

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Bremond Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 211 N Main Bremond, TX 76629	

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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884</p> <p>Based on observation, interview, and record review the facility failed to ensure residents unable to conduct activities of daily living (ADLs) received the necessary services to maintain good grooming and personal hygiene for two of six residents (Resident # 15 and Resident #18).</p> <ol style="list-style-type: none"> 1. The facility failed to ensure Resident # 15's nails were cleaned and did not have any rough edges. 2. The facility failed to ensure Resident # 18's facial hair was removed and nails were cleaned. <p>These failures could place residents at risk for poor hygiene, dignity issues, and decreased quality of life.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Record review of Resident #15's Face Sheet dated, 06/27/2024, reflected a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnoses of rheumatoid arthritis unspecified site (a chronic inflammatory disorder that can affect more than just your joints), unspecified lack of coordination (uncoordinated movement is due to a muscle control problem that causes an inability to coordinate movements), age- related physical debility (generalized weakness, exhaustion, poor balance, and decreased physical activity), muscle weakness (lack of muscle strength), and chronic pain syndrome (long standing pain that persists beyond the usual recovery period or occurs along with a chronic health condition, such as arthritis. It may affect people to the point that they can't work, eat properly, and/ or take part in physical activity). <p>Record review of Resident #15's Annual MDS Assessment, dated 05/02/2024, reflected the resident had a BIMS score of 12 reflected his cognition was moderately impaired. Resident # 15 did not reject care. Resident #18 was assessed to require assistance with personal hygiene, toileting, dressing, bathing, and transfers. Resident #15 had diagnosis of arthritis (joint inflammation) and muscle weakness (lack of muscle strength).</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #15's Comprehensive Care Plan, dated 05/15/2024, reflected Resident #15 preferred bed baths. Intervention: Staff will offer shower/ bed bath three times weekly. Staff will educate Resident #15 about proper hygiene. Resident #15 had rheumatoid arthritis and was at risk for decreased in ADLs and increased joint pain. Intervention: monitor for increased joint pain- give meds/ treatment per order - assess for signs of relief of pain. Resident #15 required assistance with ADLs. Interventions: Resident #15 required assistance with bathing, dressing, toileting, transfers, and eating.</p> <p>Record review of Resident #15's Treatment Administration Record (TAR) dated 06/01/2024 - 06/31/2024 reflected Resident #15 did not refuse nail care.</p> <p>Record review of Resident #15's nurses notes from 05/01/2024 thru 06/26/2024 Resident #15 did not refuse nail care.</p> <p>Observation on 06/25/2024 at 10:21 AM Resident # 15 was in his room sitting in wheelchair watching television. Resident #15 had blackish hard substance underneath the forefinger and middle fingernails on his right hand. His middle and ring fingernails was rough around the edges. There was an odor of bowels on his right hand.</p> <p>In an interview on 06/25/2024 at 10: 24 AM Resident #15 stated he tried to clean his nails but he was not physically able to clean his own nails or trim his nails. He stated some of his nails was rough and needed to be smoothed but he was not able to do this and he would try but he was afraid he would get his nails infected if he tried. Resident #15 also stated he needed assistance with his nails and all his care. He stated someone came in yesterday (06/24/2024) to trim his nails and they said his nails did not need to be trimmed. He asked the staff to file his nails and the staff stated they did not file nails all they did was trim nails. He stated his nails were dirty yesterday afternoon after the staff left the room. He stated the person never returned to his room and he did not ask anyone else to assist him. He stated if she stated it was not their job to file the nails he was not going to ask anyone else. Resident #15 did not recall the person's name. Resident #15 stated he has not refused any nail care from staff.</p> <p>2. Record review of Resident #18's Face Sheet dated, 06/26/2024, reflected a [AGE] year-old female admitted on [DATE] with diagnoses of unspecified dementia (affects memory, thinking and social abilities), contracture of muscles, unspecified upper arm (occurs when your muscles, tendons, joints, or other tissues or shorten causing a deformity and can cause loss of movement in the joint), muscle weakness (lack of muscle strength).</p> <p>Record review of Resident #18's Quarterly MDS Assessment, dated 04/01/2024, reflected the resident had a BIMS score of 0 indicated her cognition was severely impaired. Resident #18 did not reject care. She was assessed to be dependent on staff for ADLs such as: eating, oral hygiene, toileting hygiene, personal hygiene, showers, lower body dressing and all transfers except sit to lying and lying to sitting on side of bed.</p> <p>Record review of Resident #18's Comprehensive Care Plan, dated 03/07/2024, reflected Resident #18 had a diagnosis of dementia (affects memory, thinking and social abilities) with expected decline in cognitive impairment over a period of time as a natural progression of the disease. Intervention: document decline in cognitive status. Resident #18 was identified needed assistance with ADLs (the type of ADLs was not specified).</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #18's Treatment Administration Record (TAR) dated 06/01/2024 - 06/31/2024 reflected Resident #18 did not refuse nail care.</p> <p>Record review of Resident #18's nurses notes from 05/01/2024 thru 06/26/2024 Resident #18 did not refuse nail care.</p> <p>Observation on 06/25/2024 at 10:36 AM Resident #18 was sitting in her Geri chair listening to music. She had slightly curled facial hair approximately 2-3 inches long on the left side of her face near her mouth. Resident #18 had blackish hard substance underneath her nails on her middle and ring finger on the right hand. She also had hard blackish and her ring and fore finger on her left hand.</p> <p>In an interview on 06/25/2024 at 10:39 AM Resident #18 was not interview able. She did not respond verbally or with gestures to any questions.</p> <p>In an interview on 06/27/2024 at 11:00 AM the DON stated it was a joint effort between the CNAs and the nurses to complete nail care on the residents. She stated the nurses was responsible for residents with diagnosis of diabetes (a disease in which the body's ability to produce or respond to the hormone insulin was impaired). The Director of Nurses stated nail care was scheduled by the TAR and when residents received showers. She also stated nail care was also expected to be completed as needed. She stated if a resident had blackish substance underneath their nails the substance may be dirt and not bacteria. She stated no one knows if it was bacteria underneath the residents' fingernails. The DON stated if the scent was feces was noticed underneath residents' fingernails there was a potential this may be bacteria. She stated it was a possibility a resident may become physically ill such as vomiting or diarrhea if they ingested bacteria from feces. She also stated if a resident had rough fingernails there was a possibility the resident may scratch themselves and develop a skin tear. The DON stated she did not believe women having facial hair was a dignity issue or any type of issue. She stated if a resident was not able to communicate verbally if they wanted facial hair she did not believe this was an issue for the female resident to have facial hair. She stated if there was any refusal of nail care it would be documented in the nurses notes or on the TAR.</p> <p>In an interview on 06/27/2024 at 11:20 AM LVN A stated the nurses and CNAs were responsible for nail care. She stated the nurses was responsible to trim and clean all resident's nails with a diagnosis of diabetes. LVN A stated it was the CNAs responsibility to clean and trim all other residents' nails. She stated the nurses checked the diabetic nails weekly and the CNAs reported to the nurses if any diabetic nails needed to be cleaned or trimmed. LVN also stated the nurse would document on the TAR (Treatment Administrator Record) and/ or nurses notes if any resident refused nail care. She stated if there was a blackish substance underneath the residents' nails, there was a possibility the substance may had bacteria underneath the residents' nails. She also stated if a resident swallowed the bacteria there was a possibility a resident may become extremely ill with stomach issues such as diarrhea. She stated if a resident scratched themselves with rough nails there was a potential a resident may develop a skin tear. LVN A stated she was not aware of anyone refusing nail care; however, she would need to refer to the TAR to know for certain if Resident # 15 or Resident #18 refused nail care.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 06/27/2024 at 11:30 AM CNA E stated the nurses completed all diabetic fingernails and the CNAs was responsible for all other residents' nails. She stated the CNAs was responsible to complete nail care such as trimming, filing, and cleaning the nails. She stated the staff was very busy and it was difficult to complete nail care on residents except when the resident was in the shower. CNA E also stated if a resident's nails needed to be cleaned, trimmed, or filed and it was not their shower day there were times the staff was not able to clean, trim or file the residents' nails. CNA E stated there were also times the nursing staff may have time to do one of the nail tasks but not all three tasks such as filing, cleaning, and trimming. She stated if a resident had blackish substance underneath their nails it was usually from their bowels. She stated if a resident swallowed some of their bowels the resident may become ill with sores in their mouth, yeast infections in their mouth, get E. coli (a bacteria that is commonly found in the lower intestine of warm-blooded organisms) and may develop major stomach problems such as diarrhea. She stated she worked with Resident #15 and Resident #18 and she was not aware of them refusing nail care. She stated if a resident's nails were rough there was a possibility the resident may scratch themselves and develop a skin tear or possibly scratch their eye and cause a tear on their eyeball.</p> <p>Record review of the Facility Policy on ADLs dated, 05/05/2023, reflected Activities of daily living (ADLs), refer to tasks related to personal care including, grooming, dressing, oral hygiene, transfer, bed mobility, eating, bathing and communication system. POLICY: The Facility provides care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. The Facility provides necessary care to all residents that are unable to carry out activities of daily living on their own to ensure they maintain proper nutrition, grooming, and hygiene.</p> <p>*</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32452</p> <p>Based on observations, interviews, and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one of five residents reviewed for accidents and hazards. (Resident #1).</p> <p>The facility failed to ensure CNA E followed Resident #1's care plan for the use of a mechanical lift for all transfers with two staff assist and failed to follow the manufacture instructions for use which resulted in Resident #1 receiving an improper and potentially dangers transfer.</p> <p>These failures placed residents at risk of injuries, hospitalization , or diminished quality of care.</p> <p>Finding Include:</p> <p>Review of Resident #1's face sheet dated 06/26/2024 reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses Cerebral palsy (A group of disorders that affect movement, muscle tone, balance, and posture.), Anxiety Disorder (Fear characterized by behavioral disturbances.), Abnormal posture, and Contractures (A permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen and a decrease in ROM).</p> <p>Review of Resident #1's quarterly MDS assessment dated [DATE] reflected Resident #1 was assessed to have a BIMS score of 15 indicating she was cognitively intact. Resident #1 was further assessed to have functional limitation in range of motion in her bilateral upper and lower extremities. Resident #1 was further assessed to be dependent on staff for transfers.</p> <p>Review of Resident #1's comprehensive care plan reflected a problem dated 04/21/2021 that was revised on 04/15/2024 Resident #1 requires assistance with ADLs related to impaired cognition, impaired mobility and incontinence of bowel and bladder related to cerebral palsy. Approaches included: Transfers total assist with 2 person assist utilizing a Hoyer lift.</p> <p>Review of Resident #1's consolidated physician orders reflected an order dated 01/09/2019 Transfer with assist of Hoyer lift.</p> <p>Observation on 06/26/2024 at 1:26 PM revealed CNA E outside of Resident #1's room preparing to provide care. CNA E went to get the Hoyer lift. CNA E entered Resident #1's room alone with the Hoyer lift. Resident #1 was sitting in a specialized wheelchair and was observed to have contractures (a permanent tightening of the muscles, tendons, skin and surrounding tissues that causes the joints to shorten and stiffen) to her neck, spine, bilateral arms, and legs. Resident #1 had abnormal posture and was leaning to her right side. CNA E She positioned the mechanical lift around Resident #1's wheelchair and hooked the sling to the Hoyer lift. Without locking the wheels on the mechanical lift, she lifted Resident #1 and maneuvered the mechanical lift to the bed. CNA E then closed the legs locked the mechanical and lowered Resident #1 to the bed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 06/26/2024 at 1:45 PM CNA E stated she was trained to use two people for mechanical lift transfers. CNA E stated she performed the transfer alone because she thought the other aide was coming to help and when she did not come; she went ahead with the transfer. CNA E stated she should have waited on the other aide for safety reasons CNA E further stated the wheels on the mechanical lift were supposed to be locked when lifting the resident.</p> <p>In an interview on 06/26/2024 at 1:53 PM the DON stated it was her expectation for two people be present for mechanical lift transfers for safety reasons.</p> <p>In an interview on 06/26/2024 at 3:27 PM Resident #1 stated the staff usually used two people to transfer her with the Hoyer but sometimes they only use one. Resident #1 stated she had not been injured during any transfers and felt safe.</p> <p>Review of the facility's policy Mechanical Lifts: General Guidelines dated 05/05/2023 reflected Prepare the environment by 1) Securing the appropriate number of caregivers. In most cases, a minimum of 2 people is required to operate the lift and handle the patient or resident .</p> <p>Review of the Hoyer lift manufacturer instruction manual dated 2024 reflected .Safety Precautions . ALWAYS lock the wheels when lifting .</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32452</p> <p>Based on observation, interviews, and record review, the facility failed to ensure, based on the comprehensive assessment of a resident, residents who had not used psychotropic drugs were not given these drugs unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record for 1 of 5 residents (Resident #21) reviewed for unnecessary medications.</p> <p>The facility failed to ensure Resident #21 had behavior and side effect monitoring for his prescribed antidepressant medications Fluoxetine and Trazadone and his antipsychotic medication Abilify.</p> <p>These failures could place resident at risk of receiving unnecessary psychotropic medications with possible medication side effects, adverse consequences, and decreased quality of life.</p> <p>Findings included:</p> <p>Review of Resident #21's face sheet dated 06/26/2024 reflected a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses Alzheimer's Disease (A type of brain disorder that causes problems with memory, thinking and behavior. This is a gradually progressive condition.), Dementia (A group of symptoms that affects memory, thinking and interferes with daily life.), and Major Depressive disorder (A mental condition characterized by a persistently depressed mood and long-term loss of pleasure or interest in life, often with other symptoms such as disturbed sleep, feelings of guilt or inadequacy, and suicidal thoughts.)</p> <p>Review of Resident #21's Admission MDS assessment dated [DATE] reflected Resident #21 was assessed to have a BIMS score of 8 indicate moderate cognitive impairment. Resident #21 was assessed to have inattention, disorganized thinking and altered levels of consciousness that fluctuates. Resident #21 was further assessed to have verbal behaviors one to three days a week.</p> <p>Review of Resident #21's comprehensive care plan reflected a problem dated 06/25/2024 Psychotropic drug use Resident #21 is at risk for adverse consequences related to receiving antipsychotic medication for treatment of Psychosis related to Alzheimer's/Dementia. Approaches included Assess/record effectiveness of drug treatment. Monitor and report signs of sedation, anticholinergic and/or extrapyramidal symptoms Monitor resident's behavior and response to medication .Quantitatively and objectively document the resident's behavior.</p> <p>Review of Resident #21's consolidated physician orders reflected the following orders:</p> <p>*Fluoxetine 40mg oral once daily dated 03/22/2024 ,</p> <p>*Trazodone 100 mg oral at bedtime dated 03/22/2024,</p> <p>*Abilify 5mg once daily dated 03/22/2024,</p> <p>*Behavior monitoring twice daily for antidepressant drug Fluoxetine and trazodone dated 03/04/2022,</p> <p>(continued on next page)</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32452</p> <p>Based on interview and record reviews the facility failed to ensure PRN orders for psychotropic drugs were limited to 14 days, except if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, for one of five residents reviewed for unnecessary medications. (Residents #21)</p> <p>The facility failed to ensure Resident #21's PRN order for Haldol dated 05/06/2024 had a stop date transcribed onto the MAR to ensure the medication did not extend beyond 14 days causing Resident #21 to receive 7 doses beyond the physician ordered stop date of 05/20/2024.</p> <p>This deficient practice placed residents with PRN psychotropic drugs at risk for side effects of psychotropic drugs which include nausea, drowsiness, dizziness, confusion, constipation, diarrhea, and delirium and placed residents at risk for receiving unnecessary medications.</p> <p>Findings included:</p> <p>Review of Resident #21's face sheet dated 06/26/2024 reflected a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses Alzheimer's Disease (A type of brain disorder that causes problems with memory, thinking and behavior. This is a gradually progressive condition.), Dementia (A group of symptoms that affects memory, thinking and interferes with daily life.), and Major Depressive disorder (A mental condition characterized by a persistently depressed mood and long-term loss of pleasure or interest in life, often with other symptoms such as disturbed sleep, feelings of guilt or inadequacy, and suicidal thoughts.)</p> <p>Review of Resident #21's Admission MDS assessment dated [DATE] reflected Resident #21 was assessed to have a BIMS score of 8 indicate moderate cognitive impairment. Resident #21 was assessed to have inattention, disorganized thinking and altered levels of consciousness that fluctuates. Resident #21 was further assessed to have verbal behaviors one to three days a week.</p> <p>Review of Resident #21's comprehensive care plan reflected a problem dated 06/25/2024 Psychotropic drug use Resident #21 is at risk for adverse consequences related to receiving antipsychotic medication for treatment of Psychosis related to Alzheimer's/Dementia. Approaches included Assess/record effectiveness of drug treatment. Monitor and report signs of sedation, anticholinergic and/or extrapyramidal symptoms Monitor resident's behavior and response to medication .Quantitatively and objectively document the resident's behavior.</p> <p>Review of Resident #21's consolidated physician orders reflected the following orders:</p> <p>*dated 05/06/2024 Haloperidol 0.5mg one tab every 8 hours as needed for aggression. The order had a stop date of 05/07/2024.</p> <p>*dated 05/07/2024 for Haloperidol 0.5mg one tab every 8 hours as needed for aggression with a stop date of 05/20/2024.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Bremond Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 211 N Main Bremond, TX 76629	
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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #21's MAR dated 05/01/2024 through 05/31/2024 reflected an entry for haloperidol 0.5mg one tab by mouth every eight hours as needed for aggression. No stop date was indicated on the MAR for the medication. The haloperidol was signed as given past the medication stop date on six occasions: 05/23/2024 through 05/26/2024, 05/28/2024 and 05/30/2024.</p> <p>In an interview on 06/26/2024 at 4:00 PM LVN A stated Resident #21's order for Haldol was only supposed to be for 14 days but when it was put on the MAR no end date was indicated so we continued to use the medication as needed.</p> <p>In an interview on 06/27/2024 at 9:38 AM the DON stated she got the clarification for Resident #21's order for Haldol since on 05/06/2024 the order did not include a stop date so on 05/07/2024 it was clarified to have a stop date of 05/2024. The DON stated she put the order into the computer to include the stop date. She stated she did not print a new MAR she stated the nurses have access to the MARs in the computer. The DON stated they do not use the computer MARs to pass medications since they still use paper. The DON stated the change was on the change screen (24-hour report) and the nurses can see that. She stated there were a lot of steps done to prevent the error, but it occurred anyway Its Ridiculous</p> <p>In an interview on 06/27/2024 at 9:45 AM LVN A stated any order change does show up on the change screen but if the MARs with changes are not printed out the changes could be missed. LVN A stated that was why Resident 21's Haldol was given past the discontinuation date.</p> <p>Review of the facility's policy Medication Management Program dated 07/13/2021 reflected The Facility implements a Medication Management program to meet the pharmaceutical needs of patients and residents, according to established standards of practice and regulatory requirements . Licensed nurses will evaluate, assess, monitor, document and report the effectiveness of the medication regimen that includes all medications and supplements prescribed to treat illness, disease process, or enhance the patient's/resident's quality of life . 1) Reduce Unnecessary and Supplementary Medications . b) Review medication regimen to discontinue unnecessary drugs.</p>		

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NAME OF PROVIDER OR SUPPLIER Bremond Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 211 N Main Bremond, TX 76629	

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884</p> <p>Based on interview and record review, the facility failed to employ staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition services for one of one kitchen staff (Dietary manager) reviewed for qualified dietary staff.</p> <p>The facility failed to ensure the Dietary Manger completed an approved dietary manager training course.</p> <p>This failure could place the residents at risk for the spread of food borne illness and residents not having their nutritional needs met.</p> <p>Findings included:</p> <p>Record review of the personnel file for the Dietary Manager reflected she had not completed the certified Dietary Manager course. She had a date of hire of 03/04/2019.</p> <p>Interview on 06/26/2024 at 11:00 AM the Dietary Manager stated she began taking classes online approximately 3 years ago and she did finish her classes but did not take the test. She stated she did not have any proof of her passing classes online or when she signed up for the dietary manager courses. She stated she was not a certified Dietary Manger and she was not working under Registered Dietician license or a Certified Dietary Manager License. She stated she did have her food handler certificate and that was the only food service certificate she had at this time. She also stated she did not report to anyone that she did not have her certified dietary manager license and no one asked to see it until now. She stated she thought with her experience as a cook over [AGE] years and working the kitchen had justified her not being a qualified Dietary Manager.</p> <p>Interview via telephone on 06/26/2024 at 11:51 AM The Registered Dietician Consultant stated the Dietary Manager was not working under her license. She stated she thought the Dietary Manager had her certificate. She stated if she did not finish the Dietary Manger Course online she was not qualified to be a Dietary Manager.</p> <p>Interview on 06/27/2024 at 12:30 PM the Administrator stated he was not aware that the Dietary Manager did not have her certification/ license. He stated he had been in the facility for three weeks and was focusing on the nursing department and then he was going to focus on the dietary department. He stated he would be working on this issue. He stated all license of department heads was expected to be in their personnel records. He stated a registered dietician comes in and does the documentation. A request for the policy of dietary manager qualifications was made and was not provided at time of exit.</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884</p> <p>Based on observation, interviews, and record review, the facility failed to prepare puree food by methods that conserve nutritive value, flavor, and appearance for one of one kitchen.</p> <p>The facility failed to provide puree recipes for the Dietary Manager to follow when preparing puree food.</p> <p>This failure could affect residents on puree diet at risk of receiving inadequate diet that could affect their health.</p> <p>Findings included:</p> <p>Observation on 06/26/2024 7:10 to 7:40 AM, Dietary Manager began to pureed eggs. She placed the eggs into the pureed blender and began to puree the eggs. She did not measure the eggs or have a recipe to follow. Observation of Dietary Manger pureed bacon The bacon was not the same size. One piece of bacon was shorter. The Dietary Manger place bread into the pureed blender and added water to the bread without measuring the water. She did not measure any food she pureed.</p> <p>Interview on 06/26/2024 at 7:50 AM, Dietary Manger stated she was required to use juice such as orange or apple juice when she pureed bread but she always used water. When asked where her recipes were to pureed food, she stated she did not have any recipes and did not follow recipes when pureed food. She stated she always used her judgement on how much food to place into the food blender. She stated she had been cooking approximately [AGE] years and she knew how much food to use without measuring the food or follow a recipe. She stated she did not need a recipe. She exited the kitchen and entered her office to search if she did have recipes. The Dietary Manager stated she did not have the spring/ summer recipes to follow and she did not know how to get the recipes.</p> <p>Interview via telephone on 06/26/2024 at 11:51 AM the Registered Dietician Consultant stated all recipes was online and everyone had access to these recipes. She stated she had shown the Dietary Manager how to access these recipes. She stated all cooks including the cooks with years of experience was expected to follow the recipes especially when they are pureeing food. She also stated it was very important to use the correct measurements. The Registered Dietician Consultant stated if the correct measurements were not used the consistency of the pureed food may not be correct. She stated water was never to be used in any foods when adding liquid during the puree process. She stated it was best practice to use broth, milk, or butter. She did not respond when asked what may happen to the pureed food if water was used as the liquid during the pureed process.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/27/2024 at 11:15 AM the Administrator stated the dietary manager had been working as a cook for a very long time and she knew what she was doing when she prepared pureed food or any type of food. He stated he did not agree with guessing how much food to be added when the dietary manager pureed the food when being observed on Tuesday (06/26/2024). He stated he was not going to answer if it was ok not to follow a resident when pureeing food. The Administrator stated when an employee had been pureeing food repetitive every day it became repetition and they knew how to measure the food without a recipe and knew what size scoop to use with all foods. He stated if a cook pureed food all the time they would have it memorized and would be able to correct the pureed food if it did not look right without using a recipe.</p> <p>Record review of the Facility Policy on Nutrition Policies and Procedures revised on 08/01/2020 reflected prepare puree foods as per recipe.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884</p> <p>Based on observation, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food accordance with professional standards for food service of one of one kitchen reviewed for food storage, meal prep and sanitation.</p> <ol style="list-style-type: none"> The facility failed to seal, label and date partially frozen chicken cubes and a personal cell phone on the food prep table. The facility failed to ensure dietary staff practiced proper hand hygiene and glove use. The facility failed to follow recipes when preparing pureed food. The facility failed to ensure regional maintenance director and a contractor wore hair nets and a beard net when entered the kitchen, the dietary staff appropriately wore a hair net, and nursing staff wore a hair net when in the kitchen. <p>These failures could place residents at risk for health complications and foodborne illnesses.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Observation on 06/25/2024 from 9:06 AM to 9:16 AM there was an open clear plastic bag not labeled or dated of partially frozen cubed chicken on the food prep table. A cell phone was lying on the food prep table near a pot and the open bag of the partially frozen cubed chicken. <p>In an interview on 06/25/2024 at 9:17 AM the Dietary Manager stated she had been away from the food prep area for several minutes. She stated the cubed chicken was pre-cooked. She also stated the plastic bag the chicken was stored in was not to be left opened and should have been closed until the time she was going to cook the chicken. She stated anything could fall into the bag of chicken. The Dietary Manager stated if there were flies in the kitchen the fly could fall into the open bag of chicken and fly out of the bag without the dietary staff knowledge which would contaminate the chicken cubed chicken. She also stated she was not a nurse and did not know if a resident would become ill if ingested contaminated chicken.</p> <p>Observation on 06/25/2024 at 9:22 AM Dietary Manager removed the cell phone from the kitchen area. She did not sanitize the food prep area and placed ladles where the cell phone was lying on the food prep area.</p> <p>Observation on 06/25/2024 at 9:45 AM Dietary Manager picked up one of the ladles laying on the area where cell phone was laying. She placed the ladle in the pot on the stove where dumplings were being prepared.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 06/25/2024 at 9:48 AM Dietary Manager stated she did place ladles where the cell phone was lying on the food prep table. She stated she removed the cell phone from the food prep table and did not sanitize the food prep area where the cell phone was located. Dietary Manager stated there was a potential the ladles may be contaminated after touching surface where the cell phone was lying on the food prep table. She stated cell phones are not sanitary and was considered contaminated. She also stated there was a possibility the bacteria from the cell phone could have cross contaminated the ladles. She stated she was not a nurse and does not know if a resident may become physically ill if the ladle had germs on it and was in the pot where food was being prepared. She stated she was expected to sanitize the food prep area after she removed the cell phone. She also stated the food prep area where the phone was located was not considered sanitized.</p> <p>Observation on 06/26/2024 from 7:10 AM to 7:25 Dietary Manager was preparing pureed food. She touched her shirt, her hair covering and the oven door handle. She did not wash or sanitize her hands and touched the outside of the fourchettes (where you place your fingers into a glove) on both gloves. She donned the gloves and touched inside the scoop. This portion of the scoop was used to hold the scramble eggs she obtained from the silver container on the steam table and she place the eggs in a white plastic container. Her middle finger and her fore finger on her right hand did touch top of the eggs when she was placing the scrambled eggs into the pureed blender. The Dietary Manager pureed the eggs and carried the pureed blender to the dishwashing room to clean before using it to puree other foods. She did not remove her gloves and before she entered the dishwashing room she touched the top of garbage can to throw away a napkin. The Dietary Manager proceeded to clean the pureed blender. She touched several surfaces on the dishwasher. She returned to the food prep area and did not change her gloves and touched part of the bacon she placed in the pureed blender.</p> <p>Interview on 06/26/2024 at 7:25 AM the Dietary Manager stated she did not wash or sanitize her hands prior to placing gloves on her hands when she pureed the eggs. She stated she did touch her shirt and she was in a hurry and did not know if she touched the eggs. She also stated she did touch the inside part of the scoop where eggs were placed after she dipped the scoop inside the scramble eggs on the steam table. The Dietary Manager stated it was possible she touched the garbage can lid when she discarded paper towel. She also stated she did not remove her gloves while she was in the dishwasher room and she did return to the kitchen and she did touch part of one piece of bacon without changing her gloves. She stated she was expected to change her gloves, wash hands and place new gloves on and she did not do this between tasks. She also stated there was a possibility germs or bacteria was on her gloves and she could have contaminated the containers, the scoop, and the food. She stated she was not a nurse and did not know if a resident may become ill if the ate any contaminated food.</p> <p>Observation on 06/26/2024 at 7:30 AM Dietary Aide B donned gloves without washing his hands and touched the lid of garbage can to throw away napkin. He touched inside of clean plates.</p> <p>Interview on 06/26/2024 at 7:32 AM Dietary Aide B stated he had been informed to always wash his hands before wearing gloves. He stated it was difficult to wash his hands and then wear gloves due to being difficult to attempting to place the gloves onto his hands. He stated he did not know if not washing his hands would contaminate the gloves. He did not respond to any further questions about hand sanitation, wearing gloves and touching clean plates with potential contaminated gloves.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 06/26/2024 at 7:33 AM the Dietary Manager removed her gloves and placed new gloves on without washing or sanitizing her hands. She touched the fourchettes of the gloves when she donned the gloves. She touched the bread with her gloved hands and place the bread in the pureed container. After she pureed the bread and placed the bread in a silver container on the steam table, she went to her office and looked for recipes. She touched 3 manuals in her office, picked up a pen and wrote something on a sheet of paper, touched her desk, moved her personal phone on her desk and touched a cup on her desk. She was wearing the same gloves. The Dietary Manager returned to the kitchen area with the same gloves on her hands and she picked up the food thermometer and touched the part of the thermometer used to place into the food to check the temperature of the food.</p> <p>Interview on 06/26/2024 at 7:50 AM The Dietary Manager stated she realized she did not remove her gloves and wash her hands after she had begun touching the outside of the gloves when she was placing the gloves on her hands. She stated she knew she had already made a mistake earlier and she would probably be written out for not washing her hands or changing her gloves earlier and she thought if she was already getting written out she would just continue since she made the same mistake again. She stated she was required to change her gloves in between tasks and wash her hands prior to placing new gloves on her hands. She stated she did touch the bread without changing her gloves. She also stated when was in her office she touched the manuals, pen, paper, her cell phone on her desk and probably touched the cup on her desk. She stated she did enter the kitchen without changing her gloves and touched the part of the thermometer she placed in the food to obtain a temperature of the food. She stated she was expected to change her gloves and wash her hands after she left her office and before she obtained temperature of the food. She stated she had already made mistake of not changing her gloves and she was not thinking clearly.</p> <p>Interview via telephone on 06/26/2024 at 11:51 AM The Registered Dietician Consultant stated anyone enters the kitchen area was required to wear a hair net. If a male had facial hair the male was required to wear a beard net. She stated this included anyone working in other departments such as nursing and any contractors entered the kitchen. She stated hair could fall onto food, food prep areas and clean dishes. She did not respond to any other questions if someone was not wearing a hair net in the kitchen.</p> <p>Observation on 06/27/2024 at 10:38 AM Dietary Aide C gave Regional Maintenance Director a hair net and beard net. Dietary Aide C was wearing gloves and his middle finger and fore finger on his right hand touched the Regional Maintenance Director palm on his right hand. Dietary Aide C touched his own shirt and touched the door handle of the kitchen door. He exited the main area of the kitchen and entered the dishwashing room and touched the following clean silverware without changing his gloves: the tines (area of the fork where food is placed prior to eating the food) of six clean forks, touched inside the scoop where food is placed in a spoon of four spoons, and touched the top of four knives.</p> <p>Interview on 06/27/2024 at 10:41 AM Dietary Aide C stated his fingers inside his gloves did touch the Regional Maintenance Director hand. He also stated he did not change his gloves and did touch the part of the fork and spoon where residents would put the food on the fork and spoon to put the food in their mouths. He also stated he did touch the tip of the forks and there was a possibility the silverware may have germs on them from his gloves. He stated if a resident did eat some germs they may become sick with stomach problems may have diarrhea.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview on 06/26/2024 from 7:30 to 7:32 AM Dietary Aide B was standing near clean plates his hair net was not covering all of his hair. There was approximately 6-8 inches of hair on the side and the back of his head not covered. Dietary Aide B stated there was a possibility hair may fall onto the plates. He stated his hair was not completely covered with the hair net. He stated he was not a nurse and did not know what possibly may happen to a resident if hair was on resident plate or food and the resident ate the hair.</p> <p>Observation on 06/26/2024 at 8:07 AM, CNA D entered the kitchen area without wearing a hair net. She was standing five to six feet inside the kitchen. CNA D was within approximately less than one foot next to uncovered plates of food for residents eating in their rooms. Her hair was shoulder length.</p> <p>In an interview on 06/26/2024 at 8:12 AM CNA D stated she was standing inside the kitchen and was standing over plates of food uncovered. She stated she was standing near the food prep area. She also stated she was expected to wear a hair net anytime anyone entered the kitchen. She stated she had been in-serviced on wearing hair nets when nursing staff entered the kitchen. CNA D stated there was a possibility her hair could have fallen onto the food as she was standing over the plate of food that was going down the hall on a hall cart. CNA D stated hair was considered contaminated and a resident may become ill if there was hair on their food and the resident ate the hair. She also stated the resident may become physically ill with vomiting or diarrhea from the bacteria from the hair.</p> <p>Interview on 06/27/2024 at 8:40 AM the Administrator stated he would provide all dietary staff personnel records and their check off list of training. The Dietary Manager personnel record was the only dietary personnel record provided.</p> <p>Observation on 06/27/2024 at 9:55 AM a Contractor entered the kitchen and he had approximately 8 inches of facial hair around his chin. He was not wearing a hair net or beard net. He was standing in the food prep area of the kitchen.</p> <p>Interview on 06/27/2024 at 9:58 AM the Contractor stated he was aware of wearing a hair net and beard net when he entered the kitchen and he stated he frequently made deliveries to this kitchen throughout the month. He stated he forgot to place the hair net and beard net on when he entered the kitchen. He stated he knew this was a rule and he did not follow the rules. He stated there was a possibility hair could fall onto surfaces in the kitchen. The contractor did not respond to any further questions about hair being contaminated or the importance of wearing hair net and beard net.</p> <p>Interview on 06/27/2024 at 10:02 AM The Dietary Manager stated the contractor had been explained to wear hair net and beard net when he entered the kitchen. She stated there was a possibility he could have contaminated the food being prepared when standing near the food prep table. She stated there were hair net and beard net accessible at the door when entering the kitchen. Requested in-services on the following: hand sanitizing/ wearing gloves, pureed food, follow recipes, and wearing hair nets/ beard nets, label/ dating food, keeping containers of food closed until ready to use, and storing personal items on the food prep tables. These in-services were not provided at time of exit.</p> <p>Observation on 06/27/2024 at 10:30 AM there were beard nets and hair nets stored at the entrances to the kitchen. The Regional Maintenance Director was standing by the food prep table in the kitchen area without wearing a hair net or beard net. There were containers of food on the food prep table where he was standing.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 06/27/2024 at 10:35 AM the Regional Maintenance Director stated he did know to wear a hair net and beard net when he entered the kitchen. He stated this was standard protocol in every kitchen in a nursing home. He stated he was standing near the food prep table and there was food where he was standing. He also stated it was a possibility hair may fall into the food. He stated he was not a nurse and did not know what would happen to a resident if they ate food with hair on the food.</p> <p>Interview on 06/27/2024 at 11:15 AM the Administrator stated any staff including contractors that entered the kitchen was expected to wear hair nets and if needed a beard net. He stated there was a possibility of hair falling on food prep surfaces, plates and /or foods. He stated he was not a nurse and did not know what may happen to a resident if the resident ingested hair. He stated hair may or may not be contaminated it was according to the individual. He stated all dietary staff was expected to wear gloves when in the kitchen. The Administrator also stated he did expect the dietary staff to change their gloves in between tasks or when touch any contaminated item. He stated the staff was expected to wash hands prior to placing gloves on their hands. The Administrator did not answer any questions about if the dietary staff was wearing contaminated gloves and touched food, plates, silverware, or any food containers. He stated the staff personal items including cell phone was not to be placed on the food prep table. He stated if it was on the food prep table he did expect the table to be sanitized. The administrator did not respond to the question if the food prep table was not sanitized and food was being prepared on that table if the there was a possibility of cross contamination. Requested in-services from the dietary department such as: hand sanitizing/ wearing gloves, pureed food, follow recipes, and wearing hair nets/ beard nets, label/ dating food, keeping containers of food closed until ready to use, and storing personal items on the food prep tables. These in-services were not provided prior to exit.</p> <p>Record review request via email on 06/26/2024 at 5:32 PM reflected in-services given to dietary staff prior to 06/24/2024 was requested on the policies requested such as:</p> <ol style="list-style-type: none"> 1. Following Recipes 2. Employee personal items where food was being prepared. 3. Hand Hygiene and wearing gloves. 4. Hair nets and beard nets. 5. Label, dating and storage of foods 6. Copy of the kitchen cleaning schedule <p>These was not provided at the time of exit.</p> <p>Record review of the facilities Nutrition Policies and Procedures revised on 06/20/2203 reflected appropriate hair restraints such as hats, hair covers or nets, and beard restraints [NAME] involved in food production activities. Hand hygiene is the most important component for preventing the spread of infection. Proper hand washing technique will be used when hand washing is indicated. Wash hands before putting on gloves, when changing into a fresh pair of gloves, and immediately after removing gloves. Before handling food. After contact with soiled or contaminated articles. Antimicrobial gel cannot be used in the kitchen during food preparation.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Bremond Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 211 N Main Bremond, TX 76629	
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Food and Drug Administration Food Code, dated 2022, reflected, .3-302.12 Food Storage Containers, Identified with Common Name of Food .3-305.11 Food Storage.(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32452</p> <p>Based on interviews and record review, the facility failed to ensure resident's medical records included documentation that indicated the resident, or their responsible party, received education of the benefits, and potential side effects, of the influenza or pneumococcal immunization, receipt of the influenza or pneumococcal immunization, or residents did not receive the influenza or pneumococcal immunization due to medical contraindication, or refusal, for 1 of 5 residents reviewed for immunizations. (Resident #8)</p> <p>The facility failed to document in Resident #8's medical records for having had received education, whether by self or with responsible party, of the benefits, and potential side effects, of the influenza immunization and receipt of the of the pneumococcal immunization or having had not received the pneumococcal immunization due to medical contraindication or refusal.</p> <p>This failure could place residents at risk of contracting a viral illness, influenza and pneumococcal, or being informed of the benefits/risk which could cause respiratory complications and potential adverse health outcomes.</p> <p>Findings include:</p> <p>Review of Resident #8's face sheet dated 06/27/2024 reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses Dementia (A group of symptoms that affects memory, thinking and interferes with daily life.), Cerebral infarction (the pathologic process that results in an area of necrotic tissue in the brain. It is caused by disrupted blood supply (ischemia) and restricted oxygen supply (hypoxia).) , and acute respiratory failure with hypoxia (is a life-threatening condition where the lungs cannot provide enough oxygen to the body or remove enough carbon dioxide.).</p> <p>Review of Resident #8's quarterly MDS assessment dated [DATE] reflected Resident #8 was assessed to have a BIMS score of 6 indicating severe cognitive impairment. Resident #8 was further assessed to have been offered the influenza and pneumococcal vaccine and declined.</p> <p>Review of Resident #8's comprehensive care plan reflected no entries regarding immunization status.</p> <p>Review of Resident #8's consolidated physician orders reflected the following orders:</p> <p>*dated 03/10/2022 Last Pneumonia vaccine received.</p> <p>*dated 03/10/2022 May administer influenza vaccine annually.</p> <p>Review of Resident #8's immunization records in the EMR reflected no pneumonia vaccine record. Further review reflected an entry for influenza vaccine dated 09/29/2023 indicating the vaccine was not administered related resident refused based on conscientious objection. Under the section if education provided to resident/family or POA the facility checked 'no' on the form.</p> <p>(continued on next page)</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 06/27/2024 at 12:38 PM the RNC stated immunizations should be done and verified on admission. She stated if consent was not given then the facility should provide education regarding the benefits and potential side effects of the immunization.</p> <p>In an interview on 06/27/2024 at 12:45 PM the DON stated immunization should be done and verify on admission and consent and history should be done at that time. She stated immunizations were done by the MDS coordinator but since she was not at the facility anymore and the immunizations for Resident #8 got missed. The DON stated moving forward she would make sure residents immunization history was recorded for what vaccines were administered and make sure if residents or family's refuse vaccines that education was provided.</p> <p>Review of the facility's policy Immunization Recommendations for Patients, Residents and Health care Workers dated 07/15/2021 reflected The facility complies with current immunization and vaccination recommendations and requirements (where required), for patients, residents, and staff. 1. Prior to offering or providing immunizations, applicable medical screening and evaluation will be provided. This screening may be done by a licensed health care provider, such as a physician. 2. Immunizations will not be given if determined to be medically contraindicated . One-time informed consent can be part of the admission process for influenza, pneumococcal, and other vaccines eliminating the need for annual consent except in states where annual consent is required. The facility will track all staff and resident vaccination status for all vaccines. Resident vaccination status will be documented in their medical record and include: Education provided to the resident or resident representative regarding the benefits and potential risks associated with the vaccines .</p>

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32452</p> <p>Based on interview and record reviews, the facility failed to implement their policy to ensure the residents, or their responsible party, received education of the benefits and risks, or potential side effects of Covid-19 immunizations, receipt of Covid-19 immunizations, or the residents did not receive the Covid-19 immunizations, due to medical contraindication, or refusal, for 1 of 5 residents who were reviewed for immunizations. (Resident #7)</p> <p>The facility failed to document in Resident #7's medical records for having had received education, whether by self or with their responsible party, of the benefits and risk, and potential side effects, of the Covid-19 immunization, receipt of the Covid-19 immunization, or having had not received the Covid-19 immunization due to medical contraindication or refusal.</p> <p>This failure could place residents at risk of not being informed of complications and potential adverse health outcomes.</p> <p>Findings include:</p> <p>Review of Resident #7's face sheet dated 06/27/2024 reflected an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses Anemia (Deficiency of healthy red blood cells in blood. Red blood cells are essential to carry oxygen to all parts of the body.) , Dementia (A group of symptoms that affects memory, thinking and interferes with daily life.) and right femur fracture.</p> <p>Review of Resident #7's quarterly MDS assessment dated [DATE] reflected Resident #4 was assessed to have a BIMS score of 1 indicating severe cognitive impairment.</p> <p>Review of Resident #7's comprehensive care plan reflected no entries regarding immunization status.</p> <p>Review of Resident #7's consolidated physician orders reflected no entries regarding immunizations.</p> <p>Review of Resident #7's immunization records in the EMR on 06/26/2024 reflected no entry regarding COVID-19 Vaccination.</p> <p>In an interview on 06/27/2024 at 12:38 PM the RNC stated immunizations should be done and verified on admission. She stated if consent was not given then the facility should provide education regarding the benefits and potential side effects of the immunization.</p> <p>(continued on next page)</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 06/27/2024 at 12:45 PM the DON stated immunization should be done and verify on admission and consent and history should be done at that time. She stated immunizations were done by the MDS coordinator but since she was not at the facility anymore and the immunizations for Resident #7 got missed. The DON stated moving forward she would make sure residents immunization history was recorded for what vaccines were administered and make sure if residents or family's refuse vaccines that education was provided.</p> <p>Review of the facility's policy Immunization Recommendations for Patients, Residents and Health care Workers dated 07/15/2021 reflected The facility complies with current immunization and vaccination recommendations and requirements (where required), for patients, residents, and staff. 1. Prior to offering or providing immunizations, applicable medical screening and evaluation will be provided. This screening may be done by a licensed health care provider, such as a physician. 2. Immunizations will not be given if determined to be medically contraindicated . One-time informed consent can be part of the admission process for influenza, pneumococcal, and other vaccines eliminating the need for annual consent except in states where annual consent is required. The facility will track all staff and resident vaccination status for all vaccines. Resident vaccination status will be documented in their medical record and include: Education provided to the resident or resident representative regarding the benefits and potential risks associated with the vaccines .</p>		