Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Pointe Wellness Center	2301 N Oregon St El Paso, TX 79902

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51012 Based on observation, interviews and record review the facility failed to ensure residents the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 resident (Resident #41) of 22 residents reviewed for call light placement. -The facility failed to ensure that Residents #41 call lights were within their reach on 12/09/2024. This failure places the resident at risk of not being able to call for assistance when needed. Findings included: Record Review of Resident #41's Admission Record dated 12/10/24, revealed [AGE] year-old male who was admitted to the facility on [DATE] and readmitted [DATE]. Record review of Resident # 41's Hospital History and Physical dated 10/02/24, revealed diagnoses: Parkinson's disease with dyskinesia (Parkinson's disease is a movement disorder of the nervous system), cerebellar ataxia (Cerebellar ataxia is a condition characterized by poor muscle control that affects walking, balance, hand coordination, speech, swallowing, and eye movements), seizures, and traumatic brain injury (TBI). Record Review of Resident #41 Annual MDS dated [DATE] revealed BIMS score of 3, indicating severe cognitive impairment. Record Review of Resident #41's Care Plan initiated 11/14/20 revealed Communication problem r/t impaired ability to understand others and be understood r/t TB. Care plan intervention ensures Call light in reach. Risk for injury R/T seizure disorder Initiated: 12/01/2020. Intervention includes Keep call light in reach. In an observation on 12/09/24 at 2:54 PM, Resident #41 revealed he was lying in bed, and the call bell was clipped on the overhead light and was out of resident's reach. In an interview on 12/09/24 at 2:56 PM with CNA E, it was revealed that Resident #41 was not able to use the call light due to his bilateral hand contractures. CNA E stated she checked the resident every 15 minutes, or the resident would yell if he needed assistance. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/11/24 at 4:00 PM with ADON, it was revealed call lights should be placed within reach. He stated, If resident has contractures and is unable to use the call light, they should place a pad call light. ADON stated staff had been trained to report to the nurses if the residents cannot use a regular call light so a pad call light can be provided as needed. In an interview on 12/11/24 at 11:13 AM with LVN B, revealed Resident #41 had Parkinson's Disease, and had bilateral hand contractures. LVN B said the CNAs had not informed him that Resident #41 was not able to use a regular call light. LVN B stated, Resident #41 would be able to use a pad call light since he would be able press the call light pad with his left hand to call for assistance as needed. LVN B stated staff checked residents every 45 minutes. LVN B stated there was no reason for residents to not have their call light within their reach. In an interview on 12/11/24 at 11:40 AM with CNA A stated Resident #41 was able to use the call light with his left hand, if it was placed in his left hand, or clipped on his shirt. In an interview on 12/12/24 at 11:51 AM with the DON stated, CNA's, Nurses, or any staff could voice concern if a resident needed a call light pad instead of a regular call light due to resident's physical limitations. The state surveyor requested the facility's call bell policy, and was informed by the DON that the facility did not have a call light policy.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49854 Based on observation , interview, and record review the facility failed to ensure residents had the right to have reasonable access to the use of a telephone and a place in the facility where calls can be made without being overheard for 3 of 22 (Residents #17, #34 and #40) residents reviewed for telephone use. The facility failed to provide a place for Resident #17, #34, and #40 to make telephone calls without privacy or being overheard. This failure could place all residents that use the telephone at risk of conversations being overheard and privacy rights not being respected . The findings included : Record review of Resident #17's Admission Record, dated 12/12/24, reflected [AGE] year-old male admitted on [DATE] and readmitted on [DATE]. Record review of Resident # 17's Hospital History and Physical dated 03/31/23, revealed diagnoses of dementia without behavioral disturbance, and Alzheimer's disease. Record review of Resident # 17's Quarterly MDS dated [DATE], revealed a BIMS score of 15 demonstrating he was cognitively intact. In an observation on 12/09/24 at 10:30 AM in the hallway of the second floor of the facility, Resident # 17 was observed sitting on his wheelchair using the phone that was located at the nurses' station. There were several residents at arm's length from Resident #17 as well as an LVN and a CNA standing behind the nurses' station at about four feet away from resident #17 In an Interview on 12/09/24 at 10:35 AM with LVN C, stated he had assisted Resident# 17 to place a phone call to his family using the telephone located at the nurses' station. LVN C said the residents were able to use a phone on the first floor located in the chapel area if they wanted privacy, but the phone was not working because of the construction going on at the facility. LVN C said he had been in-serviced on residents' rights and their rights for privacy. LVN C said he understood Resident# 17 needed a private place to make his phone call. He stated the possible negative outcome would be that other residents and/or staff members overheard Resident #17's conversations over the phone and Resident #17 could feel embarrassed to discuss personal matters with his relatives due to the lack of privacy in the hallway and nurses' stations. (continued on next page)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/11/24 at 8:39 AM with CNA A stated some residents had personal cell phone and that's how they communicated with their relatives and those residents that did not have a cell phone, could request to use the telephone located at the nursing stations in the 4 floors of the facility or at the chapel. CNA A said they had a cordless phone that residents can use but it only covers half the hall and the residents at the end of the hallway would not be able to make calls in their rooms, so most residents preferred to use the phone located at the nurses' station. CNA A stated she believed this violated the resident's privacy because there's always people at the nurse station and in the hallway and this could make the residents feel embarrassed to use the phone. In an interview on 12/11/24 at 9:21 AM with Resident #17, stated he called his family regularly and especially during the Holy Days. He said he used the phone located on the 1st floor of the facility, but it had not been working for over 6 months because of the on-going construction at the facility. Resident #17 stated there was no door where the phone was located on the first floor and there was no privacy, but at least he could hear the conversation without the need to yell. He said that he would like to have more privacy when he called his relatives because he could not hear them with all the residents and staff that were in the hallways. Resident #17 stated he did not want a cell phone because he did not know how to use them, and he did not know where to pay for the services and everything that had to do with owning a cell phone. In an interview on 12/11/24 at 3:00 PM with the Social Worker, revealed she had been working at the facility for about 5 months and did not remember if she had been trained in Resident Rights and their rights to privacy. The Social Worker said when the Residents needed to make a telephone call, the facility would check the residents care plan to make sure they can contact the family and if they had a legal guardian, they would review the care plan to see if they are allowed to contact someone outside the facility. The Social Worker said there was a phone at the chapel. She said the residents also made calls at the nursing stations located on every floor of the facility. The Social Worker showed the state surveyor the telephone at the chapel, and it was not working. The Social Worker reviewed the policy and procedure on Resident Rights and their right to privacy with the state surveyor present. She said it was not appropriate for the residents to have personal phone calls in the hallway at the nursing station because this was a violation of the Residents privacy. She stated the negative outcome for the residents could be they did not feel comfortable while talking to their family or if they called a relative and they had grievances, they might not voice them fearing that staff or another resident would hear them talking on the phone. In an interview on 12/11/24 at 3:58 PM with the Administrator she stated there was a telephone available in the chapel area that the residents could use. The Administrator said that the telephone was working and explained the steps for making a phone call which consisted of dialing the telephone number, then pressing a call button at the top. The surveyor informed the Administrator LVN C, and the Social Worker had attempted to make a call, and they were not able to do so. The Administrator said that she would teach Resident #17 how to use the phone and to maybe install an accordion door at the entrance of the chapel to provide privacy. She said Resident #17's privacy was violated because he was using the phone in the hallway and there was no privacy there near the nurse's station. She said that the residents could feel embarrassed having a conversation when there's people around and they might not contact their relatives making them feel isolated. (continued on next page)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/12/24 at 9:30 AM, with DON, stated Resident #17 knew where to go to make private phone calls. The DON said the facility could remind the residents that they can make their phone calls in private at the chapel. She stated that they can also go into the activities area where they can place a call in private. The DON said that Resident #17's privacy was not respected because he made his call in the nurse's station in the presence of other residents and staff. In an interview on 12/12/24 at 8:51 AM with Resident #40, stated that whenever she needed to use the phone, she asked a staff to assist her. Resident #40 said she used the phone at the nurses' station to talk to her relatives. She said she would like to have privacy, but those were the only telephones available to call her family. She said that sometimes she felt embarrassed using the phone at the nurse's station because there were always people around in that area. Resident #40 said she would like to have her personal phone to have privacy when she calls her relatives. In an interview on 12/12/24 at 8:57 AM with Resident #34, stated she used to make phone calls when she was on the third floor at the nurse's station. Resident #34 said she would have to wait until there was nobody or less people near the station so that way, she could have privacy when using the telephone. Resident #34 said she would like to have her own phone in her room so that way she could have privacy when she speaks to her relatives. In an interview on 12/12/24 at 9:03 AM with LVN H, stated that she did not know the residents needed to have privacy when they made phone calls. LVN H said the facility had cordless phones for the residents to use which they could take to their room and have a phone call conversation in private. LVN H said she was trained in Resident Rights and their right to privacy, but she forgot to provide privacy for Resident #17 when she used the telephone. LVN H said the possible outcome for residents not being provided with privacy could result in them feeling embarrassed for making phone calls where they could be overheard by others, and this could also make them feel they don't want to call their relatives. Record review of the facility's policy titled Resident Rights, Social Services Manual 2003 revised 11/28/16, Revealed, the resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the president's own expense.

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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** 49850 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that include measurable objectives and time frames to meet residents' mental, nursing, mental and psychosocial needs that are identified in the comprehensive assessment for 2 of 22 residents (Resident #39, Resident # 33) reviewed for care plans. 1. The facility failed to implement the resident 's care and Resident #39 was not seen by the podiatrist, and her toenails were long . 2. The facility failed to develop a care plan that addressed Resident #33's wandering behavior. This failure could place residents increased risk of being unable to maintain their highest practicable physical well-being. The findings included: 1. Record review of Resident # 39's Admission Record dated 12/12/2024, reflected [AGE] year-old women who was originally admitted into the facility on [DATE], and readmitted on [DATE]. Record review of Resident # 39's Hospital History and Physical, date of service 10/28/2022 reflected resident #39 has diagnosis of fibromyalgia (body pain and tiredness), and Diabetes Mellitus. Record review of Resident #39's Quarterly MDS dated [DATE], revealed BIMS score of 14 demonstrating resident was cognitively intact. Active diagnoses: Diabetes and Peripheral Vascular Disease. Record review of Resident #39's Care Plan dated 12/03/2024, revealed Resident had Diabetes Mellitus. Intervention: Toenails should always be cut straight across, never cut corners. File rough edges with emery board. Refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails. Resident has Peripheral Vascular Disease r/t Diabetes Heart disease. Intervention Educate the resident on the importance of proper foot care including proper fitting shoes, wash and dry feet thoroughly, keep toenails cut, inspect feet daily, daily change of hosiery and socks. Record review of Resident #39's Physician's Order Summary did not have an order podiatrist service. Observation on 12/09/2024 at 10:35 AM, revealed Resident #39's toenails were yellow in color and chipped (missing part of the nail) and outgrown about 2-3 cm in length . In an interview on 12/11/24 at 11:29 AM LVN G revealed, a podiatrist comes every other month to cut the toenails for the residents. She said the CNAs do not provide toenail care. The Nurses will make emergency podiatrist appointments to send residents to the podiatrist office for emergency toenail care or make appointments with the podiatrist for those residents whose insurance does not cover in-house podiatry services. (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 on 12/11/24 at 11:38 AM with Resident #39, stated podiatrist that come in to cut her nails due to her diabetes. The last time the doctor was in to see residents was about a month and a half ago. Resident #39 stated she's told nurses periodically she needed to have her toenails cut them and no one came to cut her toenails. Resident cannot recall the names of who she told. In an interview and record review on 12/11/24 at 3:01 PM with ADON revealed, CNAs were responsible for reporting to the nurses when residents had long toenails. He said the CNAs had been trained to document in the Weekly Skin Assessments when residents had long toenails, so the nurses can schedule podiatry appointments as soon as possible. ADON reported the contracted podiatrist came to the facility every 3 months and they can also schedule emergency podiatry appointments as needed. The ADON checked the podiatrist's appointment binder and said he had not found an appointment for Resident #39. He said, We will schedule an appointment for Resident #39 as soon as possible. In an interview on 12/11/24 at 4:19 PM with the Social Worker, stated she took over the scheduling of podiatrist appointments about two weeks ago. The social worker stated Medical Records Clerk had not kept up with scheduling podiatry appointments prior to her taking over podiatrist appointments. She said the last visit from a podiatrist was on August 13, 2024. She said the podiatrist was supposed to come to the facility every 2 months. She said the nurses could schedule emergency podiatrist appointments and the residents would be transported to the podiatrist's office. Social worker stated Resident #39 had not been seen by the podiatrist in the past 5 months. Social workers stated she will need to do an in-service the nursing staff in notifying her when residents needed podiatry care so she could compile a list for the next podiatry visit. In an interview on 12/11/24 at 4:37 PM with the DON, revealed the facility had a podiatrist contract that provided services to the residents every 90 days. She said if a resident needed services prior to 90 days, the facility could schedule an emergency appointment. She said it was the responsibility of the CNAs to let the charge nurses know if they noted a resident had long toenails while being showered. She said the CNAs documented on the Shower Sheets if the resident needed toenail care. She said the nurses reviewed the Shower Sheets, or the CNAs could report to the nurses if a resident had long toenail, so the nurse could schedule a podiatry appointment as needed. In an interview on 12/12/24 at 09:05 AM LVN G, revealed with Resident #39 had not reported to him she had lone toenails. LVN G said the CNAs were responsible for reporting to the nurses when the residents had long toenails. He said the podiatrist came to the facility every 2 months and the nurses made a list of the residents that needed to be seen by the podiatrist. He said that the nurses also made appointments with the podiatrist for those residents who needed emergency toenail care. In an interview on 12/12/24 at 09:13 AM CNA F, revealed Resident #39 had not voiced any complaints about having long toenails. She said the CNA are trained to check for long toenails so the nurses can schedule the resident's to be seen by the podiatrist. She said the CNAs are not allowed to cut the toenails. She said the CNAs are responsible for checking for long toenails when they shower the residents and for notifying the nurses know if any resident needs toenail care. In an interview on 12/12/24 at 09:29 AM with Resident #39 stated she only had pain when her toenails got caught in the blanket or if the blanket puts pressure on her toes. She said she was showered on Tuesday, Thursday, and Saturday. The CNAs never offered to cut her toenails. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and record review on 12/11/2024 at 4:10 PM with MDS Coordinator revealed the Social Worker was responsible for completing the Behavior Section of MDS assessment. She confirmed that the Care Plan dated 12/10/2024 did not address the wandering behavior. She stated, I will add the wandering behavior to the care plan right away. Interview on 12/11/2024 at 4:10 PM with the Social Worker revealed she had completed the Behavior Section of the Quarterly MDS dated [DATE] and had completed the care plan. She said she was informed of residents' behaviors at the morning meetings and used the information to fill out MDS Behavior Section. She said the facility did not have a system in place for the nurses on the floor to report to her resident behaviors. Interview on 12/12/2024 at 11:22 AM with the DON revealed Social Services, MDS Nurses and Charge Nurses on the floor were responsible to monitor and ensure care plans were being implemented. She stated that residents who are identified as elopement risks are assessed quarterly. Any charge nurse can complete assessment. She states that once resident is identified as elopement risk their information is placed in elopement binders on every floor and in the reception area as a precaution. She states that CNAs and nurses have access to Kardex system which identifies a summary of care plan task and interventions that are supposed to be implemented. -Record review of Kardex information provided by DON dated 12/12/2024 for Resident #33 revealed that wandering behavior interventions had been added to behavior/mood section. -Record review of the facility nursing policy and procedure manual on Comprehensive Care Planning revealed, each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, and psychosocial needs. The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented. 51010

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49850 51012 Based on observation, interview, and record review the facility failed to provide proper treatment and care to maintain mobility and good foot health in accordance with professional standards of practice, including to prevent complications from the resident's medical conditions and if necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments for 2 of 22 residents (Resident #39, Resident #62) reviewed for foot care. --The facility failed to provide access to podiatrist for Resident #39. -The facility failed to provide access to podiatrist for Resident #62. This failure could place residents at risk of poor foot hygiene and a decline in residents' physical condition. Findings include: 1. Record review of Resident # 39's Admission Record dated 12/12/2024, reflected [AGE] year-old women who was originally admitted into the facility on [DATE], and readmitted on [DATE]. Record review of Resident # 39's Hospital History and Physical, date of service 10/28/2022 reflected resident #39 has diagnosis of fibromyalgia (body pain and tiredness), and Diabetes Mellitus. Record review of Resident #39's Quarterly MDS dated [DATE], revealed BIMS score of 14 demonstrating resident was cognitively intact. Active diagnoses: Diabetes and Peripheral Vascular Disease. Record review of Resident #39's Care Plan dated 12/03/2024, revealed Resident had Diabetes Mellitus. Intervention: Toenails should always be cut straight across, never cut corners. File rough edges with emery board. Refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails. Resident has Peripheral Vascular Disease r/t Diabetes Heart disease. Intervention Educate the resident on the importance of proper foot care including proper fitting shoes, wash and dry feet thoroughly, keep toenails cut, inspect feet daily, daily change of hosiery and socks. Record review of Resident #39's Physician's Order Summary did not have an order podiatrist service. Observation on 12/09/2024 at 10:35 AM, revealed Resident #39's toenails were yellow in color and chipped (missing part of the nail) and outgrown about 2-3 cm in length . In an interview on 12/11/24 at 11:29 AM LVN G revealed, a podiatrist comes every other month to cut the toenails for the residents. She said the CNAs do not provide toenail care. The Nurses will make emergency podiatrist appointments to send residents to the podiatrist office for emergency toenail care or make appointments with the podiatrist for those residents whose insurance does not cover in-house podiatry services. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Grace Pointe Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2301 N Oregon St El Paso, TX 79902	

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/11/24 at 11:38 AM with Resident #39, stated podiatrist that come in to cut her nails due to her diabetes. The last time the doctor was in to see residents was about a month and a half ago. Resident #39 stated she's told nurses periodically she needed to have her toenails cut them and no one came to cut her toenails. Resident cannot recall the names of who she told. In an interview and record review on 12/11/24 at 3:01 PM with ADON revealed, CNAs were responsible for reporting to the nurses when residents had long toenails. He said the CNAs had been trained to document in the Weekly Skin Assessments when residents had long toenails, so the nurses can schedule podiatry appointments as soon as possible. ADON reported the contracted podiatrist came to the facility every 3 months and they can also schedule emergency podiatry appointments as needed. The ADON checked the podiatrist's appointment binder and said he had not found an appointment for Resident #39. He said, We will schedule an appointment for Resident #39 as soon as possible. In an interview on 12/11/24 at 4:19 PM with the Social Worker, stated she took over the scheduling of podiatrist appointments about two weeks ago. The social worker stated Medical Records Clerk had not kept up with scheduling podiatry appointments prior to her taking over podiatrist appointments. She said the last visit from a podiatrist was on August 13, 2024. She said the podiatrist was supposed to come to the facility every 2 months. She said the nurses could schedule emergency podiatrist appointments and the residents would be transported to the podiatrist's office. Social worker stated Resident #39 had not been seen by the podiatrist in the past 5 months. Social workers stated she will need to do an in-service the nursing staff in notifying her when residents needed podiatry care so she could compile a list for the next podiatry visit. In an interview on 12/11/24 at 4:37 PM with the DON, revealed the facility had a podiatrist contract that provided services to the residents every 90 days. She said if a resident needed services prior to 90 days, the facility could schedule an emergency appointment. She said it was the responsibility of the CNAs to let the charge nurses know if they noted a resident had long toenails while being showered. She said the CNAs documented on the Shower Sheets if the resident needed toenail care. She said the nurses reviewed the Shower Sheets, or the CNAs could report to the nurses if a resident had long toenail, so the nurse could schedule a podiatry appointment as needed. In an interview on 12/12/24 at 09:05 AM LVN G, revealed with Resident #39 had not reported to him she had lone toenails. LVN G said the CNAs were responsible for reporting to the nurses when the residents had long toenails. He said the podiatrist came to the facility every 2 months and the nurses made a list of the residents that needed to be seen by the podiatrist. He said that the nurses also made appointments with the podiatrist for those residents who needed emergency toenail care. In an interview on 12/12/24 at 09:13 AM CNA F, revealed Resident #39 had not voiced any complaints about having long toenails. She said the CNA are trained to check for long toenails so the nurses can schedule the resident's to be seen by the podiatrist. She said the CNAs are not allowed to cut the toenails. She said the CNAs are responsible for checking for long toenails when they shower the residents and for notifying the nurses know if any resident needs toenail care. In an interview on 12/12/24 at 09:29 AM with Resident #39 stated she only had pain when her toenails got caught in the blanket or if the blanket puts pressure on her toes. She said she was showered on Tuesday, Thursday, and Saturday. The CNAs never offered to cut her toenails. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review on 12/12/24 at 10:37 AM Shower Sheets for Resident #39 did not document resident had long toenails. In an interview on 12/12/24 at 11:14 AM with the DON, revealed observation completed by the CNAs during showers and the nurses assessments must be completed every shift. She said CNAs should know that they need to report long toenails to nurses right away and document this in the resident's electronic record. The DON stated there was no documentation in the electronic record for Resident #39 that reflected she had long toenails. Record review on 12/12/24 at 03:20 PM of resident #39's Physician's Progress Notes revealed no documentation of toenail care or a podiatrist note. Record Review on 12/12/24 at 3:50 PM of Resident #39's Shower Sheet from November 1, 2024 through December 10, 2024 revealed no documentation of toenails needing attention or a podiatrist appointment. 2. Record review of Resident # 62's Admission Record dated 12/15/2024, reflected resident [AGE] year-old female who was admitted into the facility on [DATE]. Record review of Resident # 62's Hospital History and Physical, dated 11/15/2024 reflected resident has diagnoses multifactorial encephalopathy (a condition where brain function is impaired due to a combination of several factors, leading to symptoms like confusion, memory problems, or personality changes). Record review of Resident #62's Quarterly MDS revealed resident's BIMS score is 3 indicating severe impaired cognition. Resident's active diagnoses include non-Alzheimer's dementia and need for assistance with personal care. Record review of Resident #62's Care Plan revealed ADL Deficit. Interventions: included checking toenail length and trim and clean on bath day and as necessary. Report changes to the nurse, and if diabetic, nurse is to provide toenail care. Record review of Resident #62's most recent Podiatrist progress note dated 08/13/24, revealed Physical Exam Resident's toenails are long, moderately thick, discolored with subungual debris (debris that is trapped under the nails). The podiatrist's progress notes physical exam also revealed remaining nails are long, dystrophic Dystrophic nails (nails that are deformed, discolored, or splitting caused by injury, infection). Podiatrist follow-up recommended for resident 3-6 months or as needed for a more acute problem. In an observation on 12/09/24 at 4:00 PM, revealed Resident #62's toenails were long, thick yellow toenails, and the left big toe toenail was black color and long. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/11/24 at 11:28 AM with CNA A, revealed nail care was provided to residents during shower which schedules are as follows: Monday, Wednesday, and Friday are A Beds, and Tuesday Thursday and Saturday are B beds. CNA A stated CNA's did not provide toenail care to diabetic residents and they were trained to notify the nurses when the diabetic residents had long toenails. CNA A stated the podiatrist trimmed the toenails for diabetic residents. She states she is aware resident #62 has long toenails and one of the toenails appears black which CNA A states she noticed 2 weeks ago. CNA A they had been trained to check resident toenails when the residents are showered and to document in the Shower Sheets if residents have long toenails. The Shower Sheets are given to the nurses and the assigned nurses will sign off on the Shower Sheet and they make the arrangements for the residents to be seen by the podiatrist. CNA A stated the Podiatrist was pending to come and see resident #62. In an interview 12/11/24 at 11:31 AM with LVN B, revealed that it was the protocol for CNAs to assess resident's nails during showers and CNA's can clip toenails except for the diabetic residents. LVN B statds CNA's assessed nails once a week and documented their findings on Shower Sheets that had a drawing of a human body so the CNA's can mark and add notes of concern or change. LVN B stated the shower sheets were turned in to the ADON. LVN B said diabetic resident were seen by podiatrist every 3 months and the Social Worker moitored the podiatry services provided to the residents. In an interview on 12/12/24 at 09:52 AM with LVN B, revealed Resident #62 did not like to be touched and yelled when the CNAs attempted to provide toenail care. LVN B states Resident #62 had not had a podiatrist appointment for approximately 3 months. LVN B stated ingrown toenails place the resident at risk to infection, or injury caused by the long toenails. In an Interview on 12/11/24 at 03:56 PM with ADON, revealed diabetic residents are seen by a Podiatrist every 3 months. ADON stated that the previous Medical Records Clerk was responsible for scheduling podiatrist appointments for residents and had retired, and now the Social Worke had been appointed to make the podiatrist appointments for the residents. ADON stated if resident's nails are really bad, an appointment is made to have concerns addressed by the podiatrist. ADON said Shower Sheets are provided to the CNAs, so they can write any skin concerns, long toenails and notify the nurse. ADON states the nurse notify the Social Worker and she was responsible for scheduling podiatrist appointments. ADON stated the risk of lack of nail care includes the long untrimmed nails affect resident's circulation and risk for pain. In an interview on 12/11/24 at 4:20 PM with the Social Worker, revealed she just took over the responsibility of scheduling podiatrist appointments approximately two weeks ago for the residents. SW stated the previous Medical Records Clerk was responsible for making the podiatry appointments, and was not keeping up with the appointments. She said the Podiatrist was coming to the facility every 2 months, but there had not been a podiatrist visits for approximately 5 months. Social Worker stated if emergency podiatry were needed for the residents, the nurses could schedule emergency podiatrist appointment and the facility transporter took the residents to the appointments. Social Worker stated resident #62 was not scheduled and would be following up to see if the nurses provided toenail care. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Pointe Wellness Center	2301 N Oregon St El Paso, TX 79902

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/12/24 at 11:33 AM with DON, revealed Resident #62 was scheduled to see the diatrist in January 2025. DON states nurses would check the CNA Shower Sheets to verify which residents had long toenails and needed to see the podiatrist. DON states nail care would appear in the personal hygiene tasks in the residents electronic record. DON said CNAs should check the residents every shift, and document in the electronic record if residents have long toenails. This prompt is then to be reported to the charge nurses. Record Review of Facility Policy revealed Foot Management is the daily assessment. Policy revealed foot care is especially important in those residents with diabetes mellitus or peripheral circulatory conditions because of their susceptibility to infection and skin breakdown. Policy notated if required, trimming of the toenails is performed by a podiatrist. Record Review of facilities Nursing policy and procedure manual dated 2003, revealed policy on Foot Care-Foot Management is the daily assessment, bathing, lubrication, and protection of the feet. Foot care is especially important in those residents with diabetes mellitus, or peripheral circulation conditions because of their susceptibility to infection and skin breakdown. If required, trimming of the toenails is performed by a podiatrist. Procedure: 1. Request referral to podiatrist if nail trimming is needed. 16. Daily assessment of the feet should be done when care is given. Goals:1. The resident will maintain intact skin integrity. 2. The resident will be free from infection. 3. The resident will remain free from injury to the feet. Procedure: 1. Become familiar with medical conditions that compromise circulation in the feet and assess the need for nail trimming. Request referral to podiatrist if nail trimming is needed.

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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** 49850 51012 Based on observation, interview, and record review the facility failed to ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice for 2 (Resident #26 and Resident #39) of 2 residents observed for oxygen management. -The facility failed to keep the oxygen concentrator filter clean for Resident #26. --The facility failed to keep the oxygen concentrator filter clean for Resident #39. These failures could place residents at risk of a significant reduction in the quality of oxygen being delivered, inadequate oxygen support, and decline in health. Findings included: 1. Record Review of Resident #26's Admission Record dated 12/12/24, revealed resident is [AGE] year-old male with original admitted into the facility 3/18/2018 and readmitted [DATE]. Record Review of Resident #26 MDS revealed BIMS score of 10, meaning moderate cognitive impairment. MDS revealed medical diagnosis of Chronic Obstructive Pulmonary Disease (is a common long-term lung disease that makes it difficult to breathe). Record review of Resident # 26's Hospital History and Physical, dated 11/15/24 revealed resident had medical history of COPD. Record Review of Resident #26's Care plan revealed interventions of oxygen supplementation therapy is to administer as ordered. Care plan noted resident is at risk for respiratory infections/distress related to Chronic Obstructive Pulmonary Disease. Interventions include keeping the room cool and free of irritants. Record Review of Resident #26's Physicians Order Summary dated 12/12/24 reveal oxygen order of @ 3 l/min via nasal cannula continuously r/t signs and symptoms of Shortness of breath and dyspnea every shift related to Chronic Obstructive Pulmonary Disease with Acute Exacerbation. In an observation on 12/09/24 at 9:47 AM revealed Resident #26 was lying in bed with head of bed elevated at 45 degrees and call bell was within reach. He was had a nasal cannula and was receiving oxygen via oxygen concentrator at 3 liters per minute. The air filter to the concentrator was observed dirty with debris. In an interview on 12/12/24 at 9:41 AM with CNA A, revealed the oxygen concentrators are cleaned by the CNA's every week or as needed. CNA A said that she believed the oxygen concentrator filters were cleaned every Friday during the night shift. She states the residents are at risk for infection if oxygen concentrator filters are not cleaned. (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 on 12/12/24 at 9:46 AM with LVN B, revealed the night shift nurses or CNAs are assigned to clean the oxygen concentrator filters every Friday. LVN B said the CNA's and Nurses were responsible for checking the oxygen concentrator filters. LVN B said the potential risk for oxygen concentrator filters not being clean includes potential fire hazard and at risk of infection due to bacteria in filters. In an interview on 12/12/24 at 11:35 AM with DON, stated the nurses were responsible for checking Resident #26's oxygen concentrator filter to ensure the filter was kept clean. The DON said the order for weekly cleaning of the oxygen filter had been discontinued on 0/31/24 by a nurse that was no longer employed at the facility. The state surveyor requested a copy of the physician's order to discontinued cleaning of oxygen concentrator filter order and was not provided prior to exit. 2. Record review of Resident # 39's face sheet dated 12/12/2024, reflected [AGE] year-old women who was originally admitted into the facility on [DATE], and readmitted on [DATE]. Record review of Resident # 39's Hospital History and Physical, date of service 10/28/2022 reflected resident #39 has diagnosis of hypoxia (is a dangerous condition that occurs when your body tissues don't have enough oxygen) on nasal cannula oxygen, morbid obesity. Record review of Resident #39's Quarterly MDS dated [DATE], revealed residents BIMS score is a 14 indicating cognition is intact. Resident's active diagnosis includes Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease (a long-term condition that prevents the lungs and respiratory system from working properly), and Respiratory Failure . Record review of Resident #39's Care Plan dated 12/03/2024, with a Focus: The resident has Shortness of Breath Anxiety, Hypoxia asthma, dependence on supplemental oxygen. Goal: The resident will maintain normal breathing pattern as evidenced by eupnea (normal healthy breathing), normal skin color, and regular respiratory rate/pattern. Interventions: Maintain a clear airway by encouraging resident to clear own secretions with effective coughing. If secretions cannot be cleared, suction as needed to clear secretions. Monitor /document changes in orientation, increased restlessness, anxiety, and air hunger. Monitor/document/Report breathing abnormalities to MD: Bradypnea (abnormal slow breathing), Tachypnea (quick shallow breathing), Hyperventilation, Kussmaul's respirations (abnormal breathing pattern characterized by rapid, deep breathing at a consistent pace. It's a sing of medical emergency), Cheyne-Stokes (abnormal breathing pattern), Apneusis (a type of abnormal breathing pattern), Biot's respirations (is a breathing pattern that has periods of regular deep breathing), Ataxic patterns (is an abnormal pattern of breathing characterized by complete irregularity of breathing) Notify the charge nurse the resident is having trouble breathing. Care Plans did not address the cleaning of the oxygen concentrator filter on a weekly basis. Record review of Resident #39's current Physician's Orders dated 12/12/2024, revealed facility did not have an order to clean the oxygen concentrator filter on a weekly basis. Review of Discontinued Physician's Orders revealed the orders to clean the oxygen concentrator filter on a weekly basis had been discontinued on 09/01/24. Observation on 12/09/24 at 9:40 AM, revealed Resident #39's oxygen concentrator filter covered with a thick coat of dust. (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 on 12/12/24 at 9:05 AM with LVN G Charge Nurse reveled, that nursing must ensure they are following resident care plans. LVN G said the concentrator oxygen should be cleaned by the night shift every week on Friday, that includes cleaning the filter in the back of the oxygen concentrator. LVN G said, If any staff member sees that the oxygen concentrator filter needs to clean, we are not going to wait until Friday night for them to clean it, so the responsibility falls on all staff. In an interview on 12/12/24 at 11:02 AM with Oxygen Concentrator Care Contact Services, stated the oxygen concentrator filter should be cleaned with soap and water and let air dried completely before usage. The oxygen concentrator filter should be inspected and clean weekly. The state surveyor was provided a copy of the manufacturer's manual documented the oxygen concentrator filter should be inspected and clean weekly with soap and water. The oxygen concentrator filter should air dry completely before usage. In an interview on 12/12/24 at 11:14 AM, with the DON stated oxygen concentrator filters should be cleaned on Fridays during night shift. DON verified resident's orders to clean the oxygen filter on a weekly basis had been discontinued on 9/12/24. She did not know why the order had been discontinued. Record Review of Oxygen Concentrator Manufacturer's Manual documented, do not allow either the air intake or the air outlet vents to become blocked. This can cause the Oxygen Concentrator to overheat and impair performance. Do not operate the Oxygen Concentrator without the air intake filter in place. If a second filter is provided, insert the replacement filter before you clean the dirty filter. Clean the dirty filter in a warm soap and water solution then dry thoroughly prior to use. Record Review of facility policy dated March 21, 2023, revealed Oxygen concentrators should be cleaned according to manufacturer recommendations. Policy revealed to change or clean oxygen concentrator filters according to manufacturers' recommendations.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51012 Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident; and failed to have an established system in place for accurate reconciliation of controlled substances for 2 of 4 medication carts that had controlled substances and safe and secure storage of medications for of 2 of 3 medication carts reviewed for medication storage. -The facility failed to ensure Licensed staff signed the Controlled Substance Medication Count Record after counting and verifying that all controlled substances in the medication cart had been accounted for with the on-coming and off-going nurses. -The facility failed to ensure liquid medication stored in medication carts on two halls (200 and 400) did not have dried drippings on the sides of the bottles. - The facility failed to ensure medication carts located in 200 Hall and 400 Hall stored medications separately according to routes of administration in the medication cart storage bins. -The facility failed to place a change of direction label on the pharmacy label when physician's order was changed. This failure could result in drug diversion of controlled substances. Findings include: Record Review revealed Controlled Medication Count Record for Rooms 201-214 revealed blanks in documentation on 12/12/24 for the on-coming Nurse in the evening and off-going nurse on the night shift. 1. In an interview and record review on 12/12/24 at 10:20 AM with LVN D revealed she had signed the Controlled Substance Medication Count Record prior to counting controlled substance with the on-coming nurse on the evening shift. LVN D stated I must have signed the Controlled Medication Count Record by accident. She stated the risk for signing Controlled Medication Count Record prior to counting controlled substances with the on-coming nurse could result in drug diversion. 2. In an observation and interview on 12/11/24 at 10:00 AM, with LVN G 2 bottles of Geri-Tussin Cough Syrup had dry drippings on sides of the bottle. LVN G stated, I will immediately clean the sides of the bottle. There was a bottle of Liquid Protein that was not dated when opened, according to the manufacturer's label on the bottle. The manufacturer's label on the bottle said to date the bottle when opened and to discard the bottle 3-month after opening. There was a bottle of Acidophilus Probiotic Dietary Supplement and a bottle of Vitamin C were stored with external medications in the bottom drawer of the medication cart. The Sharps Disposal Container attached to side of the medication cart was filled past the recommended line on the Sharps container. LVN G stated he was about to change the Sharps container. LVN G immediately replaced the full Sharps Disposal Container. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 12/11/24 at 10:15 AM, with LVN D on the 2nd floor revealed Medication cart for rooms 217-231 had a bottle of Geri-Tussin Cough Syrup had dried drippings on the sides of the bottle. LVN D stated, I will clean it. It was observed that nasal spray was stored with lubricant jelly in same drawer without a divider. In an interview on 12/12/24 at 11:50 AM with the DON revealed she completed medication cart audits on a monthly basis. She said the medication cart audit included checking that medications were stored by routes of administration. DON said controlled substance counts should be completed at the change of shift by the on-coming and off-going nurse, and both nurses should sign and date the Controlled Medication Count Record immediately after verifying the counts were correct. The DON stated the risk for not counting controlled substances at the change of shift according to facility's policy & procedure can result in potential for drug diversion. The DON stated, the nursing staff are trained on an annual basis and upon hire on counting controlled substances according to facility's policy & procedures. DON stated the last in-service on Counting Controlled Substance at the change of shift for the nurses was completed on September 2024. Pharmacy Label: In an observation and interview on 12/10/24 3:25 PM with LVN C during medication pass observation revealed pharmacy label for Buspirone for Resident #33 documented Buspirone HCl give one 5 mg tablet by mouth three times a day. Review of the electronic Medication Record with LVN C revealed Buspirone HCL 5 mg to be given three times a day had been discontinued on 11/08/24. The electronic Medication Record revealed a new Physician's Order dated 11/25/24 for Buspirone HCl tablet give 10 mg by mouth two times a day at 3:00 PM and 9: 00 PM. It was observed that LVN C placed a change of direction label on the medication blister packet pharmacy label after the state surveyor had noted the medication container did not have a change of direction label. LVN C stated the risk of not placing a change of direction label on the medication blister [NAME] could result in not administering the medication according to physician's orders. In an interview on 12/11/24 at 4:01 PM with the LVN G ADON, revealed licensed staff had been trained to immediately place a change of direction label on the medication blister packet pharmacy label when there was a change in physician's order. He said if nurses failed to place a change of direction label on the blister packet pharmacy label, it placed the resident at risk of not getting the prescribed dose of the medication. Record Review of facility's policy revealed all current medications and dosage schedules are to be listed on the resident's current medication administration record. Record Review of facility's Pharmacy Manual Policy & Procedure dated 2003 on Controlled Drugs Audit and Accountability revealed the audit sheets is where nursing staff will sign to indicate that the controlled drugs were audited and that the responsibility of accountability of the controlled drugs is being changed to a different nursing staff. This form has columns to indicate the total number of controlled audit sheets present at each shift change audit. Record Review of Coaching Form dated 12/12/24 provided by DON to state surveyor for LVN D revealed she had been counseled regarding signing Controlled Substance Count book in advance prior to counting controlled substances with the on-coming nurse.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51012 Based on observation, and interview, the facility failed to provide pharmaceutical services that assured the accurate acquiring, receiving, dispensing of medications. -The facility failed to ensure opened bottles of Acidophilus Probiotic Dietary Supplement was refrigerated after opening in the 400 Hall medication cart. These failures could place residents at risk for not having their medications available or at decrease efficacy of medications by not following manufacturer's specifications, and cross contamination. The findings included: 400 Hall In an observation on 12/11/24 at 10:34 AM of Medication Aide's medication cart on the 4th floor with LVN B, revealed bottle of Acidophilus Probiotic Dietary Supplement was dated as opened on 11/03/24. LVN B confirmed the manufacturer's label on the bottle said to Refrigerate after opening. LVN B immediately removed the medication bottle from the medication cart.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51010 Based on observations, interviews, and record reviews the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for kitchen sanitation and food storage -The facility failed to store foods in the refrigerator in sealed containers. -The facility failed to keep 1 of 23 spice bottles stored on metal storage rack completely sealed. The facility failed to keep the kitchen ceiling tiles free of dried brown water stains throughout kitchen. -The facility failed to keep ceiling vents free of lint that were directly above food preparation area. - The facility failed to replace missing ceiling tiles in room between the kitchen and Dishwashing Room and in the Dry Storage Room. - The facility failed to maintain Vegetable sink in operational condition. -The facility failed to follow the Three-Compartment Sink Procedures that specified procedure to sanitize pots and pans. -The facility failed to maintain a working trash can next to the hand washing sink in the kitchen. These failures could affect residents by placing them at risk of food borne illnesses. Finding Included: Observation on 12/08/24 at 8:10 AM during the initial tour in the kitchen with the Dietary Manager revealed: -Plastic bag of shredded cheese stored in the refrigerator was not completely sealed. - Two metal racks used to store food in the room between the kitchen and dish washing room revealed 1 spice bottle opened and not sealed. -Missing ceiling tile in room between kitchen and dishwashing room along with dried water stains on surrounding ceiling tiles. -Missing ceiling tiles in dry food storage room along with water stains on surrounding ceiling tiles. - Lint on ceiling directly above food preparation area. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Trash can next to the hand sink had a cracked lid and the food pedal was not working. -In an interview on 12/11/24 at 03:21 PM with the Dietary Manager, Dietary supervisor stated all opened food containers needs to be placed in sealed plastic bags or sealed containers, that are labeled and dated accordingly. She stated the dietary staff had been trained on food storage and know that all food containers are completed sealed prior to storing them on the shelves or the refrigerator. She said the risk of having improperly closed containers in kitchen could lead to cross contamination of foods, and cause foodborne illnesses. She stated several ceiling tiles had been removed several weeks ago due to water leak on resident floors. She stated that risks posed by this include a safety hazard for staff, dirt and debris that can fall on food that is being prepared,, it She said this can result in dust build up on surfaces of food containers stored in dry food storage, and can allow for bugs or insects to get in the kitchen. -Record review of facility Dietary Services Services Policy & Procedure Manual dated 2012 on Food Storage and Supplies revealed all facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. We will ensure storage areas are clean, organized, dry and protected from vermin and insects. Open packages of food are stores in closed containers with covers or in sealed bags and dated as to when opened. Three Compartment sink: -Observation, interview and record review on 12/08/24 at 12:10 PM in the presence of the Dietary Manager, revealed [NAME] H washing pots and pans in three compartment sink. It was observed that dietary staff washed pan, rinsed and dipped it in and out quickly from sanitizer compartment. The surveyor asked dietary cook how long dishes should be placed in sanitizer compartment, he stated for at least 10 seconds. It was observed the Three-Compartment Sink Procedure was posted directly above the Three-Compartment sink. [NAME] H and the Dietary Manager confirmed that instructions stated the pots and pans should be completely immersed in the sanitizer solution for at least one minute. [NAME] H stated that he usually left the pots and pan in sanitizer for 1 minute, but had not done it, because he got nervous. -In an interview with Registered Dietitian, revealed that because of the type of sanitizing solution that was being used at the facility, it would indeed have to be left in solution for 1 minute. -In an interview with Dietary Manager stated, dietary staff had been trained to follow Three-Compartment Sink procedure that was posted above the sink as an easy reminder for staff. She stated, the risk of not sanitizing dishes for specified amount of time can cause cross contamination which can lead to foodborne illnesses. -Record review of Three Compartment sink procedure instructions posted above the Three Compartment Sink revealed, sanitize with warm water 65-75 degree F. Fill the sanitizer compartment with proper sanitizer solution. Completely immerse cleaned items in the sanitizer solution for at least one minute. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Record review of facility dietary services policy and procedure manual 2012 on Equipment Sanitation states all equipment and utensils shall be sanitized by one of the following methods: Immersion for at least one-half minute in clean, hot water at a temperature of at least 180 degrees F. Immersion for a period of at least one minute in a sanitizing solution containing at least 50 ppm of available chlorine at a temperature not less than 75 degrees F. 2. Observation on 12/08/24 at 8:10 AM during the initial tour in the kitchen with the Dietary Manager revealed, the Vegetable Sink was not working. There was a sign posted above the Vegetable Sink that documented Vegetable Sink was not working. The trash can next to the hand sink had a cracked lid and the food pedal was not working. In an interview on 12/11/24 at 03:21 PM with the Dietary Manager, revealed the trash can had broken a couple of days ago and she had reordered a new trash that was pending delivery. She said, the risk of having a working trash can lead to contamination of hands by lifting the trash can lid to throw away used paper towels. She stated the vegetable sink has been out of order for a year, and that vegetables were washed in the three compartment sink. She said the risk of not having a designated sink for washing vegetables could result in cross contamination and improperly washed vegetables that could possibly lead to foodborne illnesses. Record review of the facility's Dietary Services policy & procedure Manual dated 2012 revealed policy & procedure on Equipment Sanitation revealed We will provide clean and sanitized equipment for food preparation. The facility will clean all food equipment in a sanitary manner. Procedure: Pots and Pans: All equipment and utensils shall be sanitized by one of the following methods: Immersion for at least one-half minutes in clean, hot water at a temperature of at least 180 degrees F. Immersion for a period of at least one minute in a sanitizing solution containing: At least 50 ppm of available chlorine at temperature not less than 75 degrees F.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49850 51012 Based observations, interviews, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections during laundry room observation, and 1 of 1 treatment cart observed for Infection Control. -The facility failed to ensure staff performed hand hygiene when passing out food trays. -The facility failed to ensure opened packages of gauze non-sterile sponges were stored in sealed plastic bags. -The facility failed to ensure facility staff did not store personal belongings on a clean linen table shelf. These failures could place residents at risk for cross contamination and the spread of infection. Findings included: Hand Hygiene: In an observation on 12/09/24 at 12:48 PM LVN D was observed distributing meal trays, after distributing four meal trays LVN D repositioned a resident in her wheelchair and then continued to pass out meal trays to other residents. LVN D did not perform any hand hygiene after repositioning of resident. In an Interview on 12/09/24 at 12:33 PM LVN D Charge Nurse, stated nursing staff had been trained to sanitize hands after passing each meal tray and to perform hand hygiene when repositioning a resident. LVN D stated it was important to perform hand hygiene between residents to prevent cross contamination. In an Interview on 12/11/24 at 11:29 AM LVN G charge nurse, revealed the process of performing hang hygiene during dining. There is always a person that looks at the food trays to see if the correct meal is the same as the food slip that is provided, and then the other staff that pass the meal trays out should perform hand sanitation at lease with every two meal trays. If a reposition of a resident is needed during that time, then staff will reposition the resident and then go and wash their hands and then come back to finish passing out the meal trays. Reliance is always done every month on different topics, but staff do them for hand washing as well. LVN G could not state a time specifically on how often they get in-services on hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/12/24 at 09:17 AM CNA F stated, Staff are trained to sanitize or perform hand hygiene at least after every 2 meal trays. Staff are trained to hand sanitize either in the room or in dining, because then you can transfer infections to other residents and that's a huge risk for cross contamination. Staff get trained every 3-6 months in hand washing and if needed more often. CNA F Stated that the DON, ADON, or charge nurses will come and teach them how to perform hand hygiene during in-services. In an interview on 12/12/24 at 11:14 AM DON, stated in services are done on infection control monthly, staff should be performing hand hygiene or hand sanitization before passing meal trays, especially right after repositioning of a resident. The risk of not performing hand hygiene would be infection control of cross contamination to other residents. Record review dated 12/12/2024 at 12:12 PM, DON provided of in-service record dated 11/19/2024 for infection control, revealed LVN D attended in-service training on hand hygiene. Review of the facilities Infection Control Policy and Procedure Manual AD 03-1.0, dated 2019 revealed Subject: Preventing Spread of Infection. Policy: The Facility will require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. The intent of this policy is to assure that the facility develops, implements, and maintains an infection prevention and Control Program in order to prevent, recognize, and control, to the extent possible the onset and spread of infection with the facility. The program will implement hand hygiene (hand washing) practices consistent with accepted standards of practice, to reduce the spread of infections. Treatment Cart In an observation and interview on 12/11/24 at 10:20 AM with Treatment Nurse revealed 1 of 1 treatment cart located in 200-hall contained an open package of gauze non-sterile sponges not sealed. Treatment nurse states packages should be sealed to prevent cross contamination. Laundry Observation on 12/11/24 at 2:39 PM, revealed an staff personal belongings were stored in a shelf were they stored clean divider curtains and linen. In an observation and Interview on 12/11/24 at 2:46 PM with Housekeeping Supervisor via telephone video call in the presence of the Administrator revealed two large plastic bags stored on the floor next to the clean linen cart that contained clothing and a blankets. The Housekeeping Supervisor stated, She did not know why the bags were stored on the floor. She said, I haven't seen that before. The Housekeeping Supervisor stated nothing should be stored on the floor and clean linen should be stored in covered linen carts. She said laundry staff should not store their personal belonging in clean linen. The Housekeeping Supervisor stated the laundry staff had been trained to store their personal belongings in their lockers. She said, storing staff's personal belongings in the clean linen resulted in cross contamination of the clean linen. In an observation and interview on 12/12/24 at 11:05 AM with housekeeping staff revealed two large plastic bags were stored on the floor in the clean linen room. She stated that storing the bags of clothing on the floor puts residents at risk as it is cross contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of facility policy note that all clean linen will be stored in a secured area. Policy notes the linen cart will be covered.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49854 Based on observation, interviews and record reviews the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public for 3 of 3 facility floors reviewed for environment and 1 of 1 kitchen reviewed for safe operating equipment. -Resident rooms had loose closet doors in need of repair. This failure could affect residents, placing them at risk of living in an unsafe, uncomfortable environment and decreased quality of life due to poor conditions of the facility interior and exterior; and potential for injury to residents and staff by not maintaining essential equipment in safe operating condition. Findings includes: 1. Observation on 12/09/24 at 9:54 AM during initial rounds revealed: -Rooms 219, 417 and 428 did not have sliding closet doors. -rooms [ROOM NUMBERS] closet doors were off the double track and did not have the Sliding Closet Door Bottom Guide to keep the closet doors in place when opened. -room [ROOM NUMBER], 210, 214, 217, 218, 226 and 418: closet doors were off the double track and did not have the Sliding Closet Door Bottom Guide. The closet doors were leaning towards the inside of the closet. According to https://hardwarehut.com the Sliding Closet Door Bottom Guide prevents the closet doors from swinging in or out, and ensuring smooth movement by guiding the door along its path while preventing it from derailing or damaging the walls and baseboards. In an interview on 12/11/24 at 2:55 PM with the Social Worker stated she did not know why there were missing or had broken closet doors in the residents' rooms. The Social Worker stated she had observed loose closet doors in some of the residents' rooms but she had not communicated this to the Administrator, Maintenance Supervisor or to the DON. The Social Worker stated there was a risk of the closet doors falling on top of a resident causing injury or if the doors were stuck and a the residents attempted to open the closet doors, they could injure their fingers. In an interview on 12/11/24 at 4:40 PM with the Administrator, stated the residents needed to have doors on their closets because it's a privacy issue and it contributed to a homelike environment for the residents. The administrator stated the closet doors that are off the double track could be a hazard if the closet doors fell on a resident causing injuries. The Administrator stated she was going to talk to the Maintenance Supervisor to have the residents' closet doors inspected right away. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations and interview on 12/12/24 at 10:37 AM with Maintenance Supervisor, stated he had received training on Residents' Safety. The Maintenance Director said the closet doors would not be able to fall off the double track because they have a lock at the top. The Maintenance Director stated closet doors should be the double track because the closet doors could fall on top of a resident causing injuries, if a resident pulled on the door when attempting to open the closet doors. During an observation on 12/10/24 at 10:10 AM, with the Maintenance Director in room [ROOM NUMBER], revealed the closet door was completely off of the double tracks and did not have the Sliding Closet Door Bottom Guide. The closet doors were touching the tile floor. During an observation on 12/10/24 at 10:25 AM, with the Maintenance Director in room [ROOM NUMBER], revealed the closet doors were jammed and did not open. The Maintenance Director demonstrated to the state surveyor that the closet doors were jammed, because there was a box in the closet that was pushing closet door outward since there was not a Sliding Closet Door Bottom Guide. Record review of the facility's Social Service Manual dated 2003 revealed a policy on Resident Rights, revised 11/28/16, documented Safe Environment: The resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and support from daily living safely.