Dysphagia (swallowing disorder) and Dementia. Review of Resident #46's quarterly MDS assessment dated [DATE] reflected Resident #46 was severely impaired in daily decision making. Resident #46 required partial/moderate to substantial/maximal assistance with ADLs except supervision assistance with eating. The assessment reflected Resident #46 had significant weight loss. Review of Resident #46's dietary progress notes by RD reflected the following: -dated 07/15/24 at 4:24 PM Wt. (weight) 161.2# -18# x 1mth(10%), stable x 3wks. BMI 26.0 .Intake variable per staff. Therapy working with resident on self feeding .Inadequate intake [related to] feeding difficulty and decreased appetite .continue current intervention. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-dated 08/12/24 2:52 PM Wt. 162.1# -20# x 3 mths(11.3%), -23# x 6mths(12.6%). BMI 26.2-appropriate for age. Resident alert and up at table in [Dining room] for lunch feeding self with hands and regular utensil. Divided plate .Intake variable per staff. Therapy working with resident on self feeding. Tremors in hands. [Speech Therapy] working with resident to improve intake .needs=1840-2200kcals, 74gms [protein], 2200ml fluids. Wt. stable x 1mth. continue current intervention. -dated 09/09/24 6:48 PM Wt. 165.3# -13# x 3mths(7.6%), -17# x 6mths. Wt. stable x 2mths. BMI 26.7 appropriate. Resident alert and up at table in [dining room] for lunch feeding self with regular utensils. Divided plate .Intake 50-100% per staff. Therapy working with resident on self feeding. Fed at times. Nursing reports possible lactose intolerance r/t house shakes. Est.needs=1840-2200kcals, 74gms pro, 2200ml fluids. REc: d/c house shakes and weighted utensils. Review of Resident #46's comprehensive care plan last revised on 07/24/24 did not reflect ADL assistance needs for Resident #46. It did not reflect significant weight loss for Resident #46. Review of Resident #43's face sheet undated reflected Resident #43 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Alzheimer's disease, Abnormal weight loss, Cognitive Communication deficit, major depressive disorder and Dysphagia. Review of Resident #43's quarterly MDS assessment dated [DATE] reflected Resident #43 had a BIMS of 2 indicating she was severely cognitively impaired. Resident #43 required partial/moderate assistance with ADLs. It did not indicate significant weight loss for Resident #43. Review of Resident #43's comprehensive care plan last revised on 08/21/24 reflected no care plan for ADL assistance needs for Resident #43 and no care plan for Resident #43's significant weight loss. Review of Resident #43's dietary progress notes reflected the following: -dated 07/16/24 Wt. 127.2# -16# x 3mths(11.2%), -19# x 6mths(13%). BMI 23.3. Resident alert and confused sitting at table in [dining room] for lunch feeding self. Needs cuing and encouragement to continue eating. Intake variable. REG diet. Divided plate for meals. House shake @ [Lunch] and [Dinner]. Walks away during meals .Walks about memory care unit often -dated 08/12/24 Wt. 128.1# -17# x 6mths(11.9%). BMI 23.4 appropriate for age. Resident alert and confused sitting at table in DR for lunch feeding self. Needs set up, cuing, redirection, and encouragement with meals. Intake variable. Ate 75-100% of lunch today. REG diet. Divided plate for meals. House shake @ [Lunch] and [Dinner]. Walks away during meals .Walks about memory care unit often . -dated 07/16/24 Wt. 127.2# -16# x 3mths(11.2%), -19# x 6mths(13%). BMI 23.3. Resident alert and confused sitting at table in DR for lunch feeding self. Needs cuing and encouragement to continue eating. Intake variable. REG diet. Divided plate for meals. House shake @ [Lunch] and [Dinner].Walks away during meals .Walks about memory care unit often . Interview on 09/11/24 at 11:29 AM revealed Resident #43's RP was aware of Resident #43's significant weight loss. (continued on next page)

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	675067	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gainesville Convalescent Center	1900 O'Neal St Gainesville, TX 76240

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/11/24 at 12:45 PM with CNA I revealed Resident #43 needed assistance with all ADLs. She stated Resident #43 required one person assistance with personal hygiene and oral care along with showering due to her vision issues and cognition issues. Interview on 09/12/24 at 2:42 PM with MDS Coordinator revealed she was not aware she needed to do ADL care plans for residents. She stated the ADON was responsible for significant weight loss care plans since she reviewed the weights. Interview on 09/12/24 at 9:45 AM with DON revealed resident ADL assistance needs should be care planned for residents. Interview on 09/12/24 at 9:52 AM with MDS Coordinator revealed she was not responsible for completing ADL assistance resident care plans. Interview on 09/13/24 at 1:30 PM with ADON revealed she was responsible for completing the acute care plans but MDS Coordinator was responsible for ensuring care plans were developed upon admission and updated quarterly. She stated MDS Coordinator was responsible for ADL care plans for residents. She stated Residents #43 and #46's significant weight loss should be care planned. 3. Record review of Resident #39's quarterly MDS assessment, dated 07/16/24, reflected a [AGE] year-old male with an admitted [DATE]. Resident #39 had BIMS score of 9 which indicated he was moderately cognitively impaired. He required maximum to dependent assist on all ADLs except for eating which required only set up assistance. Resident #39 was always incontinent of bowel and bladder. Diagnoses included cerebral vascular accident (stroke) and hemiplegia (condition that causes partial or complete paralysis of one side of the body). Record review of Resident #39's care plan with a revision date of 08/28/24 did not address resident's contractures to his right hand or interventions required to maintain good skin integrity to his hands. In an observation and interview on 09/10/24 at 10:02 a.m. revealed Resident #39 being provided incontinence care by Agency CNA E. Residents fingernails were long and dirty. His left hand was noted to have yellow patchy area on 3 fingers and his thumb. Resident #39 stated he thought it might be dried food. Resident's right hand was contracted and had no splint in place. Resident #39 requested a bed bath from Agency CNA E today (09/10/24) and she stated she would come back and do that for him. In an interview with Agency CNA E on 09/10/24 at 10:15 a.m. she stated Resident #39 was scheduled on 6 pm to 6 am shower list but stated he would often ask her to bathe him since he had a certain way he liked to be moved. She stated she had tried to get him to let her put the carrot (soft device used for contracted hands) in his right hand, but he stated it hurt too much and would not let them. She stated he would let them clean his nails, but they were so thick you could not cut them effectively. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the ADON on 09/11/24 at 03:27 p.m. she stated the MDS coordinator was responsible for creating and updating the care plan. She stated contractures should be care planned with interventions. She stated they had tried a carrot on Resident #39, but he did not like it and would not let them use it. She stated his nails needed to be kept cut to prevent injury to the palm of his hand. She stated the Podiatrist (foot doctor) came today (09/11/24) and cut both his toenails and his fingernails. In an interview with the MDS coordinator on 09/11/24 at 04:00 p.m. she stated she was mostly responsible for updating the care plan. She stated contractures should be care planned. She stated she was aware Resident #39 had a contracture and stated they needed to have interventions in place to prevent further decline, or if he was refusing the necessary interventions it needed to be addressed in the care plan. She stated they should indicate what other interventions could be used other than the carrot. She stated if the Resident was refusing to have his nails clipped or if staff were unable to clip them, then they also needed to address how they were going to get his nails trimmed to prevent skin breakdown. In an interview with the DON on 09/12/24 at 08:50 a.m. she stated contractures were to be care planned. She stated she knew the care plans were not comprehensive. She stated the MDS nurse was responsible for updating the care plan. She stated the care plan should be patient centered and reflect the current care needs of the resident to ensure accurate care and resident wishes. 4. Record review of Resident #7's comprehensive MDS assessment, dated 08/31/2024, revealed she was a [AGE] year-old female, admitted to the facility on [DATE] and readmitted on [DATE]. She had a BIMS score of 7 which indicated she was severely cognitively impaired. Diagnoses included hypertension (high blood pressure), dementia (loss of cognition), Parkinson's disease (brain disorder that causes uncontrollable movements), and infection following a surgical procedure. Record review of Resident #7's care plan, initiated on 05/21/2024 and updated on 07/03/2024, reflected her preference for female staff to shower her was not care planned. Record review of Resident #7's quarterly care plan conference, dated 07/03/2024 and attended by Resident #7, the MDS Nurse, and the ADON, reflected there was no mention that she preferred female staff to shower her or had concerns about showers. Record review of Resident #7's nursing order, start dated 05/28/2024 revealed resident was showered on Mondays, Wednesdays, and Fridays during the 6:00 AM and 6:00 PM shift. An interview on 09/10/2024 at 12:56 PM with Resident #7 revealed she preferred female staff to shower her and had to ask staff repeatedly to be showered. She stated she had turned down showers in the past because she preferred female staff rather than male staff or had been told that staff would shower her later and it did not happen. She was unable to remember which days she had refused or had missed a shower. She stated staff were aware she was not comfortable with male staff showering her because she had told them. Record review of Resident #7's shower sheets from 07/31/2024 through 09/13/2024 reflected she refused a shower on 08/05/2024 and 07/31/2024, signed by Agency CNA H. She was showered on 09/13/2024, 09/06/2024, 09/02/2024, 08/28/2024, and had a bed bath on 08/24/2024 signed by Agency CNA H. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #28's Quarterly MDS assessment, dated 06/28/2024, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Her BIMS score was a 15 which indicated her cognition was intact. Her diagnoses included cancer, malnutrition, asthma (inflammation and narrowing of the airways) and Chronic Obstructive Pulmonary Disease (lung diseases that cause restricted airflow), and muscle weakness. Record review of Resident #28's care plan dated revised 06/12/2024 reflected there were no problem areas or interventions regarding showers or baths. Record review of Resident #28's quarterly care plan conference, dated 06/12/2024 and attended by the DON, the ADON, and the MDS Nurse, reflected, .Will refuse showers most of the time due to male staff . An interview on 09/10/2024 at 9:54 AM with Resident #28 she stated she had not had a shower in about two weeks and refused the most recent shower because she did not want to be showered by a male aide and preferred female aides to shower her. She stated that she was uncomfortable with males showering her. She stated staff were aware because she told them she preferred a female staff member to shower her. She stated there were times that a female staff member was not available to shower her, or it was not someone she was familiar with, so she refused. Record review of Resident #28's shower sheets from 07/31/2024 through 09/13/2024 reflected she refused a shower on 09/02/2024, 08/05/2024, 07/31/2024, signed by Agency CNA H. She was showered on 08/28/2024, signed by Agency CNA H. In an interview on 09/11/2024 at 4:25 PM with Agency CNA H revealed he worked at the facility as an agency CNA during the 6 PM to 6 AM shift and was familiar with Resident #7 and Resident # 28. He stated that Resident #28 frequently refused showers and preferred female staff. He stated that Resident #7 also preferred female staff to shower her. He stated there was a female CNA on a different hall and he frequently swapped residents with her.- He said he showered some of the male residents on the female CNA's hall, and she showered some of the female residents on his hall. He stated that sometimes the female CNA was not available; and he documented on the resident's shower sheet if the resident refused a shower, in the electronic record, and informed the nurse. He stated that it was important to honor the resident preference to have a same-sex staff member to shower them because some residents, males and females, were not comfortable to be showered by an opposite-sex staff member. In an interview on 09/12/2024 at 5:00 PM with the DON revealed she thought Resident #7's preference to be showered by female staff was care planned and remembered it being discussed in the past. In an interview on 09/13/2024 at 1:17 PM with the ADON revealed Resident #7 was particular about who showered her and preferred specific female staff to shower her, and remembered it being discussed during her most recent care plan conference. She stated she remembered having a care plan conference for Resident #28 where it was discussed she preferred female staff to shower her. She stated that if a resident preferred a female or male staff to shower them, it should be care planned so that the CNAs and nurses knew what type of assistance the resident required. She stated that the MDS nurse was responsible for care planning Residents #7's and #28's preference for females. In an interview with the MDS coordinator on 09/11/24 at 04:00 p.m. she stated she was mostly responsible for updating the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility's policy Care Plans, Comprehensive Person-Centered revised March 2022 reflected A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission . Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: a. participate in the planning process; b. identify individuals or roles to be included; c. request meetings; d. request revisions to the plan of care; e. participate in establishing the expected goals and outcomes of care; f. participate in determining the type, amount, frequency and duration of care; g. receive the services and/or items included in the plan of care; and h. see the care plan and sign it after significant changes are made. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: c.includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions. 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 34918 49427

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34399 Based on interview and record review the facility failed to ensure the comprehensive care plans were prepared by an IDT that included the attending physician, a registered nurse and a nurse aide with responsibility for the resident, a member of food and nutrition services staff and the participation of the resident for one of 8 residents (Resident #50) reviewed for care plan conference. The facility failed to ensure Resident #50 had a care plan conference to discuss her treatment and discharge goals. This failure could place residents at risk for not receiving adequate or individualized care. Findings include: Review of Resident #50's face sheet undated reflected Resident #50 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of stroke, cognitive communication deficit, diabetes, anxiety disorder, Alzheimer's disease and seizures. Review of Resident #50's Admission MDS assessment dated [DATE] reflected Resident #50 had a BIMS of 14 indicating she was cognitively intact. Resident #50 had inattention and disorganized thinking. Resident #50 had wandering behavior 1 to 3 days of the 7 day look back period. Resident #50 required partial/moderate assistance with oral hygiene and bathing/shower ADLs. Resident #50 required supervision with personal hygiene ADLs. It reflected in the activities section she liked music and to go outside. Resident #50 was taking antipsychotic and antidepressant medications. Care plan assessment summary reflected delirium, cognitive loss/dementia, communication, ADL functional/rehabilitation potential, mood state, behavioral symptoms, dental care and psychotropic drug use. Review of Resident #50's comprehensive care plan last revised on 09/02/24 reflected the following: -start date 08/15/24, created date 09/02/24 Resident #50 had potential for drug related complications associated with use of psychotropic drug medications. It did not specify what psychotropic medications Resident #50 was ordered. -start date 08/15/24, created date 08/22/24 Resident #50's ADL functional state/rehabilitation potential [Resident #50] have a diagnosis of CVA (Stroke). It did not reflect specific ADL assistance Resident #50 required. Intervention reflected Assist with ADLs and comfort measures as needed. The care plan did not address Resident #50's discharge goals. Observation and Interview on 09/10/24 at 2:25 PM with Resident #50 in her room revealed she was newer to the facility. She stated she did not have a care plan meeting since admission. She stated she did not have any family to discharge with at this time, but she would like to be informed and provided her discharge plan options. She stated she wanted to be involved in her care. She stated she admitted from the hospital and was not aware of what to expect from the facility. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/11/24 at 3:20 PM with ADON revealed she had not discussed discharge options with Resident #50. She stated Resident #50 had no safe place to discharge at this time but they should have had a care plan meeting for Resident #50 already. The ADON stated the resident's ADL assistance needs should be care planned by the MDS Coordinator. Follow-up interview on 09/13/24 at 1:30 PM with ADON revealed newly admitted residents including Resident #50 should have had a care plan meeting within 21 days of admitted . She stated Resident #50 was overdue for her care plan meeting and facility will schedule Resident #50's care plan meeting for next week. She stated she was responsible for giving the list to AD on which residents needed to be scheduled for care plan meetings and AD would then schedule the residents. Review of facility's policy Care Plans, Comprehensive Person-Centered revised March 2022 reflected A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission . Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: a. participate in the planning process; b. identify individuals or roles to be included; c. request meetings; d. request revisions to the plan of care; e. participate in establishing the expected goals and outcomes of care; f. participate in determining the type, amount, frequency and duration of care; g. receive the services and/or items included in the plan of care; and h. see the care plan and sign it after significant changes are made. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: c.includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 34918 Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for one of thirteen residents (Resident # 18) reviewed for ADLs. The facility failed to ensure Resident #18 had her facial hair removed and her nails cut. These failures could place residents who were dependent on staff for ADL care at a loss of dignity and a decreased quality of life. Findings include: Record review of Resident #18's annual MDS assessment, dated 06/20/24, reflected a [AGE] year-old female with an admitted [DATE] and a re-admitted [DATE]. Resident #18 had BIMS score of 3 which indicated she was severely cognitively impaired. She required moderate assistance for bathing and personal hygiene. Diagnoses included Alzheimer's and osteoarthritis (chronic condition that breaks down the cartilage in the joints, causing pain and stiffness). Record review of Resident #18's care plan with a revision date of 04/27/24 reflected, ADLs .Self-care deficit: Requires assistance .Goals .will be clean, dry and free from odors with dignity maintained .Interventions . Provide/assist with bath or shower as per schedule and as needed . Record review of the undated shower schedule for hall 400 revealed Resident #18 was scheduled on the 6 pm to 6 am shift on Tue- Thursday and Saturdays. Record review of Resident #18's shower sheets revealed she had received a shower from the night shift CNA on 09/04/24 and Agency CNA E from the day shift on 09/06/24 and 09/09/24. In an observation on 09/11/24 at 01:40 p.m. Resident #18 was observed to have multiple chin hairs that were over 2 inches long. Resident nails were clean but approximately 1/2 inch in length and some were jagged. Resident appeared clean and had no body odor. In an interview on 09/11/24 at 01:42 p.m. with Resident #18, she stated she did not like the long chin hairs because she was a woman not a man and they bugged her. She stated she did not know the staff could take care of that for her and stated she would love to have the chin hair removed. Resident #18 stated she did not like her nails long but did not know the staff could do that for her either. In an interview with Agency CNA E on 09/11/24 at 02:00 p.m. she stated she had showered Resident #18 on 09/06/24 and 09/09/24. She stated she showers her when she is on shift. She stated the resident will let her clean her nails but would not let her cut them. She stated she had tried to get her to let her cut them yesterday (09/10/24) but had not told the nurse. She stated she meant to go back and try again. She stated she had overlooked her chin hair and stated she would take care of that today. She stated it would bug her if she had chin hair, so she knew it probably bothered the resident. She stated they are supposed to shave the residents and clean and cut their nails on shower days. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 09/12/24 at 08:52 a.m. she stated the staff were supposed to check resident's nails daily to make sure they clean and trimmed if needed. She stated if a resident was diabetic the Nurses were responsible for trimming the nails. She stated if a resident refused nail care, then they needed to notify the nurse and see if they could get the resident to let them cut their nails. She stated long nails could cause skin tears and risk of infections. She stated all residents, both male and female were to be shaved on their shower days. She stated failing to remove facial hair from a female is a dignity issue. Record review of the facility's policy, Activities of Daily living (ADL), Supporting dated March 2018, reflected, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene .If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time, or having another staff member speak with the resident may be appropriate .

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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** 34399 Based on observation, interview and record review the facility failed to provide, based on the comprehensive assessment and care plan, both facility-sponsored group and individual activities and independent activities designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident for three (Resident #13, #26 and #36) of 7 residents reviewed for activities. 1. The facility failed to provide individualized and group activities for Resident #13 on the secure unit who did not consistently attend group activities off the secure unit. The facility failed to ensure Resident #13 had an individualized activity care plan. 2. The facility failed to provide individualized and group activities for Resident #26 on the secure unit who did not attend the group activities off the secure unit. The facility failed to follow Resident #26's individualized activity care plan. 3. The facility failed to provide individualized activities for Resident #36 on the secure unit who did not attend the group activities off the secure unit. The facility failed to ensure Resident #36 had an individualized activity care plan. These failures could place residents at risk for decline in quality of life, social and mental psychosocial wellbeing. Findings included: 1. Review of Resident #13's face sheet undated reflected Resident #13 was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Metabolic encephalopathy (occurs when problems with your metabolism cause brain dysfunction), hypertension (high blood pressure), atrial fibrillation (irregular heartbeat), Dysphagia (swallowing disorder), Cognitive Communication Deficit (difficulty with communication that's caused by disruption in cognition) , Chronic Kidney Disease (disease when your kidneys stop filtering waste from your flood), Dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and Chronic Obstructive Pulmonary Disease (disease that causes air flow limitation ,less air in and out of the airways and breathing-related symptoms). Review of Resident #13's Significant Change MDS assessment dated [DATE] reflected Resident #13 was severely cognitively impaired in Daily Decision Making. Resident #13 had wandering behavior which occurred 1 to 3 days during the 7 day look back period. It reflected Resident #13's activity section was not completed for Resident #13 since he was never or rarely understood. There was no activity preference completed by staff or family. Review of Resident #13's comprehensive care plan last revised on 09/09/24 reflected Resident #13 had impaired decision making related to dementia. It reflected a start date of 01/09/24 and last edited on 09/08/24 Resident #13 had behavior problem r/t (related to) wandering, hitting walls, moving furniture, hitting staff. Intervention included to Provide a program of activities that is of interests and accommodates resident status. (continued on next page)

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	675067	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gainesville Convalescent Center	1900 O'Neal St Gainesville, TX 76240

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review revealed there was no activity care plan for Resident #13. Review of Resident #13's Activity progress notes completed by AD for December 2023 to September 2024 reflected the following: -dated 12/29/23 Resident enjoyed the holidays and visits with family. Resident attended and participated in many group and independent activities. -dated 01/14/24 at 11:41 AM resident enjoyed attending and participating in many scheduled group activities and visiting other often including family -dated 07/14/24 at 11:44 AM Resident attends and participates in some group activities in/out of unit of his choosing weekly and some independent activities daily Observation on 09/10/24 at 10:01 AM and 10:09 AM revealed Resident #13 was ambulating on his own and pacing in the common area and the hallway. Interview on 09/10/24 at 10:09 AM revealed Resident #13 stated there were not a lot of activities on the unit and he did not have much to do. He mentioned he was in the process of fixing something. Interview on 09/11/24 at 12:45 PM with CNA I revealed Resident #13 was a past smoker but did not smoke anymore. She stated Resident #13 was taken outside to the secure outside courtyard when another resident smoked. CNA I stated she would get out the items provided by Activity Director which included balls. She stated Resident #13 did like to fix things. She stated she was unable to provide individualized activities to Resident #13 on a regular basis due to needing to provide ADL care or supervision to residents on the secure unit. She stated Resident #13 went to bingo in the main dining room but she was not aware of any group activities which involved them in hands-on activities of preference to fix items. Observation on 09/11/24 at 4:07 PM revealed Resident #13 was walking and going up to the walls using his hands moving up/down on the wall mimicking like he was fixing something on the wall. Interview on 09/12/24 at 2:48 PM with AD revealed Resident #13 liked to socialize, walk, activities outside, food activities and do activities with his hands. She stated there should be an activity item which Resident #13 used since he liked to do things with his hands. She stated she was not aware Resident #13 did not have an activity care plan for his individual needs and preferences. 2. Review of Resident #26's face sheet undated reflected Resident #26 was a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of stroke, Dysphagia (swallowing disorder), diabetes, insomnia and Alzheimer's disease. Review of Resident #26's Annual MDS assessment dated [DATE] reflected Resident #26 was severely impaired in daily decision making. Resident #26 exhibited wandering behavior 1 to 3 days during a 7 day look back period. The assessment reflected Resident #26's activities care area was triggered for care planning decision. Staff activity assessment reflected Resident #26 activity preferences of spending time outdoors, spending time away from the nursing home and participating in favorite activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #26's comprehensive care plan last updated on 08/14/24 reflected Resident #26 was high risk for injury related to identified elopement risk factors and or exit seeking behavior due to impaired cognition and/or daily decision making. Resident #26 had behavior problems of kicking, hitting, slapping and refusing care. Intervention added 08/02/23 included Provide a program of activities that is of interest and accommodates resident status. Resident likes: to do things with his hands. Five (sic) him something he can do that involves his hands. Review of Resident #26's activity progress notes completed by AD for October 2023 to September 2024 reflected: -dated 10/15/23 at 11:23 AM resident wanders often in memory care unit and is often needing redirected. Resident enjoys many visits with family often. -dated 12/29/23 at 11:52 AM resident enjoyed one on one visits 3 X a week needs redirecting often. -dated 01/14/24 at 11:46 AM resident is one on one 3 X a week and needs redirecting often. family visit nightly. -dated 07/13/24 at 11:46 AM Resident is a passive participant and often needs redirected. Resident enjoys family visits often Observation on 09/10/24 at 10:00 AM revealed Resident #26 was at the door to the court yard pressing on the bar and trying to open it. At 10:10 AM Resident #26 was ambulating on his own pacing in the common area with no activity going on. TV was on in the background but Resident #26 was not paying attention to it. Observation on 09/10/24 at 2:20 PM revealed Resident #26 was in the common area walking within the secure unit. The TV in the common area was turned off with no music. Observation on 09/10/24 at 2:30 PM revealed a exercise group activity with AD and 7 residents, but no residents on the secure unit including Residents #13, #26 and #36. Interview on 09/11/24 at 12:45 PM with CNA I stated Residents #26 and #36 did not come off the unit for activities. She stated she would sometimes use a ball with Resident #26 but it had to be a bigger ball because he had behaviors of putting things in his mouth. She stated AD would come get some of the residents off the unit for group activities in the main dining room but AD did not provide group activities on the secure unit. Observation on 09/11/24 at 4:02 PM revealed Resident #26 was ambulating on the unit walking. There was no TV on and no music. There was no group activity going on for the unit. Observation and Interview on 09/10/24 at 4:10 PM with CNA I revealed she only had a basket with stress ball, small foam football and small ball that AD had put together to use with residents including Resident #13 on the secure unit. She stated these items were too small to use for Resident #26 since he put things in his mouth. She stated she did not have any hands-on activity item for Resident #13 who liked to fix things. She stated she had not had a chance to do any activities using these items today yet. She stated these items would not be good to use with Resident #36 who had behaviors of getting combative and throwing things. (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 09/12/24 at 2:42 PM with MDS Coordinator revealed she was not responsible for resident activities care plan and the AD would be responsible to update the care plan. Interview on 09/12/24 at 2:59 PM with AD reflected she did not do individualized activities with Resident #26. Interview revealed CNAs on the unit were responsible to ensure resident was provided activities. She stated when she did come on the unit she would interact with him when he was walking on the unit by walking with him about twice weekly. She stated Resident #26 did not come off the unit for group due to safety concern of exit seeking. She stated she had not reached out to family to find out about Resident #26's preferences. She stated she was not aware Resident #26's care plan was not completed for activities and thought MDS Coordinator was completing it. 3. Review of Resident #36's face sheet undated reflected Resident #36 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Heart disease with heart failure, palliative care (end of life), vascular dementia (dementia that occurs when the brain's blood supply is damaged, causing problems with memory, thinking, and behavior), dysphagia ((swallowing disorder), cognitive communication deficit and violent behavior. Review of Resident #36's quarterly MDS assessment dated [DATE] reflected Resident #36 was severely cognitively impaired in daily decision making. Resident #36 exhibited behaviors of hallucinations, delusions and rejection of care. Resident #36 was on hospice services. Review of Resident #36's comprehensive care plan last edited on 08/14/24 reflected Resident #36 had violent behaviors. It reflected last edited on 08/14/24 that Resident #36 had cognitive loss/dementia resides in secure unit and is at risk for injury from wandering in an unsafe environment . impaired safety awareness. Interventions included: Activities director to monitor/discuss activity preference and Allow resident to choose activities inside and outside that don't pose a safety risk It did not reflect an activity individualized care plan. Review of Resident #36's progress notes from April to September 2024 reflected no activity progress notes about resident activities. Review of Resident #36's assessments from April to September 2024 reflected no activities assessment for Resident #36. Interview on 09/12/24 at 3:14 PM with AD revealed Resident #36 did not like to be touched and was combative. She stated Resident #36 would listen to music and it would be good to have music playing on the secure unit. She had not reached out to family to find out more about Resident #36's activity preferences. She was not aware it was not care planned for activities for Resident #36. She stated Resident #36 did not come off the unit for group activities due to her behaviors and the stimulation would be overwhelming for her. (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 09/12/24 at 2:59 PM with AD revealed she had showed CNAs that work on the unit the activity closet which included these sensory baskets made up of little balls, stress balls and other small objects for the CNAs to use with the residents including Resident #13 on their shift. She stated not all the residents were able to come off the unit due to safety concerns and exit seeking behaviors so she would bring food items to the unit after group activities passing them out to the residents on the unit who were not able to participate in the secure unit. She stated on Tuesdays they had a coffee/donut activity in the main dining room but she brought back the donuts to them after the group activity ended for those on the unit unable to come over. She stated the residents on the unit enjoyed cookies and milk which they did for Grandparents day. She stated the MDS Coordinator did the activity care plans for residents. She stated she went to the unit about twice daily for about 15 minutes each time. She stated Resident #36 did not come off the secure unit due to safety concerns and her behaviors. She stated residents who do not have individualized activities per their preferences may have a decline in their quality of life and can affect their enjoyment level. Follow-up interview on 09/12/24 at 4:25 PM with AD revealed she did not have any activity assessments for Resident #13, #26 and #36. She stated she was behind in documentation including her activity assessments. She stated all residents should have an activity assessment completed upon admission and then updated as needed. She stated she documented in progress notes about activities but she stated she was behind in documenting activities for residents. Interview on 09/12/24 at 5:10 PM with DON revealed Residents #13 and #26 liked to do things with their hands and fix things. She stated the residents should have activities on the secure unit per their preferences and individualized needs. She stated the activities care plan should be completed. 4. Review of facility's policy Activity Programs revised June 2018 reflected Activity programs are designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident. 1. The activities program is provided to support the well-being of residents and to encourage both independence and community interaction. 2. Activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident. 3. The activities program is ongoing and includes facility-organized group activities, independent individual activities and assisted individual activities. 4. Activities are considered any endeavor, other than routine ADLs, in which the resident participates, that is intended to enhance his or her sense of well-being and to promote or enhance physical, cognitive or emotional health. 5. Our activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs . 7. Our activity programs consist of individual, small group and large group activities that are designed to meet the needs and interests of each resident. Activity programs include activities that promote: a. self-esteem; b. comfort; c. pleasure; d. education e. creativity; f. success; and g. independence .12. Individualized and group activities are provided that: a. reflect the schedules, choices and rights of the residents; b. are offered at hours convenient to the residents, including evenings, holidays and weekends; c. reflect the cultural and religious interests, hobbies, life experiences and personal preferences of the residents; d. appeal to men and women, as well as those of various age groups residing in the facility; and e. incorporate family, visitor and resident ideas of desired appropriate activities.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49427 Based on observations, interviews, and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 (Resident #7) of 6 residents reviewed for quality of care. The facility failed to follow physician orders and perform wound treatments as ordered for Resident #7. 1. The ADON failed to discontinue the previous physician order from a xeroform dressing for Resident #7's surgical incision to the updated order for a wet to dry dressing on 07/01/2024. 2. Agency LVN D failed to notify the ADON, DON, or Physician of the conflicting orders and provided a xeroform and wet to dry dressing of Resident #7's incision site on 09/10/2024. These failures could place residents at risk for complications including skin break down, infection, or decreased physical and mental functioning. Findings included: Record review of Resident #7's comprehensive MDS assessment, dated 08/31/2024, revealed she was a [AGE] year-old female, admitted to the facility on [DATE] and readmitted on [DATE]. She had a BIMS score of 7 which indicated she was severely cognitively impaired. Diagnoses included hypertension (high blood pressure), dementia (loss of cognition), Parkinson's disease (brain disorder that causes uncontrollable movements), and infection following a surgical procedure. Record review of Resident #7's care plan, initiated on 05/21/2024 and updated on 07/03/2024, reflected the resident had a surgical wound to her lower right extremity and interventions included monitor area for increase of breakdown ., signs of infection and report to the physician. Record review of Resident #7's physician orders dated 08/12/2024 to 09/12/2024 reflected, RIGHT LOWER LEG: Cleanse with NS (Normal Saline), Pat dry, apply a wet to dry dressing on site and cover with dry dressing once a day everyday and wrap with ace wrap, with a start date of 07/01/2024. Record review of Resident #7's physician orders dated 08/12/2024 to 09/12/2024 reflected, RIGHT LATERAL KNEE SURGICAL INCISION: Clean with Normal Saline APPL (apply) Xeroform, 4x4 ABD PAD (absorbent dressing) ACE BANDAGE/MEDIPORE TAPE (surgical tape) PRN (as needed) FOR SOILED BANDAGE CHANGE . with a start date of 05/28/2024 and end date of 09/10/2024. Record review of Resident #7's nurses' progress notes, by the ADON, dated 07/01/2024, reflected the physician's nurse provided an order .to do a wet to dry dressing everyday starting 7/2/24 . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/10/2024 at 2:50 PM with Agency LVN C revealed Resident #7's order for the incision site on the right lower leg was a wet to dry dressing. She stated the order was for the right lower leg from a surgical procedure and the wound was mostly healed with a small area at the bottom that was still healing. In an observation on 09/10/2024 at 2:54 PM Resident #7 was observed in her wheelchair in her room. Agency LVN C removed the ace wrap which revealed one closed surgical incision line that ran vertically down the right shin with a portion of the incision opened at the bottom of the incision. There were two small yellow square gauzes located on the top portion of the closed incision site and a white gauze over the lower portion of the open incision. Agency LVN C removed the two yellow squares and the white gauze from the incision site and wiped the site top to bottom with a gauze dipped in saline solution. The lower portion of the incision had an open area about a half of an inch long. She wiped the incision site with dry gauze, placed a wet gauze soaked with saline over the site and wrapped the lower right leg with an ace bandage. Agency LVN C stated that Agency LVN D performed the previous dressing change early in the morning of 09/10/2024. In an interview on 09/10/2024 at 3:33 PM with Agency LVN C revealed the small yellow square gauze was a xeroform dressing. She stated that was not the current order. She stated that Agency LVN D had performed the wound care. In an interview on 09/10/2024 at 3:35 PM with the DON revealed there were two orders for Resident #7's surgical incision and the order for xeroform should have been discontinued. She stated that using xeroform instead of a wet to dry dressing could cause a resident's wound to breakdown. She stated that it was the responsibility of the ADON to review and update orders weekly. Interview on 09/11/2024 at 7:36 AM with Agency LVN D revealed she did the wound dressing change for Resident #7 on 09/09/2024 and remembered she used the xeroform on the top of the closed incision site, cleaned and dressed the open portion of the incision with gauze, and covered both with a bandage and an ace wrap. Agency LVN D stated that she was aware of the two orders and thought it was confusing, so she used the xeroform on the closed part of the incision and the gauze at the bottom of the incision. She stated that when there were conflicting orders they were supposed to inform the Nurse Practitioner to determine which order to discontinue. She stated that she did not contact the Nurse Practitioner or inform the DON and was not sure why she did not inform them. She stated that the risk to the resident for using xeroform when it was supposed to be a wet to dry dressing put a resident at risk of the wound not healing properly. In an interview on 09/13/2024 at 1:17 PM with the ADON revealed the nurse on the floor was responsible for entering new orders and contacted the physician to clarify orders that conflicted. The ADON reviewed Resident #7's progress note dated 07/01/2024 that reflected the physician ordered a wet to dry dressing and was written by the ADON. She stated she was responsible to discontinue the xeroform order but must have missed it. She stated she did not think there was a risk to the resident, the xeroform kept the site moist and the wet to dry was a debridement (a procedure that removes dead, infected, or damaged tissue from a wound) of the site. Review of facility's wound care policy, titled Wound Care dated 2001 and revised July 2024 reflected, .1. Verify that there is a physician's order for this procedure .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on observation, interview and record review, the facility failed to provide treatment and services to prevent complications of enteral feeding for one of one resident (Resident #4) reviewed for feeding tubes. 1. The facility failed to ensure LVN A flushed Resident #4's G-Tube with 30 cc of water prior to the medication administration per physician's orders. 2. The facility failed to ensure LVN A dissolved all the medications prior to administration through Resident #4's G-Tube. 3. The facility failed to ensure LVN A administered medications through Resident #4's G-Tube by gravity, and instead she pushed one of the medications with the plunger and syringe. 4. The facility failed to ensure LVN A clamped the tubing before it drained completely between each medication administration. These failures could affect residents by placing them at risk of abdominal discomfort, obstruction of the G-tube and incomplete medication administrations. Findings included: Record review of Resident #4's Significant change MDS assessment, dated 06/24/24, reflected a [AGE] year-old female with and re-admitted [DATE]. Resident #4's BIMS score was 0 which indicated she was severely cognitively impaired. She was totally depended on all ADL and always incontinent of bowel and bladder and received 51% or more of total calories through a feeding tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach). Diagnoses included dehydration, dysphagia (difficulty swallowing) and cerebral palsy (a congenital disorder of movement, muscle tone or posture due to abnormal brain development). Record review of Resident #4's Care Plan, initiated on 06/20/24, reflected, .Feeding tube- Enteral nutrition for nutrition and hydration, with potential for complications, side effects .Interventions Administer tube feeding and water flushes as ordered. See MD orders for current feeding orders . Record review of Resident #4's Physicians Order Report, dated 08/11/24 through 09/11/24, reflected, .Flush G-tube with 30 cc of water prior to and after medication administration, with a start date of 09/09/24. Record review of Resident #4's medication administration record for September 2024, reflected, . Flush G-tube with 30 cc of water prior to and after medication administration, with a start date of 09/09/24. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 09/11/24 at 09:25 a.m. revealed LVN A at the medication cart to prepare Resident #4's G-tube medications. LVN A entered the resident's room with the rolling blood pressure cuff and took the resident's blood pressure. LVN A returned to the medication cart and began pulling the resident's medication without performing hand hygiene. LVN A opened a bottle of Acidophilous 10 mg (probiotic) and poured two capsules into the lid of the bottle and then used her bare hands to put one of the capsules back into the bottle and placed the remaining capsule into a plastic cup. LVN A then opened the capsule with her bare hands into the plastic cup and diluted it with 30 cc of water. LVN A then proceed to pull Amlodipine 10 mg (blood pressure medication) 1 tablet, Vitamin C 500 mg (supplement) 1 tablet, Aspirin 81 mg (analgesic) 1 tablet, Vitamin D3 2000 units (supplement) 5 tablets to equal 10,000 units, Fibercon 625 mg (supplement) 1 tablet, Lasix 40 mg (diuretic) 1 tablet, Multivitamin (supplement) 1 tablet, Paroxetine HCL 10 mg (antidepressant) 1 tablet, Senna 8.6 mg (laxative) 1 tablet, and Prostat liquid protein 30 ml. LVN A placed each of the medications into a separate plastic cup, crushed them and diluted them with 30 cc of water and entered the resident's room with the medications. LVN A went to the resident's bathroom and filled two plastic cups with water and a larger plastic container with water and placed them on the bedside table with the medications. LVN A then donned a gown and gloves and retrieved the 60-cc piston syringe and placed the syringe in the end of the resident's G-tube and drew back 30 cc of gastric residual. She re-instilled the residual to the resident's stomach. LVN A then placed the 60-cc syringe into the G-Tube and began pouring the cup containing the Vitamin D3 without first flushing the tube with 30 cc of water. The medication had not dissolved and had visible solid particles in the cup. LVN A poured the medication into the tube. The medication would not go down the tube by gravity. LVN A then picked up the plunger and placed it into the syringe and pushed the medication. The syringe was coated with the remaining undissolved medication. LVN A then removed the plunger and poured approximately 30 cc of water allowing the tube to completely empty, before pouring the next medication. LVN A continued with the next nine medications, allowing each time for the tube to completely empty prior to pouring the water flush and the next medication. LVN A then poured the undiluted, very thick Prostat into the tube, where it stayed. LVN A then removed the syringe with the Prostat and poured it back into a cup and diluted it with water. LVN A then re-attached the syringe and poured the diluted Prostat back into the tube. After completion of the medication administration LVN A flushed the tube with 30 ccs of water. She removed her gown and gloves and returned to the medication cart. In an interview with LVN A on 09/11/24 at 9:50 a.m., she stated she was supposed to flush with 30 cc of water before and after completion of medication administration and flush with 30cc between each medication. She stated she did not know she could not push the medication when it would not go down the tube. She stated she knew the medication was not dissolved well but stated she knew she could not mix the medications prior and stated they would have required a longer time to completely dissolve. She stated she was not aware she was not supposed to let the tube empty completely between medications. She stated Resident #4 was the only resident in the facility with a G-tube and she is not normally assigned to her. She stated the resident received bolus feedings but was also eating. She stated the Prostat liquid protein should be given orally since it was so thick. In an interview on 09/11/24 at 1:00 p.m. the DON stated the facility policy was to flush G-Tubes with 30cc of water before and after medications, and medications were to be given by gravity. She stated pushing the medications could cause displacement of the tube. She stated the nurse should have made sure all the medications were dissolved and they should maintain a continuous flow of medication followed by water without allowing air in between. She stated by not keeping a consistent flow it can allow air in the resident's stomach. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of LVN A's skills check for Medication administration Via G-tube dated 03/14/24 reflected she was competent in the procedure. Record review of the facility's policy, Administering Medications through an Enteral Tube, dated March 2015, reflected, .Dilute the crushed or split medication with 15-30 ml room temperature tap water (or prescribed amount) .Administer medication by gravity flow .Pour diluted medication into the barrel of the syringe while holding the tubing slight above the level of insertion .Open the clamp and deliver mediation slowly .Clamp tubing (or begin flush) before the tubing drains completely .If administering more than one mediation, flush with 15 ml (or prescribed amount) room temperature tap water between medications .When the last of the medications begins to drain from the tubing, flush the tubing with 15 ml of warm room temperature tap water (or prescribed amount) .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 49427 Based on observation, interview and record review, the facility failed to ensure that residents who needed respiratory care were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 4 (Resident #25, Resident #28, Resident #37, and Resident #253) of 6 residents reviewed for respiratory care. 1. The facility failed to obtain a Physician's order for Resident #37's continuous supplemental oxygen. 2. The facility failed to ensure Resident #25's nasal cannula, oxygen tubing and humidifier were changed out on 09/08/24 per physician orders. 3. The facility failed to ensure Resident # 28's humidifier was changed out when empty on 09/10/2024 per physician orders. 4. The facility failed to ensure Resident # 253 humidifier was changed out when empty on 09/10/2024 per physician orders. These failures could place residents who received oxygen therapy at risk of oxygen toxicity, respiratory infections, nose bleeds, and nasal discomfort. Findings Included: 1. Record review of Resident #37's significant change MDS assessment dated [DATE], reflected a [AGE] year-old female with a re-entry date of 07/23/24 to the facility. She had a BIMS score of 13 which indicated she was cognitively intact. Diagnoses included diabetes, heart failure, respiratory failure, pneumonia (infection that inflames air sacs in one or both lungs) and chronic obstructive pulmonary disease (chronic disease that blocks air flow). The resident was dependent on ADL's and required maximum assistance with transfers. Resident #37 had received Oxygen therapy while a resident. Record review of Resident #37's care plan initiated on 06/21/24 and revised on 07/10/24 reflected, .Resident requires oxygen therapy related to hypoxemia (low level of oxygen in the blood) .Interventions .Administer oxygen as ordered . Record of Resident #37's Physician orders report dated 08/10/24 to 09/10/24, reflected, oxygen at 4 Liters per minute for shortness of breath and sats (level of oxygen in the blood) below 90% as needed ., with a start date of 07/23/24. There were no orders for continuous oxygen therapy while a resident in the facility. Record review of Resident #37's Medication administration record dated September 2024 reflected, .O2 @ 4 Liters per minute for shortness of breath, Sats below 90% as needed with a start date of 07/23/24 . There were no indications noted by the staff of any oxygen administration from 09/01/24 through 09/10/24. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 09/10/24 at 09:55 a.m. Resident #37 was observed in bed with O2 via nasal cannula. The O2 concentrator was set to deliver 2.5 liters per minute. In an interview with Resident #37 on 09/10/24 at 09:56 a.m. she stated she had been on oxygen continuously since her return from the hospital in July 2024. She stated she had been receiving 2 liters of oxygen per minute. In an observation of Resident #37's oxygen concentrator with Agency LVN F on 09/10/24 at 02:10 p.m. she stated the oxygen was set to deliver approximately 3.5 liters per minute. She stated the resident was on continuous oxygen and her oxygen saturation levels would drop into the 80's if she did not have her oxygen on continuously. She stated they had to have orders for continuous oxygen and stated she was not aware there were no orders for continuous oxygen. She stated she does not know why it would have been on 2.5 liters per minute earlier today (09/10/24). She stated she was responsible for checking the oxygen levels each shift and checking the amount of oxygen delivered. She stated the resident had required up to 4 liters per minute ever since she came back from the hospital. She stated anything lower, and her oxygen saturations would drop. She stated she should have checked the orders instead of assuming the order was there. In an interview with the DON on 09/10/24 at 02:28 p.m. she stated anyone on continuous oxygen should have an order for continuous oxygen and the amount to be delivered per minute. She stated a PRN order is intended for as needed for short term use, but if they needed it all time the order needed to specify that. She stated the nurses should be checking the rate of oxygen anytime they were checking vital signs and oxygen saturation levels to ensure they were receiving the correct amount of oxygen. She stated too much oxygen could result in oxygen toxicity. 2. Record review of Resident #25's quarterly MDS assessment dated [DATE], reflected a [AGE] year-old female with an entry date of 07/01/22 to the facility. She had a BIMS score of 15 which indicated she was cognitively intact. Diagnoses included diabetes and chronic obstructive pulmonary disease (chronic disease that blocks air flow). The resident required minimal assistance with ADL's. Resident #25 had received Oxygen therapy while a resident in the facility. Record review of Resident #25's care plan initiated on 03/23/23 and revised on 08/28/24 reflected, .Resident requires oxygen therapy .Interventions .Administer oxygen as ordered .Change cannula or mask and tubing as per facility protocol and prn . Record review of Resident #25's Physician orders report dated 08/12/24 to 09/12/24, reflected, Change humidifier, nasal cannula/mask, and oxygen tubing every week on Sunday, with a start date of 05/21/22. Record review of Resident #25's Medication administration record dated September 2024 reflected, Change humidifier, nasal cannula/mask, and oxygen tubing every week on Sunday, with a start date of 05/21/22. The record was signed off on 09/08/24 (Sunday) by Agency LVN B, as completed. In an observation on 09/10/24 at 9:50 a.m. Resident #25 was observed in bed with Oxygen via a nasal cannula. The oxygen tubing and the humidifier bottle were not dated. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Resident #25 on 09/10/24 at 9:52 a.m. she stated the staff usually change the cannula and tubing on Sundays but stated it did not get changed this last Sunday (09/08/24). She stated they must have gotten busy and did not get to it. She stated it needed to be changed because it was getting to the point her nasal cannula could stand up on its own. In an interview with Agency LVN B on 09/11/24 at 03:45 p.m. she stated she had worked on Sunday (09/08/24) and had gone to change Resident #25's oxygen tubing, but when she got to the room, she had brought a short oxygen tubing and resident liked the long one since she ambulated to the bathroom. She stated she went to find the long tubing but was unable to find any and then got busy and forgot about it. She stated she had signed off on the Medication administration record that she had changed the tubing before she went to the resident's room. She stated she did not tell the oncoming shift that the tubing still needed to be changed. She stated the tubing needed to be changed weekly to reduce the risk of respiratory infections. She stated she knew she was supposed to sign off any task of medication after it was administered, not before. She stated by doing this a resident could go without ordered services or medications. 3. Record review of Resident #28's Quarterly MDS, dated [DATE], reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Her BIMS score was a 15 which indicated her cognition was intact. Her diagnoses included cancer, malnutrition, asthma (inflammation and narrowing of the airways) and Chronic Obstructive Pulmonary Disease (lung diseases that cause restricted airflow), and muscle weakness. Record review of Resident #28's care plan dated 09/21/2023 and revised 06/21/2024, reflected she required oxygen therapy due to hypoxemia (low blood oxygen) and Chronic Obstructive Pulmonary Disease (lung diseases that cause restricted airflow) and to . administer oxygen as ordered . Change cannula or mask and tubing as per facility protocol and prn . Record review of Resident #28's Physician orders report dated 08/12/24 to 09/12/24, reflected, Change humidifier, nasal cannula/mask, and oxygen tubing every week on Sunday, with a start date of 06/21/2024. Record review of Resident #28's Medication Administration Record, dated 09/01/2024 to 09/12/2024, reflected, .Change humidifier, nasal cannula/mask, and oxygen tubing every week on Sunday, with a start date of 05/21/22. The record was signed off on 09/08/24 (Sunday) by Agency LVN B, as completed. In an observation on 09/10/24 at 9:54 AM Resident #28 was observed seated in a wheelchair with oxygen via a nasal cannula. The humidifier bottle was not dated and empty. Resident #28 stated she was not aware it was empty. In an observation and interview on 09/11/2024 at 9:49 AM with Resident #28 revealed her humidifier bottle was empty and undated and had not been replaced. Resident #28 stated that a nurse told her that they were out of humidifier bottles and the shipment would arrive on 09/11/2024 or 09/12/2024. She stated she was not sure which nurse told her they were out of humidifier bottles. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Record review of Resident #253's Comprehensive MDS assessment, dated 09/09/2024, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Her BIMS score was 13, indicating her cognition was intact. Diagnoses included end stage renal disease (kidney failure), respiratory failure, stroke, and diabetes (chronic disease impacting sugar levels in the blood). Section O reflected she was admitted on continuous oxygen therapy. Record review of Resident #253's care plan dated 09/02/2024 and revised 09/092024, reflected she required oxygen therapy due to hypoxemia (low blood oxygen) and to . administer oxygen as ordered . Change cannula or mask and tubing as per facility protocol and prn . Record review of Resident #253's Physician orders report, dated 09/01/24 to 09/12/24, reflected, Change humidifier, nasal cannula/mask, and oxygen tubing every week on Sunday, with a start date of 09/10/2024. Record review of Resident #253's Medication Administration Record, dated 09/02/2024-09/12/2024, reflected it was not documented that the physician order was completed. In an observation on 09/10/2024 at 9:56 AM, Resident #253 was observed laying in bed with oxygen via a nasal cannula. The humidifier bottle was empty and undated. Resident #253 stated she was blind and did not know the humidifier bottle was empty. In an interview on 09/10/2024 at 10:42 AM with CNA G revealed the nurses were responsible to change humidifier bottles and CNAs were responsible to let nurses know if the humidifier needed to be replaced and the humidifier bottle should be dated when put in the oxygen machine. CNA G stated she had not noticed that the humidifier bottles were empty for Resident #28 and Resident #253 and was going to inform the nurse immediately. In an interview on 09/10/2024 at 10:45 AM interview with Agency LVN C revealed she was unaware that the humidifier bottle was empty for Resident #28 or Resident #253 and would address it immediately. She stated that tubing and humidifier bottles were changed every Sunday for sanitation purposes. She stated that if a CNA noticed the humidifier is low they should notify a nurse so that it could be replaced. In an interview and observation on 09/11/2024 at 10:12 AM with the ADON revealed Resident #28's and Resident #253's oxygen humidifiers were empty and undated. The ADON stated that there should be humidifier bottles in the supply closet and observation of the supply closet revealed a box of humidifier bottles. The ADON took two humidifier bottles and attempted to attach them to Resident #28's and Resident #253's oxygen machines. The ADON stated that the humidifier bottles were not the exact right size, but she was able to get them attached and working properly for the residents and she expected any other nurse to be able to do the same. The ADON stated the nurses were responsible to change the humidifier and tubing weekly or as needed. She stated if a CNA observed an empty humidifier bottle, they notified the nurse and if it was not addressed by the nurse then they were supposed to notify the ADON or the Weekend Supervisor and repeat the process or escalate it to the DON if it was not completed. She stated that it was important to ensure humidifier bottles were replaced when empty because the humidifier fluid kept the nasal passages moist to prevent nose bleeds, soreness, or a stuffy nose. She stated she was not sure if the humidifier bottle or tubing should be dated but she dated the humidifier bottles because it was what she always had done. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON on 09/12/24 at 8:48 a.m. she stated the staff were not to sign off any time before the administration of a task or a medication. She stated this placed residents at risk if the task did not get completed and not having their services or treatments administered as ordered. She stated the tubing and humidor were changed weekly to reduce the risk of respiratory infections. Record review of the facility's policy titled, Oxygen Administration, dated October 2010, reflected, The purpose of this procedure is to provide guidelines for safe oxygen administration .Verify that there is a physician's order for this procedure .Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following .signs or symptoms of oxygen toxicity .lung sounds .Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minutes .Periodically re-check water level in humidifying bottle .Oxygen/nebulizer tubing/masks to be changed by nursing department weekly, and documented in the electronic health record .

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 34399 Based on interview, and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 1 of 1 facility reviewed for RN coverage. The facility failed to provide RN coverage for 8 consecutive hours daily on Saturdays and Sundays in June, July, and August 2024. This deficient practice had the potential to affect residents in the facility by leaving staff without supervisory coverage for RN-specific nursing activities. Findings include: Record Review of RN timesheets for June to September 2024 for facility and Agency staff revealed no RN coverage for the following weekends: 06/01/24 - 06/02/24, 06/08/24 - 06/09/24, 06/15/24 - 06/16/24, 06/22/24 - 06/23/24, 06/29/24 - 06/30/24, 07/13/24 - 07/14/24, 07/20/24 - 07/21/24, 08/03/24 - 08/04/24, 08/10/24 - 08/11/24 and 08/24/24 - 08/25/24. Interview on 09/12/24 at 2:08 PM with ADON revealed she was contacted on the weekends when facility did not have RN coverage on the weekends. She stated she would notify the DON if she needed further assistance. Interview on 09/12/24 at 2:11 PM with DON revealed she did not provide RN coverage on the weekends. She stated the previous weekend RN Supervisor was a no show on the first weekend in August 2024. She stated in September 2024 they have RN coverage on the weekends from agency staff. Interview on 09/12/24 at 2:40 PM with LVN A revealed there had not been RN coverage until the last couple of weekends this month. She was not sure how long the facility had been without RN weekend coverage. She stated the agency RN coverage, which was just started in the last couple of weeks, helped and agency RN provided support to them while at the facility. She stated when the facility had no RN coverage on the weekends they would call or text the ADON about any issues or concerns. She stated there was a manager on duty each weekend but were not RNs. She stated the DON worked only during the week. Interview on 09/13/24 at 3:45 PM with LVN L revealed the facility had been without RN coverage on the weekends since previous RN was employed by the facility and now for the last 2 weeks had used agency RN coverage for the weekends. She stated when there was no RN coverage for the facility on the weekends they would call the ADON who was an LVN to assist them as needed. She stated having the agency RN was helpful and would support them while at the facility on the weekends assisting as needed. She stated the DON worked only during the week. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/13/24 at 11:00 AM with Administrator revealed she became aware yesterday of RN coverage issues on the weekend. She stated they will be using agency RN on the weekends until they can hire a full time RN for weekend coverage. She stated she was aware of the regulation to have RN coverage daily and the risk of having the ADON be the contact person for the weekends was it could place her out of the scope of her practice as an LVN. Review of facility's policy Departmental Supervision revised August 2022 reflected 1. A licensed nurse (RN/ . LVN) is on duty twenty-four hours per day, seven (7) days per week, to provide resident care services and supervise the nursing services activities provided by unlicensed staff. A licensed nurse is designated as a charge nurse on each shift. 2. A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week. RNs may be scheduled more than eight (8) hours depending on the acuity needs of the resident.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34399 Based on observations, interviews and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for the facility's only kitchen for 2 of 2 Dietary Staff (Dietary Aide J and Dietary Aide K) reviewed for kitchen sanitation. Dietary Aide J and K failed to wear effective hair restraints and to perform hand hygiene during lunch meal service on 09/10/24. These failures could place residents at risk for food contamination and food-borne illness. Findings include: Observation on 09/10/24 from 12:03 pm to 12:06 PM with Dietary Aide J revealed she was taking pureed food temps on the steam table with her hair restraint not covering about 1.5 inches on the back of her hair and about 1 inch uncovered above both of her ears. Observations on 09/10/24 at 12:07 PM revealed Dietary Aide J started putting food on the plate for resident lunch. Observation revealed Dietary Aide J was wearing a hair restraint not covering about 1.5 inches on the back of her hair and about 1 inch uncovered above both of her ears. Observation on 09/10/24 at 12:08 pm to 12:29 PM revealed Dietary Aide K was putting desserts and silverware on meal trays along with covering the plates while not wearing an effective hair restraint with uncovered about 1/2 in hair with about 5 threads of hair not covered in front, 1/2 inch not covered in the back of the hair, and 1/2 inch hair on sides near both of her ears. Observation on 09/10/24 at 12:18 PM revealed Dietary Aide K touched her face mask, did not wash hands and continued putting covers on plates and silverware on hall trays. Observation on 09/10/24 at 12:20 pm revealed Dietary Aide J was touching counter with her left hand inner part. She did not wash hands and touched the inner part of resident plate while putting food on the plate with the scoop. Observation on 09/10/24 at 12:24 PM with Dietary Aide J revealed she wiped her left palm of her hand on her apron. Observation revealed she did not wash her hands. She continued grabbing plates with her hand and scooped food unto plate. Observation on 09/10/24 at 12:26 PM revealed Dietary Aide J putting her left hand on counter then touching the inner part of the plates while plating food. Dietary Aide J was wearing a hair restraint not covering about 1.5 inches on the back of her hair and about 1 inch uncovered above both of her ears during food meal service of scooping food on resident lunch plates. Observation on 09/10/24 at 12:28 PM with Dietary Aide J revealed she touched the counter with her hand. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 09/10/24 at 12:33 PM with Dietary Aide J revealed she should have washed her hands after touching her apron. She stated the counter was clean prior to meal prep. She stated usually she did not put the plates down on the steam table and usually held them on the outer part. She stated she was not aware her hair restraint was not covering her hair. She states she was aware her hair restraints was supposed to be covering her hair. Interview on 09/10/24 at 12:34 PM with Dietary Aide K stated she should have washed her hands after touching her mask. She stated she was not aware her hair restraint was not fully covering her hair and it should have been. Interview on 09/10/24 at 12:36 PM with Dietary Manager revealed she expected dietary staff to wash hands when touching face mask, or apron and when touching surfaces that are not clean. She stated not washing hands properly placed residents at risk for food contamination and illness. She stated dietary staff not covering their hair fully and effectively with hair restraints placed residents at risk for hair getting in the food and for cross contamination. Review of facility's orientation for Dietary Aide/Dishwasher/Cook Orientation dated 04/10/24 reflected Dietary Aide J was in-serviced on handwashing. Review of facility's policy Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices last revised November 2022 reflected Food and nutrition services employees follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness . Hand Washing/Hand Hygiene 6. Employees must wash their hands: a. after personal body functions (i.e., toileting, blowing/wiping nose, coughing, sneezing, etc.); . g. during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; and/or h. after engaging in other activities that contaminate the hands .Hair nets 15. Hair nets or caps and/or beard restraints are worn when cooking, preparing or assembling food to keep hair from contacting exposed food, clean equipment, utensils and linens. Review of the FDA US Food Code 2022 reflected the following: -under section 2-3 Personal Cleanliness 2-301.11 Clean Condition Food Employees shall keep their hands and exposed portions of their arms clean. -under section 2-402.11 Effectiveness. (Hair Restraints) 1. Code of Federal Regulations, Title 21, Sections 110.10 Personnel. (b) (6) Wearing, where appropriate, in an effective manner, hair nets, head bands, caps, beard covers, or other effective hair restraints.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675067	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gainesville Convalescent Center	1900 O'Neal St Gainesville, TX 76240

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for three of thirteen residents (Resident #32, Resident #7, and Resident #4) reviewed for infection control. 1. The facility failed to ensure LVN A disinfected the blood pressure cuff in between blood pressure checks for Residents #32, Resident #7, and Resident #4) on 09/11/24. 2. The facility failed to ensure LVN A performed hand hygiene during medication administration and did not cross contaminate the medication for Resident #32 and Resident #7 on 09/11/24. 3. The facility failed to ensure LVN A did not cross contaminate Resident #32's eye drops, allergy nasal spray and antifungal powder during medication pass on 09/11/24. These failures could place residents at risk of cross contamination which could result in infections or illness. Findings include: Record review of Resident #32's Quarterly MDS assessment, dated 08/01/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #32 had a BIMS score of 15 which indicated she was cognitively intact. Diagnoses included heart failure and cerebral vascular accident (stroke). Record review of Resident #7's Quarterly MDS assessment, dated 08/31/24, reflected a [AGE] year-old female who re-entered the facility on 05/24/24. Resident #7 had a BIMS score of 7 which indicated she was severely cognitively impaired. Diagnoses included pneumonia (bacterial infection of the lungs) and seizure disorder. Record review of Resident #4's Significant change MDS assessment, dated 06/24/24, reflected a [AGE] year-old female with a re-admitted [DATE]. Resident #4's BIMS score was 0 which indicated she was severely cognitively impaired. She was totally dependent on all ADLs and always incontinent of bowel and bladder and received 51% or more of total calories through a feeding tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach). Diagnoses included dehydration, dysphagia (difficulty swallowing) and cerebral palsy (a congenital disorder of movement, muscle tone or posture due to abnormal brain development). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/11/24 at 8:25 a.m. revealed LVN A at the medication cart in front of Resident #32 and Resident #7's room preparing to pass their morning medications. LVN A stated she first needed to get the resident's blood pressure. LVN A entered the resident's room with a rolling blood pressure monitor and cuff and took Resident #32's blood pressure. LVN A then went across the room and took Resident #7's blood pressure without sanitizing the blood pressure cuff or performing hand hygiene. LVN A then returned to the cart to proceed with pulling Resident #32's morning medication. LVN failed to perform hand hygiene or sanitize the blood pressure cuff. LVN A opened the medication cart and began pulling the resident morning medication. While punching Resident #32's Lisinopril out of the blister pack the pill popped out of the plastic medication cup and fell on top of the medication cart. LVN A picked up the pill with her bare hands and placed it in the medication cup with 10 other medications. LVN A then removed a bottle of artificial tears, a bottle of Flonase allergy spray and a bottle of Nystatin powder (antifungal) from the medication cart and entered the resident's room. LVN A placed the eye drops, the Nasal allergy spray, and the Nystatin powder onto the resident's bedside table without cleaning the surface of the table. LVN A administered the oral medications to Resident #32 and then went to the bathroom to obtain a paper towel. While LVN A was in the bathroom, Resident #32 picked up the bottle of Nasal spray and self-administered her nasal spray. LVN A put on gloves without performing hand hygiene and administered the eye drops to each of the resident's eyes. LVN A removed her gloves and performed hand hygiene and put on clean gloves and applied the Nystatin powder under each of the resident's breasts. LVN A removed her gloves and then went to pick up the eye drops, Allergy spray and antifungal powder when she dropped the bottle of eye drops onto the floor. LVN A picked up the eye drops and returned to the medication cart, where she placed all three items on top of the medication cart. LVN A discarded her gloves and performed hand hygiene and then picked up the eye drops, nasal spray and anti-fungal powder and placed them back in the medication cart without sanitizing them. Continued observation of medication pass with LVN A on 09/11/24 at 9:25 a.m. revealed her outside of Resident #4's room to provide G-Tube medication administration. LVN A entered the Residents room with the rolling blood pressure cuff and monitor without sanitizing it and took the resident's blood pressure. LVN A returned to the medication cart and began pulling the resident's medication without performing hand hygiene or cleaning the blood pressure cuff. LVN A opened a bottle of Acidophilous 10 mg (probiotic) and poured two capsules into the lid of the bottle and then used her bare hands to put one of the capsules back into the bottle and placed the remaining capsule into a plastic cup. LVN A then opened the capsule with her bare hands into the plastic cup and diluted it with 30 cc of water. LVN A then proceeded to pull the remaining nine medications and entered Resident #4's room. LVN A went to the resident's bathroom and filled two plastic cups with water and a larger plastic container with water and placed them on the bedside table with the medications. LVN A then donned a gown and gloves and retrieved the 60-cc piston syringe and placed the syringe in the end of the resident's G-tube and drew back 30 cc of gastric residual. She re-instilled the residual to the resident's stomach and proceeded with the medication administration. LVN A then removed her gown and gloves and returned to the medication cart and performed hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN A on 09/11/24 at 9:50 a.m., she stated she was supposed to clean the blood pressure cuff between each resident and stated she had not done that. She stated she just forgot. She stated she should have sanitized the eye drops and other items taken into the resident's room and should not have set them on the bedside table. She stated the resident had the Flonase in her hand before she even realized it. She stated she did not know she should not have touched the pill with her hands and stated she guessed she should have discarded the pill when she dropped it on the medication cart and was not aware she could not touch the pills with her bare hands. She stated she was supposed to perform hand hygiene before and after any contact with residents and after glove removal and guessed she had missed some steps. She stated, I just messed up. She stated all these failures could result in the spread of germs and infections. In an interview with the DON on 09/11/24 at 1:05 p.m., she stated the staff were required to clean the blood pressure equipment used after each use before using it another resident. She stated failure to do this could potentially spread germs. She stated staff were to do hand hygiene before starting their medication pass and after. She stated at no time were they to touch any medication with their bare hands, and if they dropped a pill on the cart, they should discard it. She stated they should not be placing medication bottles on the bedside table unless they have sanitized it first. She stated once she dropped it on the floor, she should have discarded the bottle of artificial tears. She stated they do frequent in-services on hand hygiene. She stated they also do annual skills checks on all the staff for hand hygiene and for the nurses they do medication administration skills checks. She stated she would be do doing re-education with LVN A. Record Review of LVN A's Medication Administration skills Validation form dated 03/14/24 reflected she was competent in medication administration which included infection control practices. Record review of the facility's policy titled Handwashing/Hand Hygiene, dated October 2023, reflected, This facility consider hand hygiene the primary means to prevent the spread of healthcare-associated infections . All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections .Indications for Hand Hygiene .Immediately before touching a resident .After touching a resident .after touching the resident's environment .Immediately after glove removal Record review of the facility's policy titled, Cleaning and Disinfection of Resident-Care items Equipment, dated September,2022, reflected, . non-critical items are those that come in contact with intact skin . Non-critical resident-care items include .blood pressure cuffs .and computers .Non-critical items require cleaning followed by either low or intermediated-level disinfection .Disinfection is performed with an EPA-registered disinfectant labeled for use in healthcare settings