STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675175	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of McKinney	1801 Pearson Ave McKinney, TX 75069

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observation, interview, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for two (Resident #3 and Resident #46) of twelve residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #3 and #46's rooms was in a position that was accessible to the residents. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. Findings included: Resident #3 Review of Resident #3's Face Sheet dated 04/24/2024 reflected that resident was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included muscle weakness, stiffness of joints, and difficulty in walking. Review of Resident #3's Annual MDS assessment dated [DATE] reflected Resident #3 had a severe impairment in cognition with a BIMS score of 07. Review of Resident #3's Comprehensive Care Plan dated 04/20/2024 reflected Resident #3 had a risk for falls related to ADL deficits and one of the interventions was to be sure the call light was within reach. The Comprehensive Care Plan also indicated resident had an actual fall on 04/03/2024. Review of Resident #3's Fall-Risk assessment dated [DATE] reflected Resident #3 was at high risk for falls. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 04/23/2024 at 10:51 AM revealed Resident #3 was sitting in her wheelchair beside her bed. It was noted that the resident's call light was on the floor under the bed. Resident #3 stated the CNA who just fixed her bed forgot to put the call light on top of the bed where she could reach it. Resident #3 further said she hoped the CNA would put the call light on top of the bed so that she could reach it when she was on her wheelchair. Resident #3 maneuvered her wheelchair towards the door of the room and said she would wait for someone to get her call light from the floor. Resident #46 Review of Resident #46's Face Sheet, dated 04/23/2024 reflected the resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included history of falling, muscle weakness, and osteoarthritis (a type of arthritis that happens when the cartilage that lines your joints is worn down and your bones rub against each other). Review of Resident #46's Quarterly MDS assessment dated [DATE] reflected Resident #46 had a severe cognitive impairment with a BIMS score of 07. Review of Resident #46's Comprehensive Care Plan dated 04/21/2024 reflected Resident #46 had a decreased mobility and one of the interventions was to keep the call light within reach. Observation and interview on 04/23/2024 at 9:26 AM revealed Resident #46 was on her bed resting. It was noted that the resident's call light was behind a small refrigerator situated at the side of her bed. Resident #46 stated she did not know where her call light was. The Respiratory Therapist then walked inside Resident #46's room. Resident #46 asked her where her call light was. The Respiratory Therapist looked for the call light and found the call light behind the small refrigerator. The Respiratory Therapist tried to pull the cord of the call light but said she was having a hard time pulling it. She said the call light was entangled on the string of the overhead light. The Respiratory Therapist disentangled the cord of the call light from the string of the overbed light and placed the call light where the resident could reach it. In an interview with Resident #46 on 04/23/2024 at 10:39 AM, Resident #46 stated she did not know how long her call light was behind the fridge. She said it would be better if the call light was clipped at the side of the bed so that it would not fall. In an interview with LVN A on 04/24/2024 at 10:55 AM, LVN A stated call light was important for the residents. LVN A said the residents used the call light to signal the staff that they needed assistance. LVN A added if the residents did not have their call lights, they might fall trying to stand up to get what they needed or to go to the bathroom. LVN A further added the residents might get mad or agitated if they cannot communicate their needs. LVN A said if the resident was on the wheelchair, the call light must be with them on the wheelchair. If the resident was mobile and could roll themselves, the call light must be placed on top of the bed where the residents could reach the call lights. LVN A also said all the staff were responsible in making sure the residents had their call lights. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Respiratory Therapist on 04/24/2024 at 1:26 PM, the Respiratory Therapist stated call lights were important for the residents because the call lights were one of the ways the resident could tell the staff that they needed something. She said because the call lights were important for the residents, the call light should always be within the reach of the residents so they could call the staff if they needed something. She acknowledged that Resident #46's call light was behind the fridge and was intertwined with the string of the overhead light. She said she had a hard time freeing the cord of the call light. She said if the call light was not with the residents, their needs, whether emergent and non-urgent would not be met. In an interview with the ADON on 04/24/2024 at 3:12 PM, the ADON stated the call light must always be accessible for the residents. The ADON said the call lights were the resident's source of help whether for basic reasons such as a glass of water, TV remote, or they needed to be changed. The ADON added the call light could be used also by the residents if they were not feeling well or if they were in pain. She said if the call lights were far from the residents, the residents would not be able to call the staff what they needed and those needs would not be addressed. She said if the call lights were not with the residents, it could result in a fall, dehydration, and annoyance. The ADON said the expectation was for the staff to make sure the call lights were with the reach of residents whether they on their bed or when the residents were up. She said they would do in-services about the call light and would remind the staff to ensure the call lights were with the residents during their rounds. In an interview with the DON on 04/24/2024 at 3:22 PM, the DON stated the call lights were inside the rooms of the residents for a reason. She said the purpose of the call lights was for the residents could call the staff if they needed something. The DON added without the call lights, the residents would not be able to tell the staff they were thirsty, needed a snack, they were in pain, they need to go to the bathroom, or they were not feeling well. The DON further added that when the call lights were not within the reach of the residents, unfavorable incidents like falls, minor hurts, or major injuries could happen. The DON said the expectation was for the staff to ensure that the call lights were always accessible for the residents. The DON concluded that moving forward, she would be on top of this issue to make sure the staff would make certain the call lights were with the residents at all times. In an interview with the Administrator on 04/25/2024 at 8:10 AM, the Administrator stated it was important that the residents had their call lights so their needs could be addressed. The Administrator said if the call lights were not within the reach of the residents, the staff would not know the residents needed something. He said he would collaborate with the clinical managers to evaluate the situation, discuss it during quality assurance and do in-services. Interview with CNA C on 04/25/2024 at 11:24 AM, CNA C stated he placed Resident #46's call light on the side of the bed and clipped it so it will not fall. CNA C said for some residents, the call light was their sense of protection. He said the call light gave them the assurance that when they were in danger or there was an emergency, they could call the staff for help. CNA C added that the resident could fall if they tried to get to their call light that was far from them. CNA C stated he would go and check the call lights on his hall. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's policy Call Light, Policy/Procedure - Nursing Clinical, rev. 05/2023, revealed Policy: It is the policy of this facility to provide the resident a means of communication with nursing staff . Procedures . 4. Leave the resident comfortable. Place the call device within resident's reach before leaving room .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49427 Based on observation, interview, and record reviews, the facility failed to provide a safe, clean, comfortable, and homelike environment for 3 of 5 (Resident #18, Resident #35, and Resident #52) residents reviewed for safe, clean, comfortable, and homelike environment. The facility failed to provide clean privacy curtains for Resident #18, Resident #35, and Resident #52. These failures could place residents at risk for an unsanitary and hazardous living conditions. Findings included: Record review of Resident #18's Quarterly MDS dated [DATE] revealed resident was [AGE] year-old male admitted on [DATE] with diagnoses of cellulitis (bacterial infection) of right lower limb, asthma (lung disease resulting in difficulty breathing) , respiratory failure, metabolic encephalopathy (brain dysfunction), muscle wasting and atrophy, anxiety disorder (persistent and excessive worry), and depression (feelings of sadness). The Resident had a BIMS score of 10 (moderate cognitive impairment). Record review of Resident #18's care plan dated 11/07/2022 revealed facility was to anticipate and meet needs of resident. Observation and interview on 04/24/2024 at 2:37 PM of Resident #18's room revealed his privacy curtain was stained with light and dark brown substances in streaks, smears, and splatters along the bottom inside and outside of the curtain and halfway up the outside edges of the curtain. Resident #18 stated that he was not sure how long they have been like that way, and it was unsanitary. Interview on 04/24/2024 at 2:41 PM with Nurse Aide H in Resident #18's room revealed this was her second week working for facility and Resident #18's curtains did not look clean and had brown marks. Nurse Aide H stated Resident #18 does not have a roommate, was not able to ambulate or get out of bed on his own and did not know why the curtain would be dirty. She stated housekeeping was only responsible for cleaning floors, bathrooms, and surfaces and would let the maintenance director know. Nurse Aide H stated having dirty curtains would be a sanitary risk for residents and she would be concerned about germs. Record review of Resident #35 Quarterly MDS dated [DATE] revealed resident was [AGE] year-old female admitted on [DATE] with an initial admitted [DATE] with diagnoses of nontraumatic intracerebral hemorrhage in cerebellum (stroke), muscle weakness, cognitive communication deficit, dysarthria (weak speech muscles), and hypertension (high blood pressure). The resident had a BIMS score of 7 (moderate cognitive impairment). Record review of Resident #35's care plan dated 02/22/2023 and revised on 02/12/2024 revealed facility was to anticipate and meet needs of resident. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 04/24/2024 at 2:00 PM revealed Resident #35 was sitting outside in an electric wheelchair, with a black hair wrap, was friendly and was a poor historian. Observation on 04/24/2024 at 3:11 PM revealed Resident #35's room had two privacy curtains with dark and light brown substance smeared on privacy curtains. Record review of Resident #52's Quarterly MDS dated [DATE] revealed resident was [AGE] year-old female admitted on [DATE] with an initial admitted [DATE] with diagnoses of seizure disorder, depression (persistent feelings of sadness), asthma (lung disease resulting in difficulty breathing), muscle wasting and atrophy, and metabolic encephalopathy (brain dysfunction). The resident had a BIMS score of 15 (cognitively intact). Record review of Resident #52's care plan dated 11/04/2022 and revised on 12/04/2023 revealed facility was to anticipate and meet needs of resident. Observation and interview on 04/24/2024 at 2:45 PM with CNA E revealed Resident #52's privacy curtain had dried brown drips, splatters, and smears along the bottom half of the curtain and along the sides of the curtain. CNA E stated she did notice Resident #52's privacy curtain was dirty and stained and had told her charge nurse more than two weeks ago and did not realize they had not been replaced yet. CNA E stated Resident #52 was not able to ambulate on her own and was not sure why the curtain was dirty. She stated it was housekeeping or maintenance's responsibility to change the privacy curtains when dirty. She stated dirty or stained privacy curtains were a health risk to resident and would immediately report the concern to her nurse. Observation and interview on 04/24/2024 2:47 PM with Resident #52 revealed she was lying in bed wearing glasses, watching television, affect was flat, and she stated she is in her bed often and had not noticed the curtain was so dirty because it is usually kept closed and hooked to the wall. Interview on 04/24/2024 at 3:27 PM with the Housekeeping Supervisor revealed housekeepers cleaned residents' room each day and were supposed to wipe down surfaces, sweep, mop, and disinfecting high contact surfaces. The Housekeeping Supervisor stated all privacy curtains were washed once a month or when dirty. She stated the housekeepers were responsible for checking if privacy curtains are dirty or stained when they clean residents' room each day and were expected to inform herself or Housekeeper G because Housekeeper G was the one who took down and put-up clean privacy curtains. The Housekeeping Supervisor stated she was aware some resident rooms had stained curtains, but thought they were all addressed and did not know Residents #18, #35, or #52 were still dirty. The Housekeeping Supervisor stated there were some curtains that had old stains because they were unable to get some stains out and they would have to reuse them. She stated each hall was color coded with different curtain and if she didn't have the curtain in the correct color or pattern a stained curtain might be reused. She stated dirty or stained privacy curtains would be a sanitary risk to residents and should immediately be replaced. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/24/2024 at 9:15 AM with Housekeeper F revealed she was told about two weeks ago by the Housekeeping Supervisor to check all the resident's privacy curtains for stains. She stated she checked halls 400 and 100 and then wrote which needed to be replaced and gave the list to Housekeeping Supervisor. Housekeeper F stated only Housekeeper G was supposed to replace privacy curtains and that some curtains were not replaced, she informed Housekeeping Supervisor again, and after a couple of days the curtains were replaced. Housekeeper F stated stained or dirty curtains posed a health risk to residents due to possible bacteria and dust build up. Interview on 04/25/2024 at 8:50 AM with the Housekeeping Supervisor revealed only Housekeeper G was supposed to replace privacy curtains because it would be unsanitary for the other housekeepers and could expose them to bodily fluids and they were instructed to inform either Housekeeping Supervisor or Housekeeper G if one needed to be replaced. She stated Housekeeper G replaced privacy curtains. Interview on 04/25/2024 at 9:00 AM with Housekeeper J revealed she cleaned Resident #18, #35, and #52 rooms on 04/24/2024 and did not recall checking their privacy curtains. Housekeeper J was shown pictures of Resident #18, #35, and #52 privacy curtains taken on 04/24/2024 and she stated the stains looked like fecal matter and the solution from feeding tubes. She stated privacy curtains are changed as needed and staff were to inform Housekeeper G if there were privacy curtains that need to be replaced. Interview on 04/25/2024 at 10:49 AM with Housekeeper G revealed he was responsible for replacing stained or dirty privacy curtains and was told by housekeepers or Housekeeping Supervisor when they need to be replaced. Housekeeper G stated sometimes stained curtains were reused because sometimes you can't get out the stains but typically, they were supposed to be thrown away. Record review of facility's policy titled Policy/Procedure .Section: Physical Environment/Homelike Environment, undated, revealed It is the policy of this facility that the facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on interviews and record review, the facility failed to ensure each resident received an accurate assessment, reflective of the resident's status for one (Resident #12) of three residents reviewed for accuracy of assessments. The facility failed to ensure Resident #12's Quarterly MDS assessment dated [DATE] accurately reflected that Resident #12 had impairments to both upper extremities and both lower extremities. This failure could place residents at risk for not receiving care and services to meet their needs, diminished function of health, and regressions in their overall health. Findings included: Review of Resident #12's Face Sheet dated 04/23/2024 revealed the resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included cerebral infarction (insufficient oxygen in the brain causing stroke), stiffness of unspecified joints, and muscle atrophy. Review of Resident #12's Quarterly MDS assessment dated [DATE] revealed the resident had a moderate impairment in cognition with a BIMS score of 11. Resident #12's Minimum Data Set, Section GG - Functional Status GG0115 Functional Limitation in Range of Motion specified Resident #12 had no impairment to upper extremity and lower extremity. Review of Resident #12's Comprehensive Care Plan dated 02/04/2024 reflected the resident had an ADL self-care performance deficit r/t to quadriplegia (paralysis of all four limbs). Review of Resident #12's Progress Notes dated 03/19/2024 reflected ROS . musc . Quadriplegic since the age of 45, can't move neck below . Observation and interview on 04/23/2024 at 10:41 AM revealed Resident #12 was in his bed resting. It was noted that the resident was unable to move his upper extremities and lower extremities. According to Resident #12, he had been in that condition since he was on an accident. He said he needed assistance to move all his limbs because he could not do it by himself. In an interview with LVN A on 04/24/2024 at 10:55 AM, LVN A stated Resident #12's both upper extremities and both lower extremities were impaired. He said the resident could not actively move them anymore. He said the resident had been in that condition since he worked in the facility. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and observation with MDS Coordinator on 04/24/2024 at 3:01 PM, the MDS Coordinator stated if the resident cannot move both the upper and lower extremities, then the resident should had been triggered for impairment since the resident was unable to move his limbs. The MDS Coordinator checked Resident #12's profile and saw that the resident's code for his functional limitations was zero for impairment to both upper and lower extremities. The MDS Coordinator went to Resident #12's room and assessed the resident. She asked the resident to wiggle his toes, and the resident was unable to. Then she asked the resident to move his fingers, and the resident was unable to do so. The MDS Coordinator said the resident should had been coded as having an impairment on both upper extremities as well as on both lower extremities. She said she would put the appropriate code for Resident #12's functional limitations. She said an accurate MDS was important because it would be the basis of the care needed by the resident. If the assessment was not accurate, the current status of the resident would not be correct resulting to a possible confusion on his care. That could also result in the resident not getting the appropriate care needed. She said this should had been brought up during meetings. In an interview with the ADON on 04/24/2024 at 3:12 PM, the ADON stated the resident should be thoroughly assessed so the staff would have an idea of the resident's current status and current needs. She said if the resident had impairments, it should be reflected on the MDS. She said accuracy in assessment would help the staff make an appropriate care plan for the resident. The ADON said if there was no accurate assessment, there could be a confusion about the care needed by the resident and might not be able to get the treatment needed. In an interview with the DON on 04/24/2024 at 3:22 PM, the DON stated the MDS should reflect the actual functionality of the resident. She said if the resident had an impairment, it should had been assessed accurately and reflected on the MDS. If the residents were not properly assessed, the proper care and needs would not be met. The DON said the expectation was the residents were properly assessed not only during admission but every day to see if there was a change in condition, any refusal of care, or resident acting different than usual. In an interview with the Administrator on 04/25/2024 at 8:10 AM, the Administrator stated the resident should be assessed carefully to know what they were able to do and what they could do anymore. He said he would collaborate with the clinical managers to evaluate the situation, discuss it during quality assurance and do in-services. In an interview with PT D on 04/25/24 at 11:48 AM, PT D stated the purpose of an assessment was to know the current status or level of function of the resident. She said a thorough assessment is needed to be able to facilitate an accurate problem list and to be able to plan the goals and interventions. She said it was also important to know the resident's functional deficits, weakness, or strengths that could help in planning. She said if a resident cannot move his hands and feet, it would be defined as an impairment. She also said that any assessment should be reflected on the resident's profile. Record review of facility policy, Resident Assessment and Associated Processes revised 1.2022 revealed, Policy: It is the policy of this facility that resident's will be assessed and the findings documented in their clinical health record. These will be comprehensive, accurate, standardized reproducible assessment of each resident . be conducted initially and periodically as part of an ongoing process . goals of care, functional and health status, and strengths and needs will be identified . Procedure: An accurate assessment will be made . Physical functioning and structural problems.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 47743 Based on observation, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for a resident for two (Resident # 12 and Resident #117) of eight residents reviewed for Care Plans. 1. The facility failed to ensure Resident #12's care plan dated 02/04/2024 included a care plan for catheter care. 2. The facility failed to create a care plan for Resident #117's order for Coumadin (blood thinner.) These failures could place residents at risk for not having care plans they needed. Findings included: 1. Review of Resident #12's Face Sheet dated 04/23/2024 revealed the resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included urinary tract infection and neuromuscular dysfunction of bladder (the muscles and nerves that control the bladder do not work properly due to illness). Review of Resident #12's Physician Order dated 07/13/2023 reflected, CHANGE S/P CATHETER. Review of Resident #12's Quarterly MDS assessment dated [DATE] revealed the resident had a moderate impairment in cognition with a BIMS score of 11. The Quarterly MDS Assessment also indicated resident had an indwelling catheter. Review of Resident #12's Comprehensive Care Plan dated 02/04/2024 reflected resident had no care plan for suprapubic catheter. Review of Resident #12's Comprehensive Care Plan on 04/24/2024 reflected resident's care plan was revised on 04/24/2024 to display the care plan for suprapubic catheter. Observation and interview with LVN A on 04/24/2024 at 10:55 AM, LVN A stated that Resident #12 had a suprapubic catheter since he cared for him. LVN A checked the resident's profile and verified the resident does not have a care plan for catheter care. He said there should be a care plan for catheter care and the interventions should also be listed in the care so the staff would know the care needed on that particular area. He said the care plan would show the direction on how to take care of the resident. He said without the care plan in place, it could reflect that the staff were not taking care of the residents. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and observation with the MDS Coordinator on 04/24/2024 at 3:01 PM, the MDS Coordinator stated care plan served as a communication tool for the family, resident, and facility. She said the care plan must have a clear and accurate reflection of what the facility was doing for the resident. She said without the care plan, there could be confusion on his care or the interventions for having a catheter will not be done. She said she was responsible in doing the care plan based on the assessment of the staff. She added Resident #12's care plan should had been discussed during interdisciplinary meetings but was missed. She said she would go ahead and put the interventions for catheter care. The MDS Coordinator went ahead and added suprapubic catheter on the care plan item as well as the interventions needed for catheter care. In an interview with the ADON on 04/24/2024 at 3:12 PM, the ADON stated every resident must have a care plan to see the steps needed to address their conditions and to evaluate if the goals were being met. She said that without the care plan, the staff would not know the resident's needs at that time resulting into needs not being met. She added if the resident currently had a catheter, it should had been reflected on the care plan. In an interview with the DON on 04/24/2024 at 3:22 PM, the DON stated the purpose of the care plan was to know the resident's needs and for the staff to know what kind of care and interventions were needed. She said without the care plan, the staff would not know the needed care and assistance the residents required. The DON said she there should be a care plan for catheter care if a resident was on catheter as well as the appropriate interventions needed. She said she would continue to educate the staff through an in-service about the significance of a care plan. The DON concluded that moving forward, she will monitor staff's observance to the policy care planning to ensure the best possible care. In an interview with the Administrator on 04/25/2024 at 8:10 AM, the Administrator stated the care plan was important to provide care with consistency. The Administrator said that without a care plan, the resident would not have the care needed and required. The Administrator concluded that the expectation was that the staff would ensure every resident was care planned. 2. Review of Resident #117's admission MDS assessment, dated 02/28/24, revealed the resident was an [AGE] year-old male admitted to the facility on [DATE]. His cognitive status was moderately impaired. His diagnoses included coronary heart disease, and lung transplant, and tracheostomy. Review of Resident #117's Order Summary Report, dated April 2024, reflected: 04/18/24 Warfarin Sodium (Coumadin) 1.5 milligrams at night for a blood thinner. Review of Resident #117's, not dated, Care Plans revealed there was not a care plan for blood thinners or Coumadin. An interview on 04/25/24 at 11:05 AM with the MDS Coordinator revealed the resident should have had an Interdisciplinary Team Meeting to add the Coumadin to Resident #117's care plans. A follow-up interview on 04/25/24 at 11:33 AM with the MDS Coordinator revealed an interdisciplinary team meeting did not occur for Resident #117 because it was over-looked. (continued on next page)

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	675175	A. Building B. Wing	04/25/2024

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Park Manor of McKinney	1801 Pearson Ave McKinney, TX 75069

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 04/25/24 at 1:48 PM with the DON revealed Resident #117 should have had a care plan for Coumadin and she did not know why it was overlooked. The DON said care plans were important for staff to be able to provide care to residents. Record review of facility's policy, Comprehensive Person-Centered Care Planning revised 1.2022 revealed Policy: It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident . Procedure . 4. The facility IDT will develop and implement a comprehensive person-centered care plan for each resident . will include resident's needs identified in the comprehensive assessment . resident's goals and desired outcomes .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48560 Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 1 (Resident #20) of 4 residents reviewed for ADLs. The facility failed to ensure Resident #20 had his fingernails cleaned and trimmed. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life. Findings include: Review of Resident #20's Quarterly MDS assessment dated [DATE] reflected Resident #20 was an [AGE] year-old male with initial admitted to the facility on [DATE]. His diagnoses included hypertension (high blood pressure), heart failure (heart doesn't pump enough blood for body needs), End stage renal disease (kidney failure), Diabetes Mellitus (high blood glucose levels), hyperlipidemia (high blood lipid levels), Alzheimer's disease (brain disorder relating to memory loss), Chronic Obstructive Pulmonary disease (lung disease that causes breathing problem), and Respiratory failure (difficulty breathing). Resident #20 had a BIMS of 15 which indicated Resident #20 was cognitively intact. Resident #20 was always incontinent of bowel and bladder and required substantial assistance with personal hygiene. Review of Resident #20's Comprehensive Care Plan, revised 12/22/23, reflected the following: Focus: ADL Self Care Performance Deficit r/t Alzheimer's Goal: Will maintain current level of function in Bed Mobility, Transfers, Eating, Dressing, Grooming, Toilet Use and Personal Hygiene, ADL Score through the review date. Interventions: Encourage to discuss feelings about self-care deficit. Encourage to participate to the fullest extent possible with each interaction. An observation and interview on 04/23/24 at 11:19 AM revealed Resident #20 was sitting on his bed with oxygen running via nasal cannula. The nails on both hands were approximately 1.0 centimeter in length extending from the tip of her fingers and had dark discoloration underneath the nails. Resident #20 stated he would liked his nails to be cleaned and trimmed by staff member since he did not have adequate dexterity. In an interview with CNA X on 4/23/24 at 11:32 AM revealed that most ADL's such as hair trimming, nail clipping care were completed during shower times. She revealed that since Resident #20 was a diabetic resident, LVNs were responsible for clipping his nails. CNA X stated that fingernail clipping should be done weekly but also as needed. In an interview with LVN K on 4/23/24 at 11:39 AM revealed that there were no specific days for nailcare but should be offered each time during showering. LVN K also stated that the CNA as well as the LVNs were responsible for providing nail care; however, CNAs could not clip nails for residents with diabetes. LVN K stated that ADLs were monitored daily. LVN K stated that risk to the resident for failure to provide ADL including nail care was increased risk of infection. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 4/25/24 9:27 AM revealed that her expectation was that nail care should be provided every day, especially during shower time. The DON stated that Resident #20 had history of refusing ADLs, but she did not remember if he had ever refused nail care. She stated that both CNAs and the LVNs were responsible for nail care and her expectation was that CNAs or LVNs to offer to cut and clean nails if they were long and dirty. She also stated that as the DON, either herself or her designee were responsible to do routine rounds for monitoring. The DON stated residents having long and dirty fingernails could be an infection control issue. Record review of the facility's policy titled ADL, services to carry out , revised date July 2020 reflected If a resident is unable to carry out activities of daily living, the necessary services to maintain good nutrition, grooming and personal oral hygiene will be provided by qualified staff .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48560 Based on observation, interview and record review the facility failed to ensure that a resident with pressure ulcers received necessary treatment and services consistent with professional standards of practice to promote healing, prevent infections and prevent new ulcers for 1 (Resident #50) of 4 residents reviewed for pressure ulcers . The facility WCN failed to perform hand hygiene or change her gloves after cleaning Resident #50's wounds. This failure could expose the residents to high risk of cross contamination, infection, worsening of wound conditions and serious illness. Findings include: Review of Resident #50's quarterly MDS assessment, dated 03/04/24, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. He was in a persistent vegetative state. His diagnoses included chronic respiratory failure, and brain damage. The resident had 2 stage III (open ulcer with full thickness tissue loss) pressure ulcers and 2 stage IV (open ulcer with full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcers. An observation on 04/25/24 at 11:47 AM of wound care for Resident #50 revealed the WCN had her supplies prepared. The resident had a wound on his right heel that was a stage III with a very small, open area with surrounding dark pink tissue. The WCN took off the soiled dressing, performed hand hygiene, changed her gloves, cleaned the wound, applied the treatment, and applied the dressing to the wound. The WCN did not perform hand hygiene or change her gloves after cleaning the wound. The resident had a wound on his left ischium (left buttocks area) that was a stage IV. The area was red, raw, and open with dark pink edges. The WCN took off the soiled dressing, performed hand hygiene, changed her gloves, cleaned the wound, applied the treatment, and applied the dressing to the wound. The WCN did not perform hand hygiene or change her gloves after cleaning the wound. The resident had a baseball sized wound with necrotic (dead tissue) tissue on his left back that was a stage IV. The WCN took off the soiled dressing, performed hand hygiene, changed her gloves, cleaned the wound, applied the treatment, and applied the dressing to the wound. The WCN did not perform hand hygiene or change her gloves after cleaning the wound. The resident had a stage IV wound on his sacrum (center of buttocks area). It was a raw, open area with dark pink edges. The WCN took off the soiled dressing, performed hand hygiene, changed her gloves, cleaned the wound, applied the treatment, and applied the dressing to the wound. The WCN did not perform hand hygiene or change her gloves after cleaning the wound. An interview with the WCN on 04/25/24 at 11:55 AM regarding wound care for Resident #50, revealed she did not perform hand hygiene or change her gloves after cleaning the wound because she said it was a clean procedure and was not necessary. An interview on 04/25/24 at 12:10 PM with the DON revealed the WCN was supposed to perform hand hygiene and change her gloves after cleaning Resident #50's wounds. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy for Skin and Wound Monitoring and Management, revised January 2022, reflected: Purpose .The purpose of this policy is that the facility provides care and services to . 2. Promote the healing of pressure injuries that are present (including prevention of infection to the extent possible) . Review of the website: https://cert.vohrawoundcare.com/how-to-change-a-wound-dressing/ , accessed on 04/25/24 reflected: Steps to applying or changing a bandage When applying a new wound care bandage or dressing, it is essential to follow a few simple steps. Because a wound is an opening to the outside it is not sterile and we apply dressings using a clean dressing technique. Step one o Assemble all of your wound care supplies that you will need to change the dressing. o Clean gloves (sterile gloves are not needed) o A clean surface to place everything on (such as a clean piece of aluminum foil or clean paper o The new bandage to be applied o Saline or wound cleanser to clean the wound o Several pieces of gauze to use in cleaning or wiping the wound o Trash bag Step two Wash your hands with soap and warm water for 20-30 seconds. After washing and drying your hands, put on clean gloves to remove the old dressing and perform the dressing removal step. Observe if there is fluid or drainage and note the drainage or wound fluid that is on the gauze. Wounds with a lot of fluid draining from them are exuding wounds. Now clean the wound by wiping with some gauze pads and saline or wound cleanser. Wipe the wound in small circles this from the middle of the wound outward and finally the skin around the wound edge. You may need several pieces of gauze. Dispose of the dirty bandage, gauze used to clean the wound, and dirty gloves in the trash . Step four Rewash your hands with soap and water for 20-30 seconds and dry them. Put on a new pair of clean gloves (you do not need sterile gloves). Now you will apply the new wound treatment and dressing .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42824 Based on interview, and record review, the facility failed to ensure a resident maintained acceptable parameters of nutritional status, unless the resident's clinical condition demonstrated that this was not possible, for one (Resident #51) of five residents reviewed for nutritional status and weight loss. The facility failed to obtain Resident #51's weight per physician order. This failure could place residents at increased risk of decline in nutritional status, weight loss, and overall health and wellness. Findings included: Review of Resident #51's Face Sheet dated 04/23/2024 revealed she was a [AGE] year-old female originally admitted to the facility 04/07/2022. Relevant diagnoses included: dementia (group of symptoms that affects memory and thinking,) dysphagia (difficulty swallowing food or liquid,) Gastroesophageal reflux disease (GERD) (acid reflux,) and malaise (vague feeling of being unwell.) Review of Resident #51's Quarterly MDS assessment dated [DATE] reflected she was severely cognitively impaired with a BIMS score of 6. She was totally dependent upon staff for eating, oral hygiene, and toileting. She was incontinent of bowel and bladder. She was 61 inches and 137 pounds at the time of this assessment. Review of Resident #51's documented weights in her EMR revealed on 01/29/2024, the resident weighed 150.4 lbs. On 04/25/2024, the resident weighed 145 pounds which was a -3.59 % loss between an 87 day, or 2 month and 27-day period. Review of Resident #51's documented weights in her EMR revealed weight fluctuations as follows: 04/25/2024 145.0 pounds 04/16/2024 131.2 pounds 04/05/2024 136.6 pounds 03/01/2024 136.6 pounds 02/01/2024 150.4 pounds 01/29/2024 150.4 pounds 12/13/2023 156.2 pounds 11/16/2023 156.8 pounds (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	09/12/2023 169.2 pounds 08/16/2023 167.8 pounds Review of Resident #51's Comprehensive Care Plan revised 04/08/2024 revealed a weight loss focus by stating [Resident #51] had significant expected weight loss of 10% in 6 months [related to] diuretic use, [history] of edema with expected fluctuation in weight with intervention that included alert dietician if consumption is poor, diuretic as ordered for edema, monitor and record food intake each meal, and weekly weights .Additionally, she was at an increased risk for decline related to GERD, bowel and bladder incontinence related to dementia, and was dependent upon staff for activities. Additional focus for potential nutritional problems related to malnutrition, dysphagia, and GERD had an intervention that included Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Review of Resident #51's physician orders on 04/23/2024 revealed she was prescribed weekly weights in the morning every Wednesday . weight monitoring . with a start date of 04/17/2024. Additional review of her physician orders revealed she was prescribed a regular diet with pureed texture, nectar thick liquids, and a supplement with all meals with a start date of 03/08/2024. She was prescribed a house supplement four times a day with a start date of 03/05/2024 and liquid protein prescribed two times a day with a start fate of 04/23/2024. It was prescribed to encourage fluid . 1 cup every four hours while awake with a start date of 02/05/2024 and to encourage fluid every shift with a start date of 01/09/2024. Finally, she was prescribed Arginald Oral Packet (Nutritional Supplement) by mouth one time a day with a start date of 02/28/2024. Record review of Resident #51's TAR on Thursday 04/25/2024 at 11:05 AM revealed LVN Z documented she completed physician order and obtained Resident #51's weight on Wednesday 04/25/2024 as prescribed. Record review of Resident #51's Clinical Record on 04/25/2024 at 11:06 AM revealed no evidence of Resident #51's weight documented for Wednesday 04/24/2024 or Thursday 04/25/2024. In interview with LVN Z on 04/25/2024 at 11:10 AM revealed she was aware of Resident #51's physician order for weekly weights each Wednesday; but she stated she did not get a chance to check it yet. She stated she documented she completed it the day prior 04/24/2024; but did not state why she did not actually obtain Resident #51's weight. She stated that she was ultimately responsible for obtaining Resident #51's weight but stated that the facility aides can be delegated to obtain resident weights when ordered. LVN Z did not state why she did not delegate this task yesterday. She stated the potential risk of not following and/or completing physician orders as prescribed poses a risk for potential harm for Resident #51, as her weight required to be monitored. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview with the ADON on 04/25/2024 at 11:25 AM revealed she was aware of Resident #51's weight loss and that she had an order for close monitoring via weekly weights each Wednesday. She stated she was not aware that Resident #51 was not weighed yesterday 04/24/2025. She stated that they typically had an aide that weighs residents with weekly weight orders, but it was ultimately the nurse's responsibly to ensure their resident's weight was obtained. She stated that if LVN Z documented Resident #51's weight was obtained on the TAR, it should have been completed, entered into the Electronic Medical Record (EMR,) and assessed for intervention based on the physician orders and comprehensive care plan. She stated if physician orders were not completed as prescribed, Resident #51 could lose additional weight and [the facility would] not be able to address it. Additionally, she stated that if false data was entered into the EMR, proper interventions may not be in place for the residents. In interview with the DON on 04/25/2024 at 11:35 AM revealed she was aware of Resident #51's weight loss and she had an order for close monitoring via weekly weights each Wednesday. She stated she was not aware that Resident #51 was not weighed yesterday, 04/24/2024, because LVN Z documented in the TAR that it was completed on 04/24/2024. She stated that they typically have an aide that weighs residents with weekly weight orders, but that aide was pulled to work the floor yesterday. She stated she expected the nurse assigned to the resident that day to ensure the weight was obtained so they can assess the need for any intervention. She stated it was her responsibility to ensure the nurses complete this task weekly, and she does this by checking the TAR documentation. She stated Resident #51 was at risk for weight loss and her physician orders of weekly weights not being followed puts her at risk for a change in condition indicating something concerning. She stated she expected LVN Z document accurately and could pose a risk to the residents if not completed. In interview with the Administrator on 04/25/2024 at 12:00 PM revealed he was aware of Resident #51's weight loss and that she required weekly weights for close monitoring. He stated that he typically had an aide weigh residents that require weekly weights, but it was the resident nurses' responsibility to ensure weights were obtained. He stated it puts resident health and wellness at risk if the facility cannot identify weight loss and intervene accordingly. Policy related to deficient practice was requested from the Administrator on 04/25/2024 at 12:03 PM, 1:37 PM, and upon exit; but it was not received prior to exit on 04/25/2024 at 5:00 PM.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review, the facility failed to ensure that Residents, who needed respiratory care, was provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for three (Resident #15, #20, and #40) of three residents reviewed for respiratory care. 1. The facility failed to ensure Resident #15's nebulizer mask was properly stored. 2. The facility failed to ensure Resident #20's nasal cannula tubing and humidity bottle were labeled or dated. 3. The facility failed to ensure Resident #40's nasal cannula tubing were labeled or dated. These failures could place the residents at risk for respiratory infection and not having their respiratory needs met. Findings included: 1. Review of Resident #15's Face Sheet dated 04/23/2024 reflected that resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included respiratory failure with hypoxia (insufficient amount of oxygen in the body) or respiratory failure with hypercapnia (high level of carbon dioxide in the blood). Review of Resident #15's Comprehensive MDS assessment dated [DATE] reflected Resident#15 had a moderate impairment in cognition with a BIMS score of 12. The Comprehensive MDS Assessment also indicated Resident #15 was on oxygen therapy while a resident in the facility. Review of Resident #15's Care Plan dated 03/21/2024 reflected resident had an altered respiratory status and one of the interventions was to administer medications/puffers as ordered. Review of Resident #15's Physician Order dated 10/08/2022 reflected, Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 1 vial inhale orally every 6 hours for SOB/WHEEZING related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH (ACUTE) EXACERBATION (J44.1); ACUTE AND CHRONIC RESPIRATORY FAILURE, UNSPECIFIED WHETHER WITH HYPOXIA OR HYPERCAPNIA. Observation on 04/23/2024 at 9:39 AM revealed Resident #15 was on his bed awake. It was also noted that his nebulizer mask was sitting inside on the drawer of his side table. The breathing mask used for the nebulizer was not bagged. Observation and interview with LVN A on 04/23/2024 at 9:46 AM, LVN A stated he administered Resident #15's nebulization and he was the one who removed it after the treatment was done. LVN A said he forgot to bag the breathing mask and just placed it on the drawer. He said the breathing mask should be cleaned after every use and should be bagged when not in use to prevent contamination and infection. LVN A disconnected the breathing mask, put it inside the plastic bag, and said he would change it. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the ADON on 04/24/2024 at 3:12 PM, the ADON stated the breathing mask should not have been exposed nor touching anything because it could cause infections. The ADON said the breathing mask should have been bagged when not in use. She said the staff administering the breathing treatment was responsible in making sure the breathing mask was clean every time the resident used it and bagged when the resident was not using it. In an interview with the DON on 04/24/2024 at 3:22 PM, the DON stated the breathing mask should be bagged when not in use. The DON said it was the proper way to store the breathing mask after it was used by the resident. She said if the breathing mask was not bagged and touching surfaces that were not clean, then oxygen administration could be compromised. The DON said the staff, including her, were responsible for monitoring that the apparatus used in oxygen therapy were bagged when not in use. She said the expectation was the breathing mask would be stored properly. The DON said she would continually remind the staff to be diligent in making sure the procedures for respiratory care were followed. In an interview with the Administrator on 04/25/2024 at 8:10 AM, the Administrator stated the breathing masks should be stored properly to prevent potential respiratory infections. The Administrator said the expectation was for the staff to be diligent in providing respiratory care in order to provide the highest level of care. He said he would collaborate with the clinical managers to evaluate the situation, discuss it during quality assurance and do in-services. 2. Review of Resident #20's Quarterly MDS assessment dated [DATE] reflected Resident #20 was an [AGE] year-old male with initial admitted to the facility on [DATE]. His diagnoses included hypertension (high blood pressure), heart failure, End stage renal disease, Diabetes Mellitus (high blood glucose levels) , hyperlipidemia (high blood lipid levels), Alzheimer's disease, Chronic Obstructive Pulmonary disease, and Respiratory failure. Resident #20 had a BIMS score of 15 which indicated Resident #20 was cognitively intact. Resident #20 was on Oxygen therapy. Review of Resident #20's Comprehensive Care Plan, revised 1/29/24, reflected the following: Focus: Has BIPAP related to Chronic Obstructive Pulmonary disease and Ineffective gas Exchange. Goals: Will have no signs and symptoms of poor oxygen absorption through the review date. Interventions: Give medications as ordered by physician. Monitor/document side effects and effectiveness. If the resident is allowed to eat, oxygen still must be given to the resident but in a different manner (e.g., changing from mask to a nasal cannula). Return resident to usual oxygen delivery method after the meal. Monitor for signs and symptoms of respiratory distress and report to physician as needed. Record review of Resident #20's Physician order dated 12/18/2023 reflected, Oxygen at 3 Liter per minute via Nasal cannula as needed for Shortness of Breath May titrate 3-4 Liter to keep Oxygen saturation above 90%. Record review of Resident #20's Physician order dated 12/18/2023 reflected, Change Oxygen Tubing and Humidifier BOTTLE every night shift every Sunday. An observation and interview on 04/23/24 at 11:19 AM revealed Resident #20 was sitting on his bed with Oxygen running via nasal cannula. It was observed that the nasal cannula tubing and humidity bottle did not have a label or date on it. Resident #20 stated he was on continuous oxygen and did not remember when the last time was the nurse had changed the nasal cannula tubing. (continued on next page)

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Park Manor of McKinney	1801 Pearson Ave McKinney, TX 75069

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #40's Quarterly MDS assessment dated [DATE] reflected Resident #40 was a 39-year -old female with readmitted [DATE] to the facility. Her diagnoses included Heart failure, Hypertension, Pneumonia, and Respiratory failure. Resident #40 was on oxygen therapy. Resident #40 had a BIMS score of 13 which indicated Resident #40 was cognitively intact. Review of Resident #40's Comprehensive Care Plan dated 1/29/2024 reflected, Focus: Has Oxygen Therapy related to heart failure. Goals: Will have no signs and symptoms of poor oxygen absorption through the review date. Interventions: Give medications as ordered by physician. Monitor/document side effects and effectiveness. If the resident is allowed to eat, oxygen still must be given to the resident but in a different manner (e.g., changing from mask to a nasal cannula). Return resident to usual oxygen delivery method after the meal. Record review of Resident #40's Physician order dated 2/22/2024 reflected, Check and record oxygen saturation every shift. Record review of Resident #40's Physician order dated 2/22/2024 reflected, Oxygen at 1 liter per minute via Nasal cannula as needed for Shortness of Breath. An observation and interview on 4/23/24 at 11:54 AM revealed Resident #40 was sitting in her wheelchair in her room. She had a portable oxygen cylinder on her wheelchair and oxygen was flowing via nasal cannula. Observed nasal cannula tubing was not dated or labeled. Resident #40 stated she was on oxygen frequently and used portable oxygen. In an interview with LVN K on 4/23/24 at 11:39 AM revealed Nurses on the night shift were responsible for changing and dating oxygen equipment every Sunday. LVN K stated that she also observed no date or label on oxygen tubing for both Resident #20 and Resident #40 during the time of this interview and will change the tubing immediately. LVN K stated that it was important to change and date all Oxygen supplies promptly because of lapses in infection control for the residents. In an interview with the ADON on 04/23/24 at 12:16 PM revealed she has been working in the facility for the last three weeks. She stated that it was her expectation that all oxygen supplies should be labeled and dated. The ADON stated that Night shift Nurses were responsible for changing and dating oxygen supplies every Sunday. As the ADON, she conducted daily rounds to ensure that Nursing protocols were followed. The ADON stated that risk for not dating or changing oxygen supplies was staff not knowing when the tubing was changed, and it increased the risk of infections to the resident. In an interview with the DON on 4/25/24 at 9:27 AM her expectation was that all oxygen tubing and supplies should be dated and labeled. It should be changed weekly and on as needed basis. The DON added it was the responsibility of Night shift Nurses every Sunday to change and date all oxygen supplies. She stated that the risk to residents for not following procedures for respiratory care was infection control. She stated as a DON, she ensured that herself or her designee conducted floor rounds daily to address any nursing concerns. The DON also stated that changing and dating medical equipment was a routine nursing protocol and additional physician orders were not required for the same. Record Review of facility policy titled ,Oxygen administration undated reflected, Oxygen tubing and Oxygen masks or nasal prongs is to be replaced weekly . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility's policy, Departmental (Respiratory Therapy) Nursing - Prevention of Infection 2001 MED-PASS, Inc. revised April 2007 revealed Purpose: The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment . Steps in the Procedure . 7. Keep the . tubing used PRN in a plastic bag when not in use. 48560

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based observation, interview, and record review, the facility failed to ensure that two (Resident #3 and Resident #46) of ten residents were provided medications and/or biologicals and pharmaceutical services to meet the needs of the residents. The facility failed to ensure MA B re-ordered medications in a timely manner for Resident #3 (Eliquis 2.5 mg) and Resident #46 (Gabapentin 300 mg). This failure placed the residents at risk of not receiving medications as ordered by the physician. Findings included: Resident #3 Review of Resident #3's Face Sheet dated 04/24/2024 reflected that resident was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included transient cerebral ischemic attack (mini strokes) and gastro-esophageal reflux disease with esophagitis (inflammation of the esophagus). Review of Resident #3's Annual MDS assessment dated [DATE] reflected Resident #3 had a severe impairment in cognition with a BIMS score of 07. The Annual MDS Assessment also indicated the resident had a stroke. Review of Resident #3's Comprehensive Care Plan dated 04/20/2024 reflected Resident #3 was in anticoagulant therapy and at risk of bleeding. Review of Resident #3's Physician Order dated 10/06/2023 reflected, Eliquis Oral Tablet 2.5 MG (Apixaban). Give 2.5 mg by mouth two times a day for anticoagulation. Observation and interview with MA B on 04/24/2024 at 8:34 AM revealed MA B was preparing Resident #3's medication. MA B was putting each medication into a small cup. MA B then said he did not have any Eliquis for Resident #3. MA B asked LVN A to pull it from the e-kit because he did not have the blister pack for Resident #3's Eliquis. LVN A came back with a single pack of Eliquis 2.5 mg for Resident #3. MA B opened the single pack and included Eliquis on the medication that he was preparing. MA B administered the medications. MA B then said he was not able to re-order Resident #3's Eliquis 2.5 mg when he saw that the medication was running low. He said he gave the last one the day before and that should had prompted him to re-order the medication. MA B opened Resident 3's eMAR and clicked on Resident #3's Eliquis and clicked the re-order button. Resident #46 Review of Resident #46's Face Sheet, dated 04/23/2024 reflected resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included stiffness of unspecified joint and osteoarthritis. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #46's Quarterly MDS assessment dated [DATE] reflected Resident #46 had a severe cognitive impairment with a BIMS score of 07. The Quarterly MDS Assessment also indicated Resident #46 had a medically complex conditions like joint stiffness. Review of Resident #46's Comprehensive Care Plan dated 04/21/2024 reflected Resident #93 had osteoarthritis with potential for increased pain level one of the interventions was to give analgesic as ordered by the physician. Review of Resident #46's Physician Order reflected, Gabapentin Capsule 300 MG Give 1 capsule by mouth two times a day for . pain. Observation and interview with MA B on 04/24/2024 at 7:25 AM revealed MA B was preparing Resident #46's medication. MA B was putting each medication into a small cup. It was noted when MA B pulled Resident #46's blister pack (a type of packaging in which a product is sealed in plastic, often with a cardboard backing) for gabapentin 300 mg, it was noted the blister pack only had one capsule left when MA B placed one capsule on the small cup of medications. MA B gave the medications to Resident #46. MA B then checked the medication cart for another blister pack for gabapentin. MA B said the resident did not have another blister pack for gabapentin. MA B checked the resident's eMAR, confirmed the medication was not re-ordered yet, and then MA then clicked re-order button. MA B said it was easier to re-order medications now because the staff could do it instantly by just clicking the system unlike before that they needed to pull the stickers, put it on the re-order form, and then fax it to the pharmacy. In an interview with LVN A on 04/24/2024 at 10:55 AM, LVN A acknowledged that MA B asked him to get Eliquis for Resident #3. He stated the medications should have been re-ordered when the medications reached the blue portion of the blister pack. LVN A said the medication should be re-ordered four to five days before the medications were consumed. LVN A stated whoever, nurse or MA saw that the medications were running low should re-order the medications. LVN A added if the medications were not re-ordered, the residents would not have any medications to take. He added they did have an e-kit but the e-kit was primarily for emergencies, STAT orders, or when the pharmacy was not able to deliver but not because the medications were not re-ordered. He added that missing Eliquis could blockage of the blood vessels due to blood clots and missing gabapentin could lead to exacerbation of pain. In an interview with MA B on 04/24/2024 at 1:54 PM, MA B stated he missed re-ordering the medications for Residents #3 and #46. He said he should re-order as soon as it was running low or as soon the medications reached the blue portion of the blister pack that said re-order. He said the residents should always have their medications so whatever medical issues they had would not worsen. He said he would edit the carts and check if there were medications needed to be re-ordered. In an interview with the ADON on 04/24/2024 at 3:12 PM, the ADON stated medications should not be re-ordered last minute because the residents would not have adequate supply of medication in circumstances that the delivery was late or did not come. The ADON added if the residents did not have their medications, their medical concerns could get worse. The ADON said the expectation was the medications be re-ordered in a timely manner to make sure that the residents have enough supply of medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 04/24/2024 at 3:22 PM, the DON stated the e-kit was for medications needed for emergencies or for new orders wherein the pharmacy haven't delivered yet. The DON said medications should be re-ordered 3 to 4 days before the medications run out. The DON said it could be through clicking the re-order button of the medication that needed to be re-ordered. The DON added if the medications were not re-ordered in a timely manner, the resident would run out of medications. The DON stated the Medication Aide and the nurses were responsible for re-ordering the medications. The DON further added if the resident will not have their medications, their condition could get worse. The DON said the expectation was to re-order the medications in a timely manner and said she would do an in-service about re-ordering medications. In an interview with the Administrator on 04/25/2024 at 8:10 AM, the Administrator stated the staff must make sure that the medications were re-ordered in a timely manner to make sure that the residents have the medications they need. The Administrator added the residents' medical issues could exacerbate if they missed their medications. The Administrator stated the expectation is the resident would not run out of medications and all staff should follow the procedure, adhere to the policy, and do the best standard of practice. Record review of facility policy, Ordering Medications, Policy & Procedure revealed Policy: Medications and related products are received from the pharmacy on a timely basis . Procedure: 2. Reorder medication (seven) 7 days in advance of need to assure an adequate supply is on hand . 4. The refill order is called in, faxed, or otherwise transmitted to the pharmacy . 5. New medications . the emergency kit is used when the resident needs the medication prior to pharmacy delivery.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42824 Based on interview, and record review, the facility failed to ensure a resident's medical record was kept in accordance with accepted professional standards and practices, including complete and accurately documented for one (Residnet #51) of five residents reviewed for medical records. The facility failed to ensure Resident #51's electronic medical record contained accurately documented information. This failure could place residents at increased risk of decline in overall health and wellness. Findings included: Review of Resident #51's Face Sheet dated 04/23/2024 revealed she was a [AGE] year-old female originally admitted to the facility 04/07/2022. Relevant diagnoses included: dementia (group of symptoms that affects memory and thinking,) dysphagia (difficulty swallowing food or liquid,) Gastroesophageal reflux disease (GERD) (acid reflux,) and malaise (vague feeling of being unwell.) Review of Resident #51's Quarterly MDS assessment dated [DATE] reflected she was severely cognitively impaired with a BIMS score of 6. She was totally dependent upon staff for eating, oral hygiene, and toileting. She was incontinent of bowel and bladder. She was 61 inches and 137 pounds at the time of this assessment. Review of Resident #51's documented weights in her EMR revealed on 01/29/2024, the resident weighed 150.4 lbs. On 04/25/2024, the resident weighed 145 pounds which was a -3.59 % loss between an 87 day, or 2 month and 27-day period. Review of Resident #51's documented weights in her EMR revealed weight fluctuations as follows: 04/25/2024 145.0 pounds 04/16/2024 131.2 pounds 04/05/2024 136.6 pounds 03/01/2024 136.6 pounds 02/01/2024 150.4 pounds 01/29/2024 150.4 pounds 12/13/2023 156.2 pounds 11/16/2023 156.8 pounds (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	09/12/2023 169.2 pounds 08/16/2023 167.8 pounds Review of Resident #51's Comprehensive Care Plan revised 04/08/2024 revealed a weight loss focus by stating [Resident #51] had significant expected weight loss of 10% in 6 months [related to] diuretic use, [history] of edema with expected fluctuation in weight with intervention that included alert dietician if consumption is poor, diuretic as ordered for edema, monitor and record food intake each meal, and weekly weights .Additionally, she was at an increased risk for decline related to GERD, bowel and bladder incontinence related to dementia, and was dependent upon staff for activities. Additional focus for potential nutritional problems related to malnutrition, dysphagia, and GERD had an intervention that included Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Review of Resident #51's physician orders on 04/23/2024 revealed she was prescribed weekly weights in the morning every Wednesday . weight monitoring . with a start date of 04/17/2024. Additional review of her physician orders revealed she was prescribed a regular diet with pureed texture, nectar thick liquids, and a supplement with all meals with a start date of 03/08/2024. She was prescribed a house supplement four times a day with a start date of 03/05/2024 and liquid protein prescribed two times a day with a start fate of 04/23/2024. It was prescribed to encourage fluid . 1 cup every four hours while awake with a start date of 02/05/2024 and to encourage fluid every shift with a start date of 01/09/2024. Finally, she was prescribed Arginald Oral Packet (Nutritional Supplement) by mouth one time a day with a start date of 02/28/2024. Record review of Resident #51's TAR on Thursday 04/25/2024 at 11:05 AM revealed LVN Z documented she completed physician order and obtained Resident #51's weight on Wednesday 04/25/2024 as prescribed. Record review of Resident #51's Clinical Record on 04/25/2024 at 11:06 AM revealed no evidence of Resident #51's weight documented for Wednesday 04/24/2024 or Thursday 04/25/2024. In interview with LVN Z on 04/25/2024 at 11:10 AM revealed she was aware of Resident #51's physician order for weekly weights each Wednesday; but she stated she did not get a chance to check it yet. She stated she documented she completed it the day prior 04/24/2024; but did not state why she did not actually obtain Resident #51's weight. She stated that she was ultimately responsible for obtaining Resident #51's weight but stated that the facility aides can be delegated to obtain resident weights when ordered. LVN Z did not state why she did not delegate this task yesterday. She stated the potential risk of not following and/or completing physician orders as prescribed poses a risk for potential harm for Resident #51, as her weight required to be monitored. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview with the ADON on 04/25/2024 at 11:25 AM revealed she was aware of Resident #51's weight loss and that she had an order for close monitoring via weekly weights each Wednesday. She stated she was not aware that Resident #51 was not weighed yesterday 04/24/2025. She stated that they typically had an aide that weighs residents with weekly weight orders, but it was ultimately the nurse's responsibly to ensure their resident's weight was obtained. She stated that if LVN Z documented Resident #51's weight was obtained on the TAR, it should have been completed, entered into the Electronic Medical Record (EMR,) and assessed for intervention based on the physician orders and comprehensive care plan. She stated if physician orders were not completed as prescribed, Resident #51 could lose additional weight and [the facility would] not be able to address it. Additionally, she stated that if false data was entered into the EMR, proper interventions may not be in place for the residents. In interview with the DON on 04/25/2024 at 11:35 AM revealed she was aware of Resident #51's weight loss and she had an order for close monitoring via weekly weights each Wednesday. She stated she was not aware that Resident #51 was not weighed yesterday, 04/24/2024, because LVN Z documented in the TAR that it was completed on 04/24/2024. She stated that they typically have an aide that weighs residents with weekly weight orders, but that aide was pulled to work the floor yesterday. She stated she expected the nurse assigned to the resident that day to ensure the weight was obtained so they can assess the need for any intervention. She stated it was her responsibility to ensure the nurses complete this task weekly, and she does this by checking the TAR documentation. She stated Resident #51 was at risk for weight loss and her physician orders of weekly weights not being followed puts her at risk for a change in condition indicating something concerning. She stated she expected LVN Z document accurately and could pose a risk to the residents if not completed. In interview with the Administrator on 04/25/2024 at 12:00 PM revealed he was aware of Resident #51's weight loss and that she required weekly weights for close monitoring. He stated that he typically had an aide weigh residents that require weekly weights, but it was the resident nurses' responsibility to ensure weights were obtained. He stated it puts resident health and wellness at risk if the facility cannot identify weight loss and intervene accordingly. Policy related to deficient practice was requested from the Administrator on 04/25/2024 at 12:03 PM, 1:37 PM, and upon exit; but it was not received prior to exit on 04/25/2024 at 5:00 PM.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48560 Based on observation, interview and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (Residents #1 and Resident #6) of four residents observed for infection control. 1. The facility failed to place Resident #1 who tested positive Clostridioides difficile (C. Diff) on 4/19/2024 in isolation until 04/22/2024, three days after the positive C. Diff result were obtained. (Per CDC website : C. diff is a bacterium that causes diarrhea and colitis (an inflammation of the colon) .Most cases of C. diff infection occur when a resident is taking an antibiotic or not long after resident has finished taking antibiotics. C. diff can be life-threatening. Some of the C. Diff risk factors included: long term use of antibiotics, older age (65 and older), recent stay at a hospital or nursing home, a weakened immune system, or previous infection with C. diff or known exposure to the germs.) 2. LVN O and NA P failed to wear appropriate PPE while caring for Resident #6 and Resident #1; who were on contact isolation, on 4/23/24. An Immediate Jeopardy (IJ) was identified on 04/24/24 at 3:40 PM. The IJ template was provided to the facility Administrator on 04/24/24 at 3:50 PM. While the IJ was removed on 04/25/24 at 11:03 AM 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 still monitoring the effectiveness of their Plan of Removal. These deficient practices could place residents at risks for spread of infection through cross-contamination of pathogens and illness, which could lead to worsening of their condition, hospitalization , or death. Findings included: 1- Record Review of Resident #1's Face Sheet dated 2/27/2024 reflected a re-admitted [DATE] to the facility. Record review of Resident #1's quarterly MDS, dated [DATE], reflected an [AGE] year-old female with an admitted [DATE]. The resident had a BIMS of 14 which indicated she was cognitively intact. She was always urinary and bowel incontinent. Active diagnoses included Heart Failure, Hypertension (high blood pressure), Diabetes Mellitus (high blood glucose), Parkinson's Disease (brain disorder that caused uncontrolled movements) , and seizure disorder. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's care plan dated 04/14/2024, and revised on 04/24/2024 reflected, [Resident #1] Focus: Has infection of UTI- ESBL (Extended-spectrum beta-lactamase (ESBL) is an enzyme found in some strains of bacteria that makes them harder to treat with antibiotics. Urinary tract infections (UTIs) caused by ESBL-producing bacteria are a serious concern for adults), C. diff and requires Contact isolation. Resident and [family member] request that keep door open. She gets anxious and start yelling if door is closed. Family refuses for her to be moved, educated on risks. GOAL: Will be free from complications related to infection through the review date. INTERVENTION: Administer antibiotic as per MD orders. Follow facility policy and procedures for line listing, summarizing, and reporting infections. Maintain standard precautions when providing resident care. Record Review of LVN K's Progress Note dated 4/19/2024 reflected, [Resident #1] is yelling about pain in her rectum due to hemorrhoids, [Resident #1] is also noted to have diarrhea and pain with urination. New orders for CBC, BMP Urine Analysis with w Culture and Sensitivity and Stool with C. Diff sample. Stool and Urine sample have been collected. Samples are in the fridge pending pick up. Lab was called and notified of STAT labs. Record Review of the LVN K's progress note dated 4/22/2024 reflected [Resident #1] tested positive for C-DIFF. Infectious Disease NP in facility at this time. Received orders for Vancomycin (Antibiotic) 250mg by mouth Four times a day x 14 days related to C. Diff, Lactobacillus (probiotic) 1 capsule by mouth twice a day; push fluids and a CBC and BMP need to be collected every Thursday. Pt to be on isolation related to C. diff. Record Review of the RN progress notes revealed there were no notes charted for 4/20/22 and 4/21/24 for Resident #1. Record review of Physician's Order for Resident #1 dated 4/4/2024 reflected, Contact Isolation for a Diagnosis of ESBL every shift for ESBL IN URINE with end date of 04/14/2024. Record Review of Physician's order for Resident #1 dated 4/19/2024 reflected, STAT: CBC, BMP Urine Analysis with w Culture and Sensitivity and Stool with C. Diff sample. Record Review of Physician's Order for Resident #1 dated 4/23/24 reflected , Contact Isolation for a Diagnosis of ESBL and C-Diff every shift related to ENTEROCOLITIS DUE TO CLOSTRIDIUM DIFFICILE, NOT SPECIFIED AS RECURRENT. Record review of the laboratory result for Resident #1 dated 4/19/2024 reflected the following: Sample Collection Date: 04/19/2024 16:51; Received Date: 04/19/2024 18:54; Reported Date: Date: 04/19/2024 at 19:40 , Positive C. Difficile Toxin EIA Positive (Positive C. diff Toxin Enzyme Immunoassay (EIA) test can indicate that resident's diarrhea and other symptoms are caused by toxin-producing C. diff.) was flagged as Abnormal (An abnormal C. diff lab test result indicates that toxins produced by C. difficile bacteria are present in the stool and causing diarrhea.) Record Review of the Infectious Disease NP note date 4/22/2024 reflected [Resident #1] reported to have elevated white Blood cells and lot diarrhea. Stool sample was sent for c-diff test and was tested positive. Pt. denies any dysuria (painful or uncomfortable urination) and denies any fever, chills, sweat, sob, cough. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an observation and interview with Resident #1 on 04/23/24 11:02 AM observed Resident #1 was in an isolation room; cohorting with Resident #6. Resident #1 was in bed with scoop mattress; fall mats on either side of the bed and cachectic looking. Resident #1's room had a foul smell. Resident stated that she was having diarrhea multiple times for last few days, [could not tell the writer exact time frame] and was told on 4/22/24 that she had infection that caused diarrhea by the Nurse. Resident #1 stated she was started on antibiotic on 4/22/24 and had some relief in diarrhea on the day of this interview. Resident #1 stated it would have helped to start the antibiotic medication earlier. She stated staff were not wearing isolation gowns before entering her room since 4/22/24. Resident #1 also stated that she was incontinent of urine and stool and wore briefs that needed to be changed by staff members. 2-Record Review of Resident #6's Face Sheet dated 3/21/2022 with a readmitted [DATE] to the facility. Record review of Resident #6's quarterly MDS, dated [DATE], reflected an [AGE] year-old female with an admitted [DATE]. The resident had a BIMS of 9 which indicated she had moderate cognitive impairment. She was frequently incontinent of urine and bowel. Resident #6 needed substantial/maximal assistance with toileting and hygiene. Active diagnoses included Pneumonia (infection in lungs), Osteoporosis (decreased bone strength or bone density), Cerebral Palsy (a group of conditions that affect movement and posture), functional urinary incontinence (toileting difficulty), non-Alzheimer's dementia (memory loss) and anxiety disorder. Record review of Resident #6's care plan with revised date of 4/24/24 revealed, Focus: Has a new onset infection ESBL UTI and requires isolation. Goal: Will be free from complications related to infection through the review date. Interventions: Ensure all immunization are up to date. Follow facility policy and procedures for line listing, summarizing, and reporting infections. Maintain isolation status. Maintain standard precautions when providing resident care. Record Review of the Physician's Orders dated 4/23/24 reflected Resident #6 had and order for Contact Isolation for a diagnosis of ESBL every shift related to URINARY TRACT INFECTION. In an observation on 4/23/24 at 2:32 PM from the hallway revealed that Resident #6 and Resident #1 shared the same room. The room was an isolation room with two contact isolation signs that stated See nurse before entering room posted on the door. The room door was open, and Resident #6 was found to be sitting on the floor of her room near the wheelchair. The isolation cart including PPE such as gloves, masks, and hand sanitizer was observed outside the door. Observed NA P rushed to the room, without performing any hand hygiene or wearing PPE. Then observed LVN O entered the isolation room without performing any hand hygiene or wearing PPE. The 2 staff members, LVN O and NA P, then proceeded to pick-up Resident #6 and sat her into the wheelchair in the room. NA P proceeded to move Resident # 6's wheelchair to the restroom. Meanwhile, LVN O came out of the room without performing hand hygiene and walked to the nurse's station. She grabbed a hand cuff blood pressure monitor and rushed back to the isolation room. Observed NA P escorted Resident #6's back from the restroom into her room. LVN O then measured Resident#6's blood pressure and walked out of the room, without performing hand hygiene, to the nurses' station and set the blood pressure monitor on the desk of the nurse's station without sanitizing it. Observed NA P then proceeding to wash her hands with soap and water and exiting the room. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with NA P on 4/23/24 at 2:43 PM, revealed that she was working in the facility as a nurse aide for the last 4 months. She stated that she was not sure that Resident #6 was on isolation and stated she did not see the isolation signage on the door. She stated that Resident #1 was on isolation since 4/22/24; but she did not wear the PPE since she was only going to help Resident #6 who was on the ground. NA P then added that she saw the isolation sign on the door at the time of this interview. NA P stated that she initially thought that Resident #6 had a fall on the ground and rushed to the isolation room but then realized that Resident #6 was on the ground to reach the wheelchair. She stated the risk to residents for not adhering to PPE and infection control guidelines was increased risk of infection and spreading it to other residents. In an Interview with LVN O on 4/23/24 at 2:51 PM revealed that she heard NA P call her to Resident #6's room. LVN O stated that she worked in a different hall than where Resident #6 was located and hence did not notice the two contact isolation signs and the see Nurse signage on the Resident #6's door. She stated she was not provided an in-service on isolation protocols. She stated that for any contact isolation room, she needed to don her gown and gloves and perform adequate hand hygiene before entering the room. She also stated it was a mistake on her part to enter a contact isolation room without performing hand hygiene or donning appropriate PPE. She stated she checked on Resident #6's blood pressure which was 147/100 and rushed out of the room again without performing hand hygiene to inform the nurse assigned to Resident #6. She then set the blood pressure monitor on the nursing station desk and stated she would be sanitizing it after some time. LVN O stated the risk to residents for not performing hand hygiene, not donning PPE, and not sanitizing medical equipment after use within an isolation room was very high risk of spread of infection. In an interview with Resident #6 on 4/23/24 at 2:58 PM, it was revealed that Resident #6 wanted to use the restroom and scooted out of her recliner to sit on the wheelchair. Since the wheelchair was a little away from the recliner, she sat on the floor to scoot towards the wheelchair to climb into it so she could use the restroom. Resident #6 stated she forgot to press the call light to alert the staff members. Resident #6 also stated that she had a urine infection and needed to use the restroom frequently. Resident # 6 stated one of the staff members [could not tell the name of the staff member to the surveyor] told her on 4/24/24 that she had an infection that required everyone entering the room wear isolation gowns and gloves so the infection would not spread to others. She stated that the LVN O and NA P that entered the room while she was on the floor sometime back, did not wear a gown or gloves while assisting her. In an interview with the ADON on 04/23/24 at 3:18 PM revealed that she had only started working at the facility 3 weeks ago. She stated she thinks Resident #6 was on isolation for ESBL on 4/23/24 and the staff were in-serviced about isolation protocols. She added her expectation was for the staff to wear PPE at all times in an isolation room; except when there was an emergency and a resident's safety takes precedence over isolation protocols. She stated that she was not aware of the incident with Resident #6 being on the ground and would investigate to find why NA P and LVN O failed to follow appropriate isolation protocols. She stated that as an ADON she was responsible for overseeing staff follow all isolation precaution guidelines. In an interview with CNA Q on 4/24/24 at 8:58 AM revealed that Resident #1 started isolation on 4/22/24 and Resident #6 started isolation on 4/23/24. CNA Q stated that Residents #1 and #6 were not on isolation on 4/19-4/21. CNA Q stated that for all isolation rooms, CNAs needed to wear a gown and gloves before entering the room and perform adequate hand hygiene. The risk of not doing so could lead to infections. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with Housekeeper F on 4/24/24 at 9:02 AM revealed that she worked on 4/21/24 and 4/22/24 and was assigned to the hall where Resident #1 and Resident #6 resided. She stated that Resident #1 and Resident #6's room was not on isolation on those days. She came back to work on 4/24/24 and was told that room (where Resident # 1 and #6 stayed) was on contact isolation and she needed to wear gloves, gown, and perform hand hygiene before entering the room. In an interview with LVN K on 4/24/24 at 9:23 AM revealed she worked on 6 am - 2 pm shift on 4/19/24 and 4/22/24. She stated that she checked Resident #1's lab results for positive C. Diff that resulted on 4/19/24. She notified the Infectious Disease NP, who gave orders for Resident #1 to be on isolation on 4/22/24. LVN K stated that Resident #1 was not on isolation when she arrived at the facility for her 6 am -2 pm shift on 4/22/24. LVN K stated that the risk to residents for not providing contact isolation was infection control concerns. In a phone interview with LVN N on 4/24/24 at 12:01 PM revealed she worked on 4/20/24 and 4/21/24 6 am - 2 pm and 2 pm -10 pm shift on the Resident #1's hall. She stated that Resident #1 was not on isolation on 4/20/24 and 4/21/24 on those days. She stated that the risk of not isolating residents with positive C. Diff promptly, was increased spread of infection. In a phone interview with the Infectious Disease NP on 4/24/24 at 12:09 PM revealed the facility made her aware of Resident #1 positive C. Diff lab result on 4/22/24 and labs for C. Diff for Resident #1 resulted positive on 4/19/24. The Infectious Disease NP stated once she learned about the positive C. Diff result for Resident #1, she gave orders to start Resident #1 on isolation. She stated the risks to residents for not placing resident on isolation promptly once C. Diff was diagnosed were lapses in infection control and quality of care can be decreased. In an interview with LVN L on 4/24/24 at 1:02 PM revealed she worked 2 pm - 10 pm Shift on 4/22/22 and was assigned to Resident #1. She stated she was provided a shift report that stated Resident #1 started isolation on 4/22/24. LVN L stated that for any contact isolation room, staff needed to wear PPE and perform hand hygiene, and failure to do so could result in risk of spreading the infection. LVN L also stated that it was a nursing protocol to place a resident with infectious disease in prompt isolation to prevent further spread of the disease to other residents. In an interview with the DON on 04/24/24 at 1:31 PM revealed she started at the facility about a month ago. She stated Resident #1's was having diarrhea and hence stat stool testing was order and collected on 4/19/24 and resulted positive for C. Diff on 4/19/24. The DON referred to the EHR and answered that per physician's orders Resident #1 was started on isolation on 4/22/24. The DON stated that she became aware of the positive C. Diff lab results on the morning of 4/22/24 in a clinical meeting. The DON stated that there was a failure to start prompt contact isolation for Resident #1 after a C. Diff diagnosis on 4/19/24. The DON stated her expectation was staff members to follow all isolation protocols for infectious diseases and wear appropriate PPE and perform hand hygiene. The DON also stated that they had started in-services for all staff members on 4/23/24 about wearing appropriate PPE and performing adequate hand hygiene. She stated that LVN O was suspended pending investigation of the incident on 4/23/24. The DON added that LVN O was one of the staff members that entered the isolation room without performing adequate hand hygiene and without doffing appropriate PPE. The DON stated that the risk to residents for not wearing appropriate PPE or not placing residents with diagnosis of infectious disease was very high chances of spreading infections. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a phone Interview with the Medical Director (MD) on 04/30/24 at 3:13 PM revealed that she was not informed about Resident#1's Positive C. Diff lab until 4/22/24. The MD stated that it was her expectation that all staff members follow transmission-based precautions for isolation rooms that included wearing appropriate PPE, performing adequate hand hygiene, and placing residents on appropriate isolation promptly. She also stated that risk for not adhering to infection control guidelines for transmission-based precautions was increased risk of spread of infections throughout the facility. In an interview with the Administrator on 04/24/24 at 03:16 PM revealed that Resident #1 was on isolation already, started earlier in month with ESBL. The Administrator added that he was not aware that ESBL isolation orders had ended on 4/14/24. He further added that he became aware that Resident #1 was positive for C. Diff on 4/22/24 since it was brought up in the morning meeting. The Administrator stated it was his expectation to start contact isolation promptly and wear appropriate PPE before caring for a resident with diagnosis of an infectious disease. The Administrator also added that the DON and the Clinical Resource RN had started in-services with all staff to adhere to wearing PPE and hand hygiene before entering all isolation rooms and failure to do so would lead to lapses in infection control. In an interview with Clinical Resource RN on 4/25/24 at 10:02 am revealed it was her expectation that staff members follow transmission-based precautions including wearing PPE, hand hygiene, starting prompt isolation and failure to do so may potentially cause lapses in infection control though out the facility. Record Review of Facility's titled IPCP Standard and Transmission-Based Precautions Policy revised date October 2022 reflected, .b. Personal protective equipment (PPE): i. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. ii. DON PPE upon room entry, then doff and properly discard PPE and perform hand hygiene before exiting the patient room to contain pathogens. C. Patient-care equipment (e.g., blood pressure cuffs). It is preferred dedicated or disposable patient-care equipment be used. If common use of equipment for multiple patients is unavoidable, clean and disinfect such equipment before use on another patient .6. Implementation: a. The facility will implement a system to alert staff, residents, and visitors that a resident is on TBP. Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g., gown and gloves) . Review of the Center for Disease Control (CDC) Website: Nursing Homes and Assisted Living (Long-term care facilities) https://www.cdc.gov/longtermcare/prevention/index.html dated December 28, 2016, reflected , C. difficile infection (CDI) is a common cause of acute diarrhea in nursing homes. Individuals with CDI serve as a source for bacterial spread to others, through the contamination of caregiver hands and shared equipment. Contamination of a resident's skin and environment is greatest when a resident has diarrhea from CDI but hasn't started on appropriate treatment. Early identification of CDI can limit the spread of C. difficile by reducing the time from symptom onset to starting therapy. Rapid containment through implementation of contact precautions for symptomatic residents can reduce contamination. Contact precautions include use of gowns/gloves and dedicated equipment during care of residents with new diarrhea (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record Review of the Inservice, dated 4/23/24 , Infection Control: Standard and Transmission Based precautions reflected facility staff were in-serviced. In-service's included transmission-based precautions and discontinuation of precautions based on CDC guidance. The surveyor attempted interviewed for all the staff that were in-serviced for Infection Control: Standard and Transmission Based precautions. In an interview with LVN Z on 4/25/24 at 12:52 pm revealed, that per in-services provided on 4/24/24 regarding appropriate PPE use, PPE donning and doffing sequence, types of isolation, TBP protocols. LVN Z also stated that all staff members caring for residents on isolation will need to follow all TBP protocols. She verbalized that residents should be placed in isolation promptly following diagnosis of an infectious disease such as C. Diff. In an interview with CNA X on 4/25/24 at 12:54 PM revealed CNA X was observed entering the room after she donned gown and gloves. She stated she received an in-service on morning of 4/24/24 on different kind of isolations, PPE, hand hygiene. She stated that for a resident on enhanced barriers, she needed to use gown and gloves, and mask was not required. For the resident on contact isolation or droplet she should use the mask. CNA X also stated that she needed to Wash her hands before entering the isolation room and after she was done with care and between change of gloves. In an interview with CNA AA on 4/25/24 at 1:01 pm revealed she received in-services on 4/24/24 and verbalized the types of precautions such as contact, droplet and others. Verbalized the PEE to use according to the type of precaution. She stated that there was an isolated signage on the door that alerted the staff members regarding isolation protocols. Verbalized hand hygiene according to the in-service done by the facility this week, and if the resident was in contact isolation for C. Diff, she had to wash hands with soap and water. In an interview with CNA Y on 4/25/24 at 1:04 PM revealed he had been working at the facility for 4 months. He stated that he received an in-service on infection control: PPE to use when going to the residents' rooms, CNAs needed to wear PPE according to the signage at the door. He verbalized different kinds of precautions: contact, droplet, enhanced precaution, donning and doffing PPE. If a resident was on the floor in an isolation room, staff must wear PPE before she assisted the resident on the floor. He stated that all staff need to perform Hand hygiene: before and after they finished providing care and frequently and when they changed gloves. In an interview with CNA C on 4/25/24 at 1:06 PM revealed different types of precaution such as contact, droplet, other. She stated that all staff should be wearing appropriate PPE and perform hand hygiene for all residents on isolation. She also verbalized hand hygiene according to the in-service done by the facility this week, and if the resident was in contact isolation for C. Diff, staff had to wash hands with soap and water. In an interview with LVN R on 4/25/24 at 1:20 pm revealed they received an in-service on infection control regarding proper way of putting PPE; donning the proper PPE for appropriate isolation, hand washing (before and after done with care and as needed), precaution could be contact, droplet or enhanced. If a resident was on the floor in an isolation room, PPE must be donned before assisting the resident on the floor. LVN R also stated that isolation protocols for TBP residents need to be done promptly. (continued on next page)

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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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with CNA BB on 04/25/24 at 1:21 PM revealed different types of isolations were contact precaution (touch), droplets (spitting), airborne (breathing). She stated that staff needed to wear PPE and perform hand hygiene during every contact with resident on isolation. She stated that she was in-serviced about proper sequence for donning and doffing PPE. She also stated that handwashing was done upon entering and leaving the room, before and after taking care of the residents, in between taking care of residents, changing gloves and washing hands again. She stated for any TBP isolation rooms, there should be a signage, PPE, hand rub, and a PPE disposal bin in every room. In an interview with CNA Q on 4/25/24 at 1:22 PM revealed she has worked in the facility since February 2024. She stated different types of isolation were precaution droplet, enhanced. For any TBP room, there needed to be a signage on the door, PPE kit outside the room. She stated that she had been provided in-services regarding always wearing a PPE [TRUNCATED]