STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675112	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coral Rehabilitation and Nursing of Arlington	1112 Gibbins Rd Arlington, TX 76011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observation, interview and record review, the facility failed to ensure each resident was treated with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for two (Resident #54 and Resident #56) of eight residents reviewed for resident rights. 1. The facility failed to assist Resident #54 to get out of bed. 2. The facility failed to provide Resident #56 clothing. This failure could place residents at risk for a loss of dignity, decreased self-worth and decreased self-esteem. Findings included: 1. Record review of Resident #54's admission MDS assessment, dated 08/22/24, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His BIMs score was 9 indicating his cognitive status was moderately impaired. His diagnoses included hip fracture and Stage III pressure ulcer. The resident had a foley catheter. The resident required maximum assistance to transfer to and from a bed to a chair. Record review of Resident #54's care plan, dated 10/14/24, reflected the resident did not have a care plan for ADL assistance to get out of bed. An observation and interview on 10/29/24 at 10:11 AM revealed Resident #54 was awake, alert, and oriented. He said he was upset. He said he wanted to get out of bed and that he had been in bed for four months. He said he was not even assisted to get out of bed for a shower and said staff would only give him a bed bath. He said he asked staff to get him out of bed, but they told him he fell the last time they tried to get him up. An interview on 10/29/24 at 2:49 PM with the ADON revealed Resident #54 did not get out of bed because of weakness. The ADON said the resident did not help to transfer and fell forward. The ADON said the resident would need a Hoyer lift. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the DON on 10/31/24 at 4:06 PM revealed she was new to the facility but had never seen Resident #54 get out of bed. She said she did not know staff did not get him up. She said a Hoyer lift could be used to get him out of bed and that he did not have to stay in bed. The DON said if a resident stayed in bed all day, then they were at risk for depression. An observation and interview on 11/01/24 at 10:55 AM revealed Resident #54 was out of bed and sitting in a geri-chair, watching TV in the common dining room with other residents. The resident said that he was glad to be out of bed. An interview on 11/01/24 at 10:58 AM with LVN A revealed she had worked with Resident #54 and said he was never assisted to get out of bed prior to 11/01/24 because he required maximum assist and could not assist to get up. She said she never used a Hoyer lift with him to get him out of bed because he transferred from another facility and did not have a wheelchair or geri-chair to transfer to. LVN A said staff started looking for his wheelchair/geri-chair on 11/01/24. LVN A said it was important for residents to get out of bed to prevent pressure sores, increase circulation, socialize, and attend activities. An interview on 11/01/24 at 11:05 AM with CNA H revealed she assisted Resident #54 to get out of bed on 11/01/24 but had not seen him out of bed before. She said on 11/01/24, staff used a Hoyer lift to place the resident in a geri-chair. CNA H said the resident was happy to be out of bed. Review of the facility policy, Resident Rights, revised August 2009, reflected: 3. Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity . 2. Record review of Resident #56's Admission MDS assessment, dated 08//24, reveal14ed she was a [AGE] year-old male who admitted to the facility on [DATE]. His diagnoses included anemia, atrial fibrillation, heart failure, hypertension, gastroesophageal reflux disease, diabetes mellitus, depression, post traumatic stress disorder, asthma. His BIMS score was 11 of 15, which indicated he was moderately impaired. Observation and Interview on 10/30/24 at 12:25 PM revealed Resident #56 was in his room sitting in his wheelchair wearing a hospital gown. The hospital gown appeared to open and expose Resident #56's back. Resident #56 stated he was wearing a hospital gown because he only had a few clothing items. He stated his clothes were dirty and had been taken to laundry. He stated a lot of his clothes were left at his previous facility (facility was permanently closed). He stated not having his clothes and having to wear a hospital gown affected his self-esteem. Resident #56 stated he had informed the Administrator multiple times that most of his clothes were left at his previous facility. He stated the administrator had not made an effort to recover his clothing from his previous facility. He stated he felt the facility had placed his needs on the back shelf. Interview with the Administrator on 11/01/24 at 4:27 PM revealed he was informed by Resident #56 that his clothing was left at the previous facility. He stated he planned to have someone check the laundry at Resident #56's previous facility. He stated Resident #56 sometimes wore a hospital gown. He stated Resident #56's dignity was not affected because he did not wear a hospital gown all the time. He stated if Resident #56's clothing was not located then the only option was to replace the clothes. He stated Resident #56 wore a size 6X and he was not able to locate new clothing. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy, Quality of Life-Dignity, dated August 2009, reflected Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality . Residents shall be encouraged and assisted to dress in their own clothes rather than in hospital gowns.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42283 Based on observation, interview, and record review the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for one(Resident #58) of six residents reviewed for reasonable accommodations. The facility failed to provide Resident #58 with a trapeze bar for repositioning self in bed. This failure could place residents at risk of not being able to have their needs met. Findings included: Record review of Resident #58's Admission MDS Assessment, dated 08/21/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included: anemia, hypertension, gastroesophageal reflux disease, neurogenic bladder, paraplegia, anxiety disorder, bipolar disorder, and asthma. His BIMS score was 15 out of 15, which revealed he was cognitively intact. Observation and interview on 10/30/24 at 1:30 PM revealed Resident #58 did not have a trapeze bar in his room. Resident #58 stated he was supposed to have a trapeze bar. He stated he used a trapeze bar to reposition himself in bed. He stated he was not able to reposition himself in bed without a trapeze bar. Resident #58 stated he informed the administrator that he needed a trapeze bar and used one at his previous facility. He stated he never received a trapeze bar while resident at the facility. He stated he had to use his call light to request staff assistance with repositioning in bed. Review of Resident #58's physician orders dated 08/28/24 from previous facility reflected: Resident (#58) to have trapeze bar to help with bed mobility (dated 03/09/23). Interview on 11/01/24 at 4:08 PM with the Regional Team Rehab Director revealed he did not know why Resident #58 used a trapeze bar at the previous facility but did not have one now. He stated he would find out why Resident #58 did not have a trapeze bar. Interview on 11/01/24 at 4:30 PM with the Regional Team Rehab Director revealed he did not know resident had an order for a trapeze bar from previous facility. He stated he would order Resident #58 a trapeze bar on 11/04/24. Interview on 11/01/24 at 5:00 PM with the Physician revealed he approved and reviewed all residents' transfer orders. He stated the physician order for Resident #58's trapeze bar from the previous facility should have transferred over. He stated he did not know why Resident #58 did not have a trapeze bar. He stated Resident #58 was able to transfer himself and did not need a trapeze bar. He stated Resident #58 was not bed bond. He stated there were no risk to Resident #58 not having a trapeze bar because staff provided assistance. He stated maybe Resident #58 did not have a trapeze bar because the facility did not have one to provide. A policy was requested from the Administrator on 11/01/24, a relevant policy was not provided.

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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** 28637 Based on observation, interview, and record review the facility failed to ensure residents received the housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for two (Resident #56 & #135) of six residents reviewed for environment. 1. The facility failed to ensure Resident #56's walls in his room were in good repair. 2. The facility failed to ensure Resident #135's room was thoroughly cleaned. This failure could place residents at risk for a diminished quality of life due to the lack of a homelike environment. Findings included: 1. Record review of Resident #56's Admission MDS assessment, dated 08/14/24, revealed he was a [AGE] year-old male who admitted to the facility on [DATE]. His diagnoses included anemia, atrial fibrillation, heart failure, hypertension, gastroesophageal reflux disease, diabetes mellitus, depression, post traumatic stress disorder, asthma. His BIMS score was 11 of 15, which indicated he was moderately impaired. Observation and Interview on 10/30/24 at 12:25 PM revealed the wallpaper was peeling off the wall in Resident #56's room. Resident #56 stated the wallpaper had been peeling off the wall since he moved into the room in August 2024. He stated the appearance of the wall in his room did not present a home-like environment. He stated he did not know if maintenance was aware of the wallpaper peeling of the wall. Review of the monthly grievance log for August 2024 - October 2024, reflected there were no concerns regarding wallpaper peeling on residents' walls. Interview with the Maintenance Supervisor on 11/01/24 at 1:54 PM revealed he was responsible for facility repairs. He stated he did not know the wallpaper was peeling off the wall in Resident #56's room. He stated the wall in Resident #56's room did not have peeling wallpaper prior residing in the room. He stated he checked the residents' rooms every so often. He stated he completed random room checks to see if repairs were needed. He stated peeling wallpaper on Resident #56's room did not present a home-like environment. He stated Resident #56 did not report any needed repairs to him. He stated Resident #56 was messy. 2. Record review of Resident #135's Admission Record dated 11/1/24 revealed he was an [AGE] year-old male admitted to the facility on [DATE]. Record review of Resident #135's electronic medical record revealed he did not have a MDS Assessment completed at the time of the survey. Review of his diagnoses list retrieved 11/1/24 reflected his admitting diagnoses included paraplegia (loss of muscle function in the lower half of the body); dementia; dysphagia (difficulty swallowing); physical debility; and Stage 2 pressure sore of his back. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 10/29/24 at 11:00 AM, Resident #135 was observed lying in bed. He stated he had only been in the facility for a few days and came there from the hospital where he had been admitted for a urinary tract infection. He stated he was there to complete his IV antibiotics and receive therapy. He stated he was hoping to gain his strength back to go home. A large area of with dried white spots on his floor near his bed and IV pole. A dried substance was also observed on the base of his IV pole along with what appeared to be the cap used to cover IV tubing. A yellow wet floor sign was situated in the doorway to his room. Resident #135 pointed to the spots on the floor and stated, They cleaned in here, sure doesn't look like they cleaned there, it looks pretty bad. He stated he did not know what the substance was unless his medicine had dripped. He stated he had not been out of bed yet and had just started therapy that morning. An observation on 10/29/24 at 3:35 PM revealed Resident #135 was in his bed sleeping. The condition of his floor had not changed, and the yellow wet floor sign was still situated in the doorway of his room. During an observation and interview on 10/30/24 at 12:00 PM, CNA T was observed passing a lunch tray to Resident # 135. She stated she had worked at the facility about a year. She stated she typically say housekeeping staff working on the rooms daily, but she did not know how often they mopped the floors. CNA T stated she had not received any complaints from the residents related to housekeeping services. During an observation and interview on 10/30/24 at 12:02 PM, Resident #135 was observed lying in bed. The dried white spots and tubing cap were still visible on his floor. Resident #135 stated he had noticed when he arrived that they keep the rest of the facility clean, can't manage to keep the room clean. Those white spots have been there a while, they don't know how to use a mop. Resident #135 stated he was still receiving therapy services in his room. During an interview on 11/1/24 at 1:45 PM, the Housekeeping/Maintenance Director stated housekeeping services were expected to be done in every room, every day. He stated the services included sweeping and mopping the floors. The Housekeeping/Maintenance Director stated he was responsible for ensuring the rooms were clean and regularly performed visual checks on the rooms to ensure they were getting cleaned. When asked about Resident #135's floors, the Housekeeping/Maintenance Director stated they were short a housekeeper on 10/29/24 and the remaining staff had to pick up extra rooms and it was possible some were missed. He stated he had not conducted the rounds as he normally would because of the facility inspection occurring that week. The Housekeeping/Maintenance Director stated the risk for residents included it could be an eyesore for the residents and items like bedside tables could get germs and increase risk for infection. He stated the nursing staff usually contacted him if IV poles or other equipment required cleaning or maintenance. During an interview with LVN L on 11/1/24 at 3:07 PM, she stated she had not noticed the spots on Resident #135's room that week. She stated the housekeeping department was typically good at keeping the floors clean and she could call them any time something needed to be addressed. LVN L stated she was unsure what the spots could have been and, if there was a spill, the nursing staff usually performed the initial cleaning and could contact housekeeping for any follow-up needed. She stated the risk to residents included, it would make me feel icky and cause me to wonder what else was not getting cleaned. (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 11/1/24 at 3:24 PM, Housekeeping Staff U stated he had worked at the facility for 4 or 5 months and was typically assigned to Resident #135's hall. He stated he was not working on 10/29/24 but he had cleaned Resident #135's room on the afternoon of 10/30/24. Housekeeping Staff U stated sweeping and mopping the floors was expected to be done every day as part of their routine services. He stated equipment was usually cleaned by nursing staff. Housekeeping Staff U stated the risk to residents included residents could get sick due to unsanitary conditions and it could create bad odors. In an interview on 11/1/24 at 4:21 PM, the Administrator stated facility administrative staff conducted daily rounds with the residents and observing the cleanliness of the rooms were part of those visits. He stated he had not received any complaints related to housekeeping services. The Administrator stated the risk to residents having dirty floors in their rooms was decreased feelings of self-worth. Record review of the facility policy titled, Quality of Life-Homelike Environment, dated Revised August 2009 reflected the following: Policy Statement: Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Policy Interpretation and Implementation: 1. Staff shall provide person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Cleanliness and order . 42283

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observation, interview and record review, the facility failed to ensure a resident who is unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for one (Resident #54) of eight residents reviewed for resident rights. 1. The facility failed to assist Resident #54 to get out of bed. This failure could place residents at risk for a loss of dignity, decreased self-worth and decreased self-esteem. Findings included: Record review of Resident #54's admission MDS assessment, dated 08/22/24, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His BIMs score was 9 indicating his cognitive status was moderately impaired. His diagnoses included hip fracture and Stage III pressure ulcer. The resident had a foley catheter. The resident required maximum assistance to transfer to and from a bed to a chair. Record review of Resident #54's care plan, dated 10/14/24, reflected the resident did not have a care plan for ADL assistance to get out of bed. An observation and interview on 10/29/24 at 10:11 AM revealed Resident #54 was awake, alert, and oriented. He said he was upset. He said he wanted to get out of bed and that he had been in bed for four months. He said he was not even assisted to get out of bed for a shower and said staff would only give him a bed bath. He said he asked staff to get him out of bed, but they told him he fell the last time they tried to get him up. An interview on 10/29/24 at 2:49 PM with the ADON revealed Resident #54 did not get out of bed because of weakness. The ADON said the resident did not help to transfer and fell forward. The ADON said the resident would need a Hoyer lift. An interview with the DON on 10/31/24 at 4:06 PM revealed she was new to the facility but had never seen Resident #54 get out of bed. She said she did not know staff did not get him up. She said a Hoyer lift could be used to get him out of bed and that he did not have to stay in bed. The DON said if a resident stayed in bed all day, then they were at risk for depression. An observation and interview on 11/01/24 at 10:55 AM revealed Resident #54 was out of bed and sitting in a geri-chair, watching TV in the common dining room with other residents. The resident said that he was glad to be out of bed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 11/01/24 at 10:58 AM with LVN A revealed she had worked with Resident #54 and said he was never assisted to get out of bed prior to 11/01/24 because he required maximum assist and could not assist to get up. She said she never used a Hoyer lift with him to get him out of bed because he transferred from another facility and did not have a wheelchair or geri-chair to transfer to. LVN A said staff started looking for his wheelchair/geri-chair on 11/01/24. LVN A said it was important for residents to get out of bed to prevent pressure sores, increase circulation, socialize, and attend activities. An interview on 11/01/24 at 11:05 AM with CNA H revealed she assisted Resident #54 to get out of bed on 11/01/24 but had not seen him out of bed before. She said on 11/01/24, staff used a Hoyer lift to place the resident in a geri-chair. CNA H said the resident was happy to be out of bed. Review of the facility policy, Resident Rights, revised August 2009, reflected: 3. Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity .

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observations, interviews and record reviews, the facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 2 (Resident #24 and Resident #56) of 8 residents reviewed for quality of care. The facility failed to identify wounds and provide needed care and services to Residents #24 and #56. This failure could prevent the resident from receiving treatments and worsening of their wounds. An IJ was identified on 11/18/24. Administrator B and DON were notified and an IJ Template was provided on 11/18/24 at 1:48 PM. While the Immediate Jeopardy was removed on 11/19/24. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place. Findings included: 1. Record review of Resident #56's admission MDS assessment, dated 08/14/24, revealed he was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included heart failure and diabetes. His Brief Interview for Mental Status (BIMS) score of 11 revealed his cognition was moderately impaired. The resident was at risk of developing wounds and pressure ulcers. Record review of Resident #56's Care Plan, dated 10/30/24, revealed the resident had a care plan because he had cellulitis of the right lower extremity related to infection. Record review of Resident #56 skin assessments for the dates of 10/25/24 through 11/08/24 reflected: - 10/25/24 indicated he had redness to his lower abdomen. - 10/30/24 indicated skin tear about 2cm. - 10/30/24 skin tear measuring 2cm, dryness and dryness noted to LLL. - 11/01/24 skin tear measuring about 2 cm in diameter, dry scaly skin. - 11/08/24 redness below abdomen, dryness to bilateral lower extremities (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An observation and interview on 10/30/24 at 1:07 PM revealed Resident #56 was seated in a wheelchair in his room. The resident was wearing a hospital gown. The resident's right lower leg had multiple open ulcers draining yellow drainage. The circular, open ulcers varied in size from nickel-sized to quarter-sized lesions. The area was red. Resident #56 said the ulcers had been open and draining for one and a half months to two months. LVN G said she was the resident's nurse. She entered the room and put on gloves. She said she did not know that he had the ulcers, and he was not receiving treatment for them. She said she would notify the physician and the ADON/WNC who was also the wound care nurse. An observation and interview on 10/30/24 at 1:12 PM revealed the ADON/WNC entered Resident #56's room wearing gloves, gown, and a mask. The ADON said he did not know the resident had wounds and told the resident, You never told me. and walked out the door to his medication cart. Then Resident #56 became very upset and said he is blaming me. I should not have to tell him I have wounds. The ADON/WNC said the resident did not like him. The ADON/WNC said he did not know why the Surveyor knew about the wounds, but he and his staff did not . The ADON/WNC said the wounds were not on the skin assessment. Resident #56 interrupted and said the wounds were present when the nurse did the skin assessment. An interview on 10/30/24 at 1:32 PM with the DON revealed she was new to the facility, and she did not realize that Resident #56 had open wounds on his right lower leg. The DON assessed the wounds and asked the resident about the wounds. Resident #56 told the DON that the wounds had been there for a while and the staff were not taking care of them. The DON told the resident she would make sure that he got treatments for his wounds. The DON said she was going to do a skin sweep in the building to look for additional residents with wounds and ensure they were being treated. Record review of Resident #56's Order Summary Report, dated 10/30/24, reflected: Cleanse cellulitis wound on the right lower leg with normal saline, pat dry and apply calcium alginate, cover with ABD pad (dressing used for large wounds) and apply adhesive dressing daily for cellulitis to the right lower leg for 23 days, with a start date of 10/31/24. 2. Record review of Resident #24's quarterly MDS assessment, dated 07/06/24, revealed he was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included stroke, peripheral vascular disease (slow and progressive disorder of the blood vessels), and diabetes. His Brief Interview for Mental Status score was left blank. His cognitive skills for daily decision-making was severely impaired. The resident was at risk of developing wounds and pressure ulcers. Record review of Resident #24's Care Plan, dated 10/30/24, after surveyor intervention, reflected the resident had an actual impaired skin integrity related to an autoimmune disease - induced wound to his left leg. Record review of Resident #24 skin assessments for the dates of 10/21/24 through 11/08/24 reflected: - 10/21/24 no skin issues noted. - 10/28/24 no skin issues noted. (continued on next page)

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	675112	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coral Rehabilitation and Nursing of Arlington	1112 Gibbins Rd Arlington, TX 76011

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- 10/30/24 autoimmune disease induced wound of the left leg, full thickness, redness to the scrotum barrier cream applied. - 10/30/24 redness to scrotum, above knee amputation, below knee amputation with blisters noted. - 11/04/24 Res Noted with recurring open areas to the left leg due to the auto immune disease. on treatment and followed by wound care doctor - 11/08/24 return of rash with scab of BKA site. Autoimmune disease induced wound of the left leg. An observation and interview on 10/30/24 at 11:30 AM revealed Resident #24 was awake, alert, and mostly non-verbal. He was able to communicate with facial expressions and hand movements. The resident pulled up his blanket and exposed his left knee which had a large area, approximately the size of a soft ball area that was red with yellow, scabbed areas. The area was very inflamed. The resident communicated that it was very irritating to him. An observation and interview on 10/30/24 at 11:35 AM revealed LVN G entered the room and she said she was Resident #24's nurse. LVN G looked at the resident's knee and said it was not like that when she did her skin assessment on 10/28/24. She said she did not know the resident had the wound and he was not currently receiving treatment for the wound. She said the resident had a history of an autoimmune disorder that would cause it to flare up. In a follow-up interview on 11/18/24 at 10:56 AM with LVN G revealed that skin assessments were to be completed once a week and all residents had orders for their skin assessments. LVN G stated she was responsible for completing Resident #24's skin assessment each week. LVN G stated that that on Monday (11/28/24) there was not a wound on Resident #24's leg but on 10/30/24 a wound was observed. She stated if a skin impairment was found while doing her skin assessment, she would document it on the skin assessment then she would tell the ADON /WNC so he could assess the skin, obtain orders, and contact the wound doctor. Record review of Resident #24's Order Summary Report, dated 10/30/24, reflected: Clobetasol Propionate External Foam 0.05 % (used to treat skin conditions). Apply to left leg stump topically two times a day for autoimmune disease-induced wound of the left leg for 23 days. In a follow-up interview with ADON /WNC on 11/18/24 at 10:30 AM revealed that all residents have skin assessments once a week completed by the floor nurses. ADON/WNC stated that CNAs are also responsible for observing and reporting any changes in residents' skin when providing care to residents, to the nurse. ADON/WNC stated a skin assessments requires a head-to-toe observation of the residents' skin and nurses should indicate any signs of skin impairment such as bruises, rashes, wound. ADON/WNC stated that once the nurse puts skin assessment into the system with skin impairments noted, it would generate on his 24-hour report that he pulls his next working day. ADON stated once he reviews the 24 hours report, he then goes to complete his own skin assessment of the resident to ensure no areas were missed, he measures the wound and contacts the MD and refer the resident to the Wound MD. ADON/WNC stated that nurses also called the MD to get an order for treatment in the interim and ADON/WNC would go behind and review the order and the wound. ADON/WNC stated that no interventions were put into place for Resident #24 as his wound was autoimmune and it can come and go randomly. ADON stated Resident #56's wound came as a result of cellulitis which the resident admitted with. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a follow-up interview on 11/18/24 at 9:24 AM with the DON revealed that ADON/WNC was responsible for wound care in the facility. DON stated that skin assessments were to be completed on all residents once a week and are documented in the electronic medical record under assessments and in the residents MAR/TAR. DON stated that if skin impairments would find, the nurse would notify he MD, family herself, obtain an order for treatment and contact the Wound MD. DON stated that the Wound MD comes to the facility on ce a week on Wednesdays. DON stated that a skin impairment would be a change in condition and an SBAR should be completed. In an interview on 11/18/24 at 11:50 AM, MD stated he had a few minutes to speak before a meeting. MD stated he did not recall Resident #24 nor his wounds. MD stated that Resident #56 had a chronic venous ulcer on his leg that did not just come about MD stated that it was his expectation that once a wound was founded that they notify him and/or his team so treatment can begin. MD stated that he knew the facility completed skin assessments but could not recall at what frequency. MD then had to leave for his meeting. In a telephone interview on 11/18/24 at 1:42 PM Wound MD stated he could not recall when Resident #56 wounds began but stated the wounds are difficult to avoid and they do improve and redevelop cyclically and depends a lot on the edema Resident #56 has at the time. Wound MD stated Resident #56's wounds were more of a reflection of underlying pathology. Wound MD stated Resident #24's were baffling to him, as he had treated his wounds before with a high dose of ointment which healed the wounds. Wound MD stated once he had taken Resident #24 off the high dose ointment, Resident #24's leg flared up again. Record review of the facility policy, Change in Resident's Condition or Status, dated December 2010, reflected: Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status . The facility did not have a policy on quality of care. Administrator B and DON were notified of the IJ on 11/18/24 at 1:48 PM due to the above failures and provided the IJ template and a POR was requested. The facility's plan of removal was accepted on 11/18/24 at 3:56 PM and included the following: 11/18/2024 F684 IJ POR All residents were at risk of being affected by this alleged deficient allegation. Resident #24 and #56 immediately had a skin assessments performed by the nurse and referred to wound care management for new treatment orders and Plan of Care updated on 10/30/2024. The Medical Director was notified of the IJ. The IJ was issued at 1:45 pm on 11/18/2024. The DON/designee immediately initiated in-services with nursing staff and CNA's on how to identify and manage changes in condition and how to communicate the changes to nurse management via SBAR and complete skin assessments in PCC. Any staff not currently present will be educated prior to working the floor. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 11/18/24 current residents who admitted after 10/30/2024 have been assessed for skin issues. Any issues identified by the nurse were documented in the care plan and interventions carried out by the nurse after being communicated to the wound care physician. The DON/designee will audit 5 random resident skin assessments visually, return demonstration, each week for 4 weeks. The DON will monitor progress in the wound care audit log. The facility's implementation of the IJ Plan of Removal was verified on 11/19/24 through the following: Record review of Resident #56's Order Summary Report dated 11/19/24 reflected: - Cleanse cellulitis wound on the right lower leg with normal saline, pat dry and apply Xeroform gauze three times per week, then cover with ABD pad and wrap with kerlix wrap daily. one time a day every Mon, Wed, Sat for Cellulitis to the right lower leg. for 23 Days, order date 11/13/24, start date 11/16/24, end date 12/09/24. - [Wound Company Name] consult, order date 10/30/24 Record review of Resident #56's Wound Evaluation & Management Summary dated 11/06/24 reflected: Venous Wound of the right shin partial thickness . etiology (quality) venous, wound size (L x W x D) 3.5 x 3.0 x 0.1 cm . Surface Area: 10.50 cm .Cluster Wound: open ulceration area of 7.35 cm . Primary Dressing(s) Xeroform gauze apply three times per week for 30 days, Secondary Dressing(s) Gauze island w/ bdr [sic] apply three times per week for 30 days; ACE bandage 6 apply once weekly for 30 days. Record review of Resident #24's Order Summary Report dated 11/19/24 reflected: - [Wound Company Name] would consult, order date of 10/30/24. - Wound MD Consult as needed, order date 11/04/24. - Clobetasol Propionate External Foam 0.05 %, (Clobetasol Propionate) Apply to left leg stump topically two times a day for AUTOIMMUNE DISEASE-INDUCED WOUND OF THE LEFT LEG FULL THICKN for 23 Days, order date 11/13/24, start date 11/13/24, end date 12/06/24. Record review of Resident #24's Wound Evaluation & Management Summary dated 11/06/24 reflected: Autoimmune disease-induced wound of the left leg . etiology (quality) autoimmune. Wound Size (L x W x D) 6.2 x 13.2 x not measurable cm . Surface Area: 81,84 cm2 Additional Wound Detail: return of rash with scab of BKA site . Primary Dressing(s) Clobetasol apply twice daily for 30 days. Record review of skin assessments for the 74 residents revealed there was not any new skin impairments noted. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interviews were conducted with staff across all shifts on 11/19/24 from 11:30 AM to 2:30 PM and included 1 RN, 1 PRN RN, 2 LVN , Staffing Coordinator/CNA, 2 CNA's, 1 Restorative Aide. revealed they had all been in-serviced by the DON. CNA's and Restorative Aide stated they were in-serviced on reporting any skin impairments to their nurse that they find when providing care to residents, they stated they were educated on completing shower sheets and indicating on the shower sheet if a resident has any skin impairments. They stated a skin impairments were anything that was not normal, such as bruises, skin tears, wounds, rashes. 1 RN, 1 PRN RN, 2 LVN stated that they were in-serviced on identifying and managing changes of conditions, communication the changes to nurse management via SBAR and completing skin assessments accurately and documentation. All nurses stated that if a skin impairment was reported to them or they find a skin impairment doing the weekly skin assessment, they are to document the skin impairment on the skin assessment, call family, the MD and obtain new orders, contact the DON and complete an incident report and an SBAR. In an interview on 11/19/24 at 11:31 AM with Administrator B revealed LVN G and ADON/WNC had been terminated on 11/18/24. Record review of employee termination form date 11/18/24 for ADON/WNC revealed he was terminated on 11/18/24 for failure to meet performance standards Record review of employee termination form date 11/18/24 for LVN G revealed he was terminated on 11/18/24 for failure to meet performance standards In a follow-up interview with Administrator B on 11/19/24 at 12:30 PM revealed that there were not any new skin impairments as a result of the skin sweep. In an interview on 11/19/24 at 1:07 PM DON stated that she in-serviced all nurses and aides on skin impairments, how to follow-up on skin impairments, completing SBAR and incident reports and obtaining treatment orders. DON stated that she told the nurses that they must refer skin issues to the wound care doctor, follow through with treatments that were ordered, notify herself, family and the MD. DON said that RN Z was responsible for wound care since ADON was no longer employed and that the charge nurses were responsible as back up. DON stated that when assessing a resident's skin staff are to take note of any redness, scrabs, open areas, rashes, anything that was not normal. DON stated that aides are to document on the shower sheet, when giving showers, if they notice any skin impairments and report the skin impairment to the nurse. DON stated that skin impairments are discussed during the morning stand-up meeting. DON stated that at the meeting staff will verify an incident reports and SBAR was completed, orders were obtained for treatment, she said if one of the items or none of the items had been completed the facility would immediately complete those tasks. DON stated the skin sweep had no new findings. An observation on 11/18/24 at 9:50 AM ADON/WNC provided wound care to Resident #56's right legs lower shin to outside leg area. An IJ was identified on 11/18/24. Administrator B and DON were notified and an IJ Template was provided on 11/18/24 at 1:48 PM. While the Immediate Jeopardy was removed on 11/19/24. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on observation, interview, and record review, the facility failed to ensure residents received appropriate supervision and assistance devices to prevent accidents for one (Resident #65) of six residents reviewed for incidents and accidents. 1. The facility failed to ensure Resident #65's smoking materials were kept at the nurses station on 10/29/24. 2. The facility failed to ensure hazardous items including razors and hand sanitizer was not stored in an area easily accessible to residents who resided within the secured unit. Hand sanitizer and disposable razors were observed in an unlocked area of the secured area. This failure could place residents at risk for accidents and injuries. Findings included: 1. Record review of Resident #65's MDS Assessment, dated 10/15/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included: chronic obstructive pulmonary disease, diabetes mellitus, malnutrition, and anxiety disorder. His BIMS section was incomplete. His Cognitive Patterns section revealed he had memory problems regarding short term memory and had modified independence regarding skill for daily decision making. Record review of Resident #65's care plan, undated, revealed he smoked and had been advised of the facility smoking policy. His goal was to be complaint with the facility smoking policy. His intervention/tasks was to remind resident and family that all cigarettes, lighter, matches, and smoking paraphernalia must be kept at the nursing station. Record Review of Resident #65's smoking evaluation dated 10/22/24 reflected all smoking materials will be kept at the nurses station and the evaluation was discussed with the resident (#65). Observation and interview on 10/29/24 at 2:00 PM revealed Resident #65 who was in one of the courtyards with a pack of cigars and a lighter. Resident #65 stated he kept his cigars and lighter in his room. He stated cigars and lighters were to be kept at the nursing station. He stated staff were aware he kept his cigars and lighter in his room. Interview on 11/01/24 at 4:21 PM with the Administrator revealed Resident #65 was not supposed to store cigars and a lighter in his room. He stated he had spoken to residents and family member regarding the smoking policy. He stated residents were informed of the smoking policy during admission. He stated he had also confiscated smoking materials from residents. He stated he was unaware Resident #65 stored cigars and a lighter in his room. The Administrator stated he thought smoking materials were stored in an orange box in the locked medication room. He stated there were no risks to Resident #65 storing cigars and a lighter in his room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy, Smoking Policy - Residents, dated August 2010, reflected This facility shall establish and maintain safe resident smoking practices. 2. An observation on 10/29/24 at 12:22 PM in the secured unit revealed a large room with no door. The room opened to a sitting area where residents often gathered. A chair was located in the room along with two locked medication carts. A gallon size jug of hand sanitizer was observed on the floor near the chair. The jug was approximately half full of a clear liquid. A large white label was affixed to the jug with red lettering that reflected, DO NOT DRINK. CNA V was observed exiting a bathroom located in the area and walking through the room. When asked about the jug of hand sanitizer, he stated he did not work on that unit and did not know why it was there. CNA V picked up the jug and walked away. In an interview on 10/30/24 at 2:05 PM, CNA P stated she worked on the secured unit from 2 PM to 10 PM and had worked at the facility for 2 years. She stated she was unaware of the items kept in the large room in the unit and did not go back there often. She stated she knew the medication carts were parked there and did not recall residents going in or out of the area. An observation on 10/30/24 at 3:05 PM in the secured unit's large open room revealed an unlocked closet in the room that contained clothing items hanging within. The floor of the closet was full of miscellaneous items including mismatched shoes, clothing items, 2 opened packages of briefs, and a 3-drawer clear storage bin. Each drawer was full of miscellaneous items including undergarments, hand towelettes, and six disposable razors. A large wooden armoire was located in the room. The armoire had shelving inside what would have been 2 doors. One of the doors was removed and was on the floor between the armoire and the wall. The shelving was full of paper documents in disarray including blank facility forms. A gallon jug of hand sanitizer was on a shelf, in the corner, partially obscured by the paper documents. It was approximately half full of clear liquid and had a large white label affixed around the top of the jug with red lettering that reflected, DO NOT DRINK. There were 2 large drawers at the bottom of the armoire. The drawers were full of miscellaneous items including remote controls, various cords and adapters, graham crackers, a 5 ml syringe labeled as 0.9% Sodium Chloride Injection (used to flush IV lines) was among the items. The syringe was full of fluid, there was no needle attached and the end had a cap attached. During an observation and interview on 10/30/24 at 3:57 PM, the DON stated she had only been working for the facility for 2 weeks. When observing the open room in the secured unit with the DON, she stated she was unaware that items had been stored in that room or the closet. She removed the hand sanitizer and stated that it should have been kept in a locked storage area. The DON stated the razors and other items presented a risk for injury to the residents. She stated the nursing staff and herself were responsible for ensuring the items were kept out of reach of the residents. A copy of any policies related to storage of hazardous items was requested at that time. During an observation and interview on 10/31/24 at 7:56 AM, when LVN L was shown the large open room in the secured unit she stated it used to be a nurses' station with a door that locked. She stated they had been previously told they were not allowed to have a locking door to that room and the door had been removed. There was no door leading to the room. She stated she was not back in that room often unless she was getting her medication cart. LVN L stated items such as razors and hand sanitizer should be stored in locked storage rooms. She stated items left in that room placed residents at risk of poisoning or injuries. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled, Medication Storage Policy, dated Revised April 2007, reflected, The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: .6. Antiseptics, disinfectants, and germicides used in any aspect of resident care must have legible, distinctive labels that identify the contents and the directions for use and shall be stored separately from regular medications . No facility policy related to the storage of hazardous items was provided by the time of facility exit. 42283

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 (Resident #54) of 3 residents reviewed for catheter care. 1. The facility failed to ensure Resident #54 had a catheter stabilization device. These failures could place residents at risk of urinary tract infections and urethral damage. Findings included: Record review of Resident #54's admission MDS assessment, dated 08/22/24, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His BIMs score was 9 indicating his cognitive status was moderately impaired. His diagnoses included hip fracture and Stage III pressure ulcer. The resident had a foley catheter. Record review of Resident #54's Face Sheet, dated 10/30/24, reflected he had a diagnosis of obstructive and reflux uropathy (a condition in which the flow of urine is blocked.) Record review of Resident #54's October 2024 Order Summary Report revealed he did not have an order for a catheter stabilization device. Record review of Resident #54's care plan, dated 10/14/24, reflected: The resident had a foley catheter. Goal: The resident will be/remain free from catheter-related trauma through review date. Facility intervention: Catheter care every shift and as needed. An observation and interview on 10/29/24 at 10:15 AM revealed Resident #54 was lying in bed and had a foley catheter. He was awake, alert, and oriented. LVN A was asked if the resident had a catheter stabilization device. LVN A said no because the resident pulled it off. The resident disagreed and said he did not ever take it off. LVN A then said it would not stay on and the resident said that was incorrect and that he never had a catheter stabilization device at all. LVN A said if the resident did not have a catheter stabilization device, then his catheter could get pulled out. An interview on 11/01/24 at 2:18 PM with the DON revealed residents with foley catheters were supposed to have orders for the catheter stabilization device. She said without the device, the catheter could become dislodged. Review of the facility policy, Urinary Continence and Incontinence, revised December 2010 reflected: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on observation, interview, and record review, the facility failed to have sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 1 (Residents #73) out of 7 residents reviewed for sufficient staff. The facility failed to have adequate staff to prevent Resident #73 from wandering out of the secured unit and into the main area of the facility. An assigned Charge Nurse and CNA were both off the unit at the time Resident #73 left the unit. This failure could place residents at risk of not receiving the necessary care and services to maintain their highest practicable physical, mental, and psychosocial well-being. Findings included: Record review of Resident #73's Admission Record dated 11/1/24 reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Record review of Resident #73's Admission MDS assessment dated [DATE] reflected he had moderately impaired cognition, he had fluctuating periods of inattention and had wandering behaviors. The MDS Assessment reflected he was dependent on staff for toileting, required maximum assistance for bathing, and was incontinent of bowel and bladder. He used a wheelchair and required partial assistance transferring from bed to chair. The MDS Assessment reflected his diagnoses included hypertension (high blood pressure); psychotic disorder; and schizophrenia (a mental health condition that can cause delusions, paranoia, and disorganized behaviors). Record review of Resident #73's Care Plan entry dated 8/11/24 reflected a focus of his required placement on secure unit due to: 1-To minimize behaviors due to overstimulation elicited from more active units. 2-To provide safe/secure environment for wandering aimlessly. 3-To provide secure environment due to risk of elopement. Goal: [Resident #73] will have no episodes of wandering into unsafe area through next review date .Interventions/Tasks: .Review quarterly for continues need for secure unit. If appropriate, implement process to place on less secure unit. An observation and interview on 10/29/24 at 11:52 revealed CNA M who was observed in the secured unit passing lunch trays while redirecting multiple residents away from the exit doors and toward the dining room. She stated she had worked there about a month. CNA M stated there were 2 CNAs assigned to the hall and a LVN who also had to work another hall outside the unit. (continued on next page)

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	675112	A. Building B. Wing	11/19/2024

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Coral Rehabilitation and Nursing of Arlington	1112 Gibbins Rd Arlington, TX 76011

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview on 10/29/24 at 12:00 PM revealed multiple residents were observed in the secured unit dining room. LVN L was observed checking the trays and passing them to residents. LVN L stated she was the Charge Nurse for the secured unit as well as the 100 Hall. She stated the trays had already been passed to the 100 Hall residents. CNA N was observed setting up meals for residents and frequently redirecting and cueing residents. CNA M was observed entering the dining room. She sanitized her hands and sat down with a resident to feed them. Resident #73 was observed in the dining room, sitting alone and feeding himself. Observations and interviews on 10/30/24 at 8:32 AM, revealed Resident #73 was in his wheelchair pressing on the glass exit door leading from the locked unit [200 Hall] to main hallway. No staff were observed in the hallway on the secured unit or in the immediate vicinity outside the door. LVN L was observed returning from the 100 Hall toward the nurses' station that faced the secure unit door. Resident #73 was then observed outside the secured unit wheeling into the main area in the facility. LVN L approached Resident #73 and assisted him back into the secured unit. No other staff were observed in the secured unit's main hallway at that time. LVN L stated the door leading to the locked unit had a delay of about 15 seconds. She stated, if a resident pressed on the door handle, the door would eventually open. The door was tested by this surveyor. Upon pressing the door handle, an audible alarm was heard along with a voice coming from the keypad indicating a security alert. A medication cart was observed outside a resident's room approximately halfway down the hall. MA O was observed exiting the resident's room and approaching the medication cart. MA O stated she had not seen Resident #73 attempting to exit the unit nor did she hear the alarm because she was inside a resident's room passing medications. LVN L stated there were two CNAs on the unit as well as the MA. CNA M entered the unit and stated she had left the unit to return breakfast trays to the kitchen. She stated she believed it was ok to leave the unit because the MA was on the hall. During an interview on 10/30/24 at 9:37 AM, CNA N stated she had seen Resident #73 wheeling himself in the hallway when CNA M left to return the breakfast trays earlier on 10/30/2024. She stated she had specifically told MA O that she needed to go and change a resident and that the other aide had stepped away. She stated she assumed MA O was watching the hall. CNA N stated she could not always hear the door alarm when she was in a resident room providing care especially if she was in the bathroom and the water was running. In an observation and interview on 10/30/24 at 12:20 PM, LVN L was observed in the secured unit attending a resident with emergency medical personnel. She stated they were attempting to get the resident transferred to a hospital related to threats he had made to himself. Observation and interview on 10/30/24 at 12:26 PM in the secured unit revealed multiple residents were gathered at the opposite end of the hall from where LVN L was attending her resident and other residents were observed wandering in the hall. The unit was very loud. Two of the residents at the end of the hall began yelling and pushing each other. CNA M and CNA N were attempting to redirect the residents and move others away from the altercation. RA S assisted and redirected one of residents involved in the altercation back to his room while CNA M redirected the other. Both residents calmed down and returned to their rooms. RA S stated she was not typically on the secured unit but was only there to help monitor the doors while testing was being conducted on the facility's electrical systems. She stated she was glad she happened to be in the unit and was able to assist. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 10/30/24 at 12:51 PM, the Administrator was observed in the secured unit speaking with the emergency medical personnel. He stated he believed the staffing was adequate within the secured unit and stated, some days good, some days they need more help. The Administrator stated staffing was based using standard PPD (per patient day calculation) type and resident acuity. He stated the staff could always call for help if needed. The Administrator stated he was aware of Resident #73 leaving the secured unit that morning. He stated he had started working there in July 2024 and that was the only known time that had occurred since he began working there. He stated it was the first facility he had worked in where a resident could press the exit door on a secured unit and it would release after 15 seconds. The Administrator stated the other facility exit doors were locked and required a code and he felt there had been no immediate risk for Resident #73. He stated he felt the staffing level was sufficient. During an interview on 10/30/24 at 2:05 PM, CNA P stated she worked in the secured unit on the 2 PM to 10 PM shift and had worked for the facility for 2 years. She stated there were typically 2 CNAs, a nurse and a MA working the secured unit, but the nurse and MA also worked on the 100 Hall and were not always there. CNA P stated they tried to make the staffing work the best they could. She stated, due to safety, they always had 2 CNAs present during showers and made sure the nurse or MA was available to watch the unit during those times. She stated she knew Resident #73 liked to go for the door but was unaware of any residents leaving the unit during her shift. During an observation and interview on 10/30/24 at 3:57 PM, the DON was in the secured unit. Multiple residents were observed in the sitting area and ambulating in the halls and getting frequent redirection by staff. The DON stated she had only worked at the facility for two weeks. She stated they could probably use additional staff in the secured unit because so much redirection was required for the residents. She stated there were always 2 CNAs, a nurse and a MA assigned to the unit and the nurse and MA were also assigned to the 100 Hall. She stated some of the residents on the unit became combative and required 2 CNAs to provide ADL care. The DON sated the risks included what had occurred earlier that day where they needed additional assistance and participation from staff. She stated, if the charge nurse was busy assisting a resident on the 100 Hall, that left residents at risk for altercations. She stated she believed they needed to re-evaluate staffing levels based on the needs of the residents in the secured unit. During a telephone interview on 10/31/24 at 12:43 AM, RN Q stated she was the charge nurse for the secured unit and 100 Hall for the 10 PM to 6 AM shift. She stated there were several residents on the secured unit who tried to get out all the time. RN Q stated they had to watch the door and communicate with each other. She stated, if she needed to be on another hall, she let the CNAs know they needed to watch the door. She stated the hardest hours were between 4 AM and 6 AM. She stated she was unaware of any residents leaving the secured unit during her shift but there were occasional falls. RN Q stated Resident #73 was very confused, could get combative during ADLs and would refuse care a lot. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/1/24 at 3:14 PM, RN R stated she worked on the secured unit and 100 Hall during the 2 PM to 10 PM shift. She stated she had a MA that also worked the 100 Hall and 2 CNAs who stayed in the secured unit. RN R stated staffing could be difficult because some residents had sundowners (neurological phenomenon associated with increased confusion and restlessness in people with dementia) and they would see increased agitation and behaviors in the evening. She stated they had to really watch the halls for residents attempting to leave and communicate well with the CNAs. She sated she tried to coordinate her resident care with the CNAs to ensure someone always monitoring the hall. RN R stated it was very difficult if she had a new resident admitted on her shift as she had to assess the resident and enter orders. She stated the risks included increased altercations between residents, injuries, or residents leaving the unit it, the doors were not monitored at all times. RN R stated she had not had any residents leave the unit during her shifts. During an interview with the Administrator and DON on 11/1/24 at 1:02 PM, the Administrator stated he determined staffing by running the PPD and acuity. He stated resident cognitive levels were a factor. The Administrator stated he had previously received complaints from the facility staff regarding staffing levels because some residents were combative and required 2 staff to provide showers and ADL care. He stated he felt there were times they could use more help. The DON stated the nurses may be challenged because the 100 Hall had skilled nursing residents. She stated, if the resident was receiving IV medications or other treatments that required monitoring while residents on the secured unit were having behaviors, it could be a challenge for the charge nurse to manage both. Both the DON and the Administrator stated risk to residents exiting the secured unit was low because the facility exit doors were locked and that provided an extra barrier to elopement. The Administrator stated there was a risk for injuries to the resident if staff were attempting to address one altercation and another one occurred. Record review of the facility's policy titled, Staffing, dated Revised April 2007 reflected, Our facility provides adequate staffing to meet needed care and services for out resident population. Policy Interpretation and Implementation: 1. Our facility maintains adequate staffing on each shift to ensure that out resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services. 2. Certified Nursing Assistants are available on each shift to provide the needed care and services as outlined on the resident comprehensive care plan .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observation, interview and record review, the facility failed to ensure residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record for 1 of 4 residents (Resident #55) reviewed for unnecessary medications. The facility failed to ensure Resident #55 did not receive duplicate medication therapy for Bupropion (anti-depressant medication). This failure could place residents at risk for adverse drug reactions (unintended, harmful events attributed to the duplicate use of these medications) and receiving unnecessary medications. Findings included: Record review of Resident #55's annual MDS assessment, dated 08/03/24, reflected Resident #55 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #55's BIMS score was 15 indicating her cognition was intact. Her diagnoses included anxiety disorder and depression. Record review of Resident #55's Care Plan dated 11/22/23, reflected the resident had depression. Record review of Resident #55's Order Summary Report reflected: 07/06/24 Wellbutrin XL (Bupropion HCL) oral tablet extended release 150 milligrams every evening shift. 10/23/24 Bupropion HCl ER oral tablet extended release 150 milligrams every 24 hours. Record review of Resident #55's Medication Administration Records, dated October 2024, reflected: 07/06/24 Wellbutrin XL (Bupropion HCL) oral tablet extended release 150 milligrams every evening shift. Resident refused dose on multiple days. The resident did take the medication daily 10/26/24 - 10/29/24. 10/23/24 Bupropion HCl ER oral tablet extended release 150 milligrams every 24 hours. Resident received dose daily 10/23/24 - 10/30/24. An observation and interview on 10/29/24 at 10:36 AM with Resident #55 revealed she was in bed. She was awake, alert, and oriented. She said she did not have any issues with her medications. There was no indication that she was experiencing any negative outcomes. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 11/01/24 at 11:02 AM with LVN G revealed she made the medication error with Resident #55. She said she received a new order for Buproprion on 10/23/24 and thought she discontinued the order for Bupropion written on 07/06/24. She said the risk to the resident was increased confusion and adverse medication reaction. An interview on 10/30/24 at 4:43 PM with the DON revealed she was new to the facility and she did not know why Resident #55 received double doses of Bupropion. She said the resident was at risk because the medication was a black box listed medication (Black box warning: may cause changes in behavior and increase the risk of suicidal thoughts.) She said she would address the issue immediately. An interview on 10/31/24 at 2:23 PM with the Physician revealed he was aware of the medication error for Resident #55. He said he did not anticipate the resident would have any adverse outcomes because 300 milligrams was still within the dosage requirements for the medication. Record review of facility policies revealed the facility did not have a policy for unnecessary medications. The facility used the CMS Tool, Unnecessary Medications, Psychotropic Medications, and Medication Regimen Review Critical Element Pathway, dated May 2017 as the facility policy.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on observation, interview, and record review, the facility failed to maintain a medication administration error rate below 5 percent. There were 5 errors out of 32 opportunities which resulted in a 15 percent error rate for three (Resident #8, #58, and #45) of three residents reviewed for medication errors. 1) LVN A failed to administer to Resident #8 his famotidine dose via J-tube (tube inserted into the small intestine to deliver food or medications) during the medication administration observation. 2) MA B failed to administer to Resident #58 his Baclofen tablet and pregabalin tablets and failed to administer the correct dose and type of Colace during the medication administration observation. 3) MA B failed to administer to Resident #45 her Flonase during the medication administration observation. This failure could place residents at risk of not receiving the intended therapeutics effects of medications. Findings included: 1) Record review of Resident #8's Admission Record dated 11/1/24 reflected he was a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #8's Annual MDS assessment dated [DATE] reflected he was cognitively intact. The MDS Assessment reflected his diagnoses included GERD (occurs when stomach acid irritates the lining of the esophagus); seizure disorder; intellectual disabilities; and dysphagia (difficulty swallowing), and he received some of his nutrition through a feeding tube. Record review of Resident #8's Order Summary Report dated 10/30/24 reflected an order for Famotidine Oral Suspension (used to treat GERD). Give 5 ml via J-tube one time a day for indigestion. Give 40 mg/5 ml (8 mg/ml) suspension. The order was dated 3/9/24. During an observation on 10/30/24 at 8:00 AM, LVN A stated she had used up Resident #8's supply of Famotidine the day before and had notified the pharmacy. She stated the medication showed as delivered in the computer, but she did not have it available. LVN A stated Resident #8 had recently began taking food by mouth rather than using formula through his feeding tube and talked about stopping the medication because he was no longer having GERD symptoms. She stated she would search for the medication and notify the pharmacy if she was unable to locate it. Record review of Resident #8's MAR dated October 2024 reflected the entry for his Famotidine was coded with 9 See Nurses Notes. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #8's Progress Notes reflected the following entry dated 10/30/24 at 9:48 AM: Note Text: Famotidine Oral Suspension Reconstituted Give 5 ml via J-Tube one time a day for indigestion Give 40mg/5ml(8mg/ml) suspension Pharmacy notified. Partial medical was sent pending approval of insurance for payment. Rest of medication will be sent tonight. 10/30/24. The entry was signed by LVN A. 2) Record review of Resident #58's Admission Record dated 11/1/24 reflected he was a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #58's Admission MDS assessment dated [DATE] reflected he was cognitively intact. The MDS Assessment reflected his diagnoses included, neurogenic bladder (bladder problems caused by disease or injury to the nervous system); paraplegia (paralysis to the lower part of the body); anxiety disorder; chronic pain syndrome; and pressure ulcers to his sacrum and both heels. The MDS Assessment reflected he experienced occasional pain. Record review of Resident #58's Order Summary Report dated 10/30/24 reflected the following orders: Colace 2-IN-1 Oral Tablet 8.6-50 MG (Sennosides-Docusate Sodium) Give 2 tablets by mouth two times a day related to constipation. The order was dated 9/21/24. Baclofen Oral Tablet 10 MG Give 10 mg by mouth two times a day for muscle relaxer. The order was dated 10/28/24. Pregabalin Oral Capsule 50 MG Give 1 capsule by mouth every 12 hours for pain. The order was dated 10/12/24. In an observation on 10/30/24 at 8:45 AM, MA B prepared the 9:00 AM medications for Resident #58. MA B administered Docusate Sodium 100 mg 2 tablets by mouth. MA B failed to administer his Baclofen 10 mg tablet or his pregabalin 50 mg capsule. Record review of Resident #58's MAR, dated October 2024, reflected the following entries: Colace 2-IN-1 Oral Tablet 8.6-50 MG 2 tablets was initialed as administered on 10/30/24 at 9:00 AM by MA B. Baclofen Oral Tablet 10 MG Give 10 mg by mouth two times a day was left blank on 10/30/24 at 9:00 AM. Pregabalin Oral Capsule 50 MG Give 1 capsule by mouth every 12 hours was coded as 13 indicating, Pending Arrival from Pharmacy on 10/30/24 at 9:00 AM by MA B. 3) Record Review of Resident #45's Admission Record, dated 11/1/24, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #45's Admission MDS assessment dated [DATE] reflected she was cognitively intact. The MDS Assessment reflected her diagnoses included, seizure disorder, anxiety disorder, and migraine (headaches). Record review of Resident #45's Order Summary Report dated 10/30/24 reflected an order for Flonase Allergy Relief Nasal Suspension 50 mcg 1 puff both nostrils in the morning for allergies. In an observation on 10/30/24 at 9:03 AM, MA B prepared the 9:00 AM medications for Resident #45. MA B failed to administer Resident #45's Flonase nasal spray along with her other medications. Record review of Resident #45's MAR dated October 2024 reflected an entry for Flonase Allergy Relief Nasal Suspension 50 mcg was coded as 13 indicating, Pending Arrival from Pharmacy on 10/30/24 at 9:00 AM by MA B. During an interview on 10/31/24 at 9:21 AM, MA B stated Resident #58's Baclofen order did not appear on her computerized MAR on 10/30/24 when she was passing her medications, but she noticed it was there today. She stated he would receive a dose today. MA B retrieved Resident #58's Baclofen medication card from her cart. The label on the medication card reflected an order date of 10/28/24, one tablet was missing from the card. MA B stated she could not explain why the medication did not appear in her computer yesterday but it did today. When asked about Resident #58's order for Colace 2-in-1, she confirmed the order in her computer was accurate and retrieved the bottle of docusate from her cart. She stated she had not previously noticed the difference in the medications. MA B checked her cart and was unable to locate a bottle of Colace 2-in-1. When MA B was asked about Resident #58's pregabalin, she stated the medication had not arrived yet. She stated, I told the nurse [LVN A] but I guess she never pulled it from the ekit. MA B stated she did not administer Resident # 45's Flonase because it was not available in her cart. She checked her cart at that time and stated it still was not there. MA B stated, when a medication was not in her cart, she told the Charge Nurse so that they could look for it. MA B walked to the nurse's medication cart and asked LVN C about Resident #45's Flonase. LVN C checked her cart and located the medication. MA B stated she had told LVN A about the missing Flonase on 10/30/24. LVN C Stated medications were getting delivered on the night shift and sometimes the medications were placed on the nurse's carts instead of the Medication Aide's carts. MA B stated the risk for missing medication doses depended on the medications. She stated, if it was pain medication, it could result in unrelieved pain. She stated the risk for administering the wrong medication or doses also depended on the medication but could cause negative side effects. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/1/24, LVN A stated she was unable to administer Resident #8's famotidine as it was not available. She stated she had called the pharmacy about it and was told they had called the insurance company and it was still pending approval. LVN A stated Resident #8's medications needed approval because he was covered under a different program and the medications came from a different vendor. She stated, because he had a special type of J-tube, the hospital did not want him to receive crushed medications as they had a history of clogging his tube, so his medications were sent in liquid form. LVN A stated she had called his physician on the morning of 11/1/24 and was approved to crush a tablet form and dissolve it in water. When asked about Resident #58's Baclofen, LVN A stated she was unaware he had missed any doses. She stated that medication could have easily been pulled from the ekit but she was never informed by MA B. LVN A stated she had previously called the pharmacy about Resident #58's pregabalin and learned it required approval from his pain management physician. She stated his pain management physician had been there on 10/30/24 and was reminded they needed to call the order into the pharmacy, and they did. She stated the medication had arrived and was being administered. LVN A stated she did not recall MA B ever telling her she could not locate Resident #45's Flonase on 10/30/24. She stated meds were usually delivered on night shift and sometimes placed in the wrong cart. LVN A stated the risk for residents missing medication doses included increased or uncontrolled pain, increased fall risk if pain was not managed and other symptoms depending upon the medication missed. During an interview on 10/31/24 at 8:40 AM, the DON stated the nurses, the ADON, and herself were responsible for ensuring medications were ordered and available. She stated she was unaware of any issues with medication availability. The DON stated she just started at the facility on 10/14/24 and the pharmacy consultant was there that day. She stated she was aware the medications were delivered at night and so may not be available the same day an order was written, and she had advised the nurses to place an order as STAT if a dose was due the same day. The DON stated she expected the nurses to let her know and to contact the pharmacy if a medication was not available. She stated the physician should be called if a medication would not be available in a timely manner. The DON stated the risk for missing medication doses depended upon the medication and included increased pain and the resident would not receive the therapeutic effect of the medication ordered. She stated the risk for receiving incorrect medications or doses included unintended side-effects. Record review of the facility's policy titled, Identifying and Managing Medication Errors and Adverse Consequences, dated, revised April 2007 reflected: Policy Statement-The staff and practitioner shall try to prevent medication errors and adverse medication consequences, and shall strive to identify and manage them appropriately when they occur. Policy Interpretation and Implementation-1. The staff and practitioner shall strive to minimize adverse consequences by: a. Following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication .

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	675112	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coral Rehabilitation and Nursing of Arlington	1112 Gibbins Rd Arlington, TX 76011

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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. 42283 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 in 1 of 1 kitchen reviewed for kitchen sanitation. The facility failed to ensure food was properly stored in the facility's kitchen on 10/29/24. This failure could place residents at risk for food-borne illness. Findings Included: Observation of the facility's refrigerator on 10/29/24 beginning at 8:58 AM revealed: - 7 tomatoes with fuzzy white and black spots; -4 carrots with fuzzy white and black spots; - 1 bag of box of bacon open and exposed to air; and - 1 bag of ham open and exposed to air. Observation of the facility's freezer on 10/29/24 beginning at 9:06 AM revealed: -1 box of striped pangasius fillet open and exposed to air; and - 1 box of beef patties open and exposed to air. Observation of the facility's seasoning shelf on 10/29/24 beginning at 9:12 AM revealed: -2 containers of paprika open and exposed to air; -1 container of poultry seasoning open and exposed to air; -1 container of ground nutmeg open and exposed to air; -1 container of chili powder open and exposed to air; -1 container of ground cinnamon open and exposed to air; -1 container of garden seasoning open and exposed to air; and -1 container of ground black pepper open and exposed to air. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with the Dietary Supervisor on 11/08/24 at 3:48 PM revealed he completed walk throughs of the kitchen daily. He stated he checked food storage throughout the kitchen. He stated the entire dietary department was responsible for ensuring proper food storage. He stated he ensured dietary staff stored food properly by completing walk throughs. He stated residents were at risk of getting sick due to improper food storage. A food storage policy was requested from the Administrator on 10/29/24 and not provided prior to exit.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observations, interviews, and record reviews the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for three (Resident #54, Resident #33, and Resident #24) of eight residents observed for infection control. 1. The facility failed to ensure Residents #54 and #33 were placed on enhanced barrier precautions. 2. LVN G failed to change her gloves and perform hand hygiene during incontinence care for Resident #24. These failures place residents at risk for healthcare associated cross contamination and infections. Findings included: 1. Record review of Resident #54's admission MDS assessment, dated 08/22/24, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His BIMs score was 9 indicating his cognitive status was moderately impaired. His diagnoses included hip fracture and Stage III pressure ulcer. The resident had a foley catheter. Record review of Resident #54's care plan, dated 10/14/24, reflected the resident had a foley catheter and a pressure ulcer. There was not a care plan for enhanced barrier precautions. Record review of Resident #54's Physician orders for October 2024, revealed there were no orders for enhanced barrier precautions. An observation on 10/29/24 at 10:15 AM revealed Resident #54's room did not have enhanced barrier precautions signage or PPE outside of the door. The resident was awake, alert, and oriented lying in bed. He had a foley catheter and said he also had wounds. LVN A entered the room and put on gloves, but no gown. LVN A approached the bedside and touched the bed sheet and resident with her arms and scrubs. LVN A's clothes touched the foley catheter tubing. The resident did not have a foley catheter stabilization device on. LVN A removed her gloves and performed hand hygiene. LVN A left the room and immediately returned with a catheter stabilization device. LVN A put on gloves and put the catheter stabilization device on the resident. An interview on 10/29/24 at 2:13 PM with LVN A revealed she did not know what enhanced barrier precautions were. She said she had never heard of it. She asked if it was a new type of barrier cream. She said Resident #54 was not on any type of isolation or barrier precautions. She said if a resident was on isolation or precautions, then it would have been on the 24-hour report, and there would have been signage on the resident's door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #33's quarterly MDS assessment, dated 08/25/24, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His cognitive skills for daily decision making were severely impaired. His diagnoses included stroke, diabetes, and quadriplegia. The resident had an indwelling catheter, feeding tube, and a tracheostomy. Record review of Resident #33's care plan, dated 11/25/23, reflected the resident had a tracheostomy, feeding tube, and a supra-pubic catheter. There was not a care plan for enhanced barrier precautions. Record review of Resident #33's Physician orders for October 2024, revealed there were no orders for enhanced barrier precautions. An observation on 10/29/24 at 9:08 AM of Resident #33 revealed his room did not have enhanced barrier precautions signage or PPE outside of the door. The resident was in bed. He was awake and non-verbal. The resident was not able to communicate. The resident had a tracheostomy, feeding tube, and catheter. An interview on 10/29/24 at 2:37 PM with CNA E revealed he had worked at the facility for two weeks and was assigned to Resident #33. CNA E said he did not know what enhanced barrier precautions were and that when he provided care to Resident #33 he only wore gloves. He said if a resident was on isolation or precautions then there would be signage on the door and PPE available outside the door. An interview on 10/29/24 at 2:41 PM with LVN F revealed he was assigned to Resident #33. He said he did not know what enhanced barrier precautions were and asked if it was a type of barrier cream. He said the resident had a tube feeding and catheter. An interview on 10/29/24 at 2:49 PM with the ADON revealed he said there was an in-service completed with staff about enhanced barrier precautions. He said based on the in-service, the staff would know who needed to be placed on enhanced barrier precautions. He said if staff did not wear the appropriate PPE of gown, gloves, and mask then the resident was at risk for spread of infection. The Surveyor requested a copy of the in-service on 10/29/24 at 2:49 PM from the ADON. It was not received prior to exit on 11/01/24. An interview on 10/31/24 at 2:23 PM with the Physician revealed he was not aware they the facility was not using enhanced barrier precautions. He said there was a risk of infection for residents that did not have enhanced barrier precautions. 3. Record review of Resident #24's quarterly MDS assessment, dated 07/06/24, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His cognitive skills for daily decision making were severely impaired. His diagnoses included stroke and diabetes. The resident was always incontinent of bladder and bowel. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation of incontinence care for Resident #24 on 10/30/24 at 11:44 AM with LVN G revealed the resident was lying in bed. LVN G put on clean gloves and pulled down the resident's brief. The brief was wet. LVN G cleaned the scrotum and penis and assisted the resident to roll to his right side. LVN G cleansed the buttocks and assisted the resident to lay on his back. LVN G grabbed barrier cream and applied it to the resident's scrotum with her soiled gloves on. LVN G then placed a new brief on the resident with her soiled gloves. After applying the brief, the LVN removed her gloves and performed hand hygiene. An interview on 10/30/24 at 11:49 AM with LVN G revealed she said she forgot to change her gloves after cleaning Resident #24. She said she was supposed to change her gloves and perform hand hygiene after cleaning the resident and there was a risk of infection to the resident if she did not. An interview on 10/31/24 at 11:06 AM with the ADON revealed he said he was not the Infection Preventionist. He said he told Administration (DON and Administrator) that he was not the Infection Preventionist. He said in the past, prior to survey he had been the Infection Preventionist. He said he did have the Infection Preventionist training. An interview on 10/31/24 at 3:56 PM with the DON revealed the ADON was the Infection Preventionist and was responsible for placing residents on enhanced barrier precautions. She said she did not know why residents were not placed on enhanced barrier precautions on 10/29/24. She said there was a risk of infection for residents who were not enhanced barrier precautions that needed to be. The DON said when staff were performing incontinence care, they were supposed to change gloves and perform hand hygiene after cleaning the resident and before applying creams and a new brief. The DON said there was a risk of contamination and infection if they did not change gloves and perform hand hygiene. Review of the CDC website on 10/31/24 reflected: https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html reflected: Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). .Enhanced Barrier Precautions expand the use of gown and gloves beyond anticipated blood and body fluid exposures. They focus on use of gown and gloves during high-contact resident care activities that have been demonstrated to result in transfer of MDROs to hands and clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated. Enhanced Barrier Precautions are recommended for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Standard Precautions still apply while using Enhanced Barrier Precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.Enhanced Barrier Precautions require the use of gown and gloves only for high-contact resident care activities (unless otherwise indicated as part of Standard Precautions). Residents are not restricted to their rooms and do not require placement in a private room. Enhanced Barrier Precautions also allow residents to participate in group activities. Because Enhanced Barrier Precautions do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. Review of the facility in-service, Infection Control, revised August 2010, revealed: This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections . The objectives of our infection control policies and practices are to: a. Prevent, detect, investigate, and control infections in the facility; b. Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public; c. Establish guidelines for implementing Isolation Precautions, including Standard and Transmission-Based Precautions; d. Establish guidelines for the availability and accessibility of supplies and equipment necessary for Standard Precautions .