STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675329	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Levelland Nursing & Rehabilitation Center	210 West Ave Levelland, TX 79336

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 49927 Based on observation, interview, and record review, the facility failed to provide information to resident's and their representatives on their rights related to filing grievances or concerns for 6 of 18 confidential residents. The facility failed to ensure 6 of 18 confidential residents were provided, through postings in prominent locations, the Grievance Procedure, access to the Grievance forms, information of who the facility's grievance official was and their contact information, how to file an anonymous grievance, and their right to obtain a written decision related to their grievance. This failure could place the residents at risk of unresolved grievances and decreased quality of life. Findings include: Interviews during Resident Council on, 10/16/2024 at 10:45 AM, attendees 6 of 18 confidential residents stated they did not know about the grievance process. They also stated they did not know where to obtain or submit a grievance form. They stated they did not know they could file a Grievance anonymously. They stated the Grievance procedure had never been discussed in Resident Council. They also stated they had not observed a posting of the Grievance procedure in prominent locations. Residents attending the group meeting did not know how to file a grievance. Residents did not know where to acquire a grievance form, who to turn the form into, and what should happen once a grievance was filed. The Residents did not know they had the right to receive a written decision once their grievance was resolved. Six Residents attended the meeting, and the six Residents in attendance had all been Residents of the facility for 6 months or longer. Observation of blank greivance forms on 10/17/2024 at 12:30 PM; blank greivance forms were observed outside of the social services office. The facility did not include instructions regarding the Grievance procedure with a prominent posting. There was no signage indicating the forms were present nor instructions advising a resident of how to submit a Grievance. The facility also did not provide an option for a resident to be able to submit a grievance anonymously. (continued on next page)

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

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DON on 10/17/2024 at 12:25 PM; the DON stated she was not aware of what the grievance policy was and would have to look it up. The DON stated the facility did not have an administrator at the time of the interview. The DON stated she thought the social worker was responsible for handling grievances. The DON stated she was not sure where grievance forms were held, but she thought the social worker kept them. The DON was unsure where grievances were documented. The DON stated if a grievance was filed, she would collaborate with staff and then meet with the resident to try to resolve the grievance. The DON stated all grievances were submitted to the facility's social worker, but the administrator or the DON was responsible for resolving grievances. The DON stated the social worker was unavailable for interview at that time. The DON was unsure of the timeframe to resolve a grievance, but she stated they would usually handle them right away. The DON stated residents were notified of their ability to file a grievance upon admission and during resident council meetings. The DON was unable to find a policy related to grievances, but she provided a policy of residents' rights which mentioned grievances. Record Review of the undated document titled Residents' Rights, revised December 2016, revealed the following: Policy Statement: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation: U. voice grievances to the facility, or other agency that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal; V. have the facility respond to his or her grievances;

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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** 49305 Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care, were provided such care, consistent with professional standards of practice for 6 (Residents #16, #17, #24, #26, #30 and #42) of 8 residents reviewed for respiratory care. 1. The facility failed to ensure that Resident #24 and Resident #42's oxygen tubing was replaced every seven (7) days. 2. The facility failed to ensure that oxygen tubing was dated for Resident #26 and Resident #30. 3. The facility failed to ensure that oxygen tubing was properly stored for Resident #16 and Resident #17. These failures could place residents at risk for respiratory compromise and infection. Findings included: 1. Resident #24 Review of Resident #24's face sheet revealed a [AGE] year-old female with an admitted [DATE] with the following diagnoses: Alzheimer's Disease (brain disorder), Osteoarthritis (joint disease), Diabetes Mellitus (uncontrolled sugar in the blood), Hypoxemia (low oxygen in the blood), and Heart Failure (inadequate ability of the heart to pump blood). Record review of Resident #24's annual MDS dated [DATE] revealed a BIMS score of 07, indicating the resident had severe cognitive impairment. Section O - Special Treatments, Procedures and Programs revealed Resident #24 used oxygen therapy while a resident. Record review of Resident #24's comprehensive care plan, dated 10/07/24, revealed Resident #24 required oxygen therapy related to heart failure. Record review of Resident #24's current Physician Orders dated 01/03/23 revealed an order for oxygen to be administered continuously at 2 liters/minute per nasal cannula (tube in nostrils) every shift related to hypoxemia (low oxygen in the blood). Record review of Resident #24's current Physician Orders dated 01/03/23, revealed an order to change oxygen tubing and prefilled humidifier water every Thursday and Sunday, or when visibly soiled. During an observation on 10/15/24 at 11:01 AM, Resident #24 had oxygen being administered at 2 liters/minute via nasal cannula. Oxygen tubing was dated 10/07/24. During an observation on 10/16/24 at 10:18 AM, Resident #24 had oxygen being administered at 2 liters/minute via nasal cannula. Oxygen tubing was dated 10/07/24. Resident #42 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #42's face sheet revealed an [AGE] year-old male with an admitted [DATE] with the following diagnoses: Thrombosis of Aorta (blood clot blocking the artery that carries blood from the heart), Chronic Obstructive Pulmonary Disease (airflow blockage and breathing-related problems), Gastroesophageal Reflux Disease (digestive condition), Hypertension (high blood pressure), Benign Prostatic Hyperplasia (enlargement of prostate gland). Record review of Resident #42's annual MDS dated [DATE] revealed a BIMS score of 06, indicating the resident had severe cognitive impairment. Section O - Special Treatments, Procedures and Programs revealed Resident #42 used oxygen therapy while a resident. Record review of Resident #42's comprehensive care plan, dated 10/09/24, revealed Resident #42 required oxygen therapy related to Chronic Obstructive Pulmonary Disease. Record review of Resident #42's current Physician Orders dated 10/16/24 revealed an order for oxygen to be administered continuously at 2 liters/minute per nasal cannula (tube in nostrils) every shift related to Chronic Obstructive Pulmonary Disease. During an observation on 10/15/24 at 11:01 AM, Resident #42 had oxygen being administered at 2 liters/minute via nasal cannula. Oxygen tubing was dated 10/07/24. During an observation on 10/16/24 at 10:22 AM, Resident #42 had oxygen being administered at 2 liters/minute via nasal cannula. Oxygen tubing was dated 10/07/24. 2. Resident #26 Review of Resident #26's face sheet revealed a [AGE] year-old female with an admitted [DATE] with the following diagnoses: Alzheimer's Disease (brain disorder), Respiratory Failure (condition where the blood has inadequate oxygen), Chronic Kidney Disease (condition causing kidneys to not function properly), Heart Failure (inadequate ability of the heart to pump blood) and Hypertension (high blood pressure). Record review of Resident #26's annual MDS dated [DATE] revealed a BIMS score of 06, indicating the resident had severe cognitive impairment. Section O - Special Treatments, Procedures and Programs revealed Resident #26 used oxygen therapy while a resident. Record review of Resident #26's comprehensive care plan, dated 10/09/24, revealed Resident #26 required oxygen therapy related to Chronic Obstructive Pulmonary Disease. Record review of Resident #26's current Physician Orders dated 10/16/24 revealed an order for oxygen to be administered continuously at 2 liters/minute per nasal cannula (tube in nostrils) every shift related to Chronic Obstructive Pulmonary Disease. During an observation on 10/15/24 at 10:39 AM, Resident #26 had oxygen tubing and humidifier water that was not dated. During an observation on 10/16/24 at 10:26 AM, Resident #26 had oxygen tubing and humidifier water that was not dated. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #30 Review of Resident #30's face sheet revealed a [AGE] year-old male with an admitted [DATE] with the following diagnoses: Chronic Obstructive Pulmonary Disease (airflow blockage and breathing-related problems), Hypertension (high blood pressure), Polyneuropathy (damage to nerves), Gastro-Esophageal Reflux Disease (digestive disease), and Congestive Heart Failure (inadequate ability of the heart to pump blood). Record review of Resident #30's annual MDS dated [DATE] revealed a BIMS score of 15, indicating the resident was cognitively intact. Record review of Resident #30's comprehensive care plan, dated 04/06/24, revealed Resident #30 required oxygen therapy related to Chronic Obstructive Pulmonary Disease. Record review of Resident #30's current Physician Orders dated 08/26/22 revealed an order for oxygen to be administered at 2-5 liters/minute per nasal cannula (tube in nostrils) as needed related to Chronic Obstructive Pulmonary Disease. During an observation on 10/15/24 at 10:46 AM, Resident #30 had oxygen tubing and humidifier water that was not dated. 3. Resident #17 Review of Resident #17's face sheet revealed an [AGE] year-old female with an admitted [DATE] with the following diagnoses: Respiratory Failure (condition where the blood has inadequate oxygen), Heart Failure (inadequate ability of the heart to pump blood), Dyspnea (difficulty breathing), Chronic Obstructive Pulmonary Disease (airflow blockage and breathing-related problems), Hypokalemia (low potassium) and Cognitive Communication Deficit (communication difficulty caused by cognitive impairment). Record review of Resident #17's annual MDS dated [DATE] revealed a BIMS score of 10, indicating the resident had moderate cognitive impairment. Section O - Special Treatments, Procedures and Programs revealed Resident #17 used oxygen therapy while a resident. Record review of Resident #17's comprehensive care plan, dated 09/09/24, revealed Resident #17 required oxygen therapy related to ineffective gas exchange. Record review of Resident #17's current Physician Orders dated 10/16/24 revealed an order for oxygen to be administered at 2-3 liters/minute per nasal cannula (tube in nostrils) every shift related to heart failure. During an observation on 10/15/24 at 10:14 AM, Resident #17 had nasal cannula and oxygen tubing laying on the floor. Resident #16 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #16's face sheet revealed an [AGE] year-old female with an admitted [DATE] with the following diagnoses: Alzheimer's Disease (brain disorder), Pulmonary Embolism (blockage of lung artery), Cerebral Infarction (stroke), Chronic Obstructive Pulmonary Disease (airflow blockage and breathing-related problems), Obesity (overweight), Dysphagia (difficulty swallowing), and Hypertension (high blood pressure). Record review of Resident #16's annual MDS dated [DATE] revealed a BIMS score of 07, indicating the resident had severe cognitive impairment. Record review of Resident #16's current Physician Orders dated 10/16/24 revealed an order for oxygen to be administered at 2 liters/minute per nasal cannula (tube in nostrils) every shift related to Chronic Obstructive Pulmonary Disease. During an observation on 10/15/24 at 10:23 AM, Resident #16 had nasal cannula and oxygen tubing laying on the floor. During an interview on 10/17/24 at 11:29 AM with LVN A, she stated oxygen tubing should be stored in bags which were to be placed by the night shift. She stated tubing should not be on the floor and it was everyone's responsibility to monitor that tubing was kept in bags when not in use. She stated oxygen tubing should be changed and dated every week on Sunday on the night shift. She stated a potential negative outcome for failure to properly change and store oxygen tubing is infection. During an interview on 10/17/24 at 11:36 AM with CNA A, she stated oxygen tubing should not be on the floor. She stated oxygen tubing should be placed in a bag when not in use and everyone was responsible for making sure tubing is stored correctly. She stated a potential negative outcome of not storing oxygen tubing correctly was spreading germs. During an interview on 10/17/24 at 01:38 PM with the DON, she stated the facility policy for changing oxygen tubing was that it was changed every Sunday on the night shift. She said the night shift charge nurse was responsible for changing and dating oxygen tubing weekly on Sunday. She stated nursing administration was responsible for assuring oxygen tubing was changed, dated, and stored according to physician's orders and facility policy. She stated nursing administration monitored the proper dispensing of oxygen by conducting rounds in the facility. She stated staff were trained on proper dispensing of oxygen through in services conducted by nursing administration. The DON stated a potential negative outcome for failure to properly change, date and store oxygen tubing according to physician's orders, was an increased risk for infection and inadequate oxygen therapy. Record review of the facility-provided policy titled Departmental (Respiratory Therapy) -Prevention of Infection, revised November 2011, revealed: Purpose The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. Preparation . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Assemble the equipment and supplies needed. Steps in the Procedure . 7. Change the oxygen cannulae and tubing every seven (7) days, or as needed. 8. Keep the oxygen cannulae and tubing used PRN (as needed) in a plastic bag when not in use.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41480 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services, in that: 1. The facility failed to ensure foods were prepared under sanitary conditions. 2. The facility failed to store and date foods stored in the refrigerator. These failures could place residents at risk for food contamination and foodborne illness. The findings included: The following observations were made on [DATE] at 09:15 AM during initial observation of the kitchen: Observed two individual deserts in the top shelf of refrigerator with no date. Package of individual cheese slices with plastic wrap not covering the cheese and no date. The following observations were made on [DATE] at 11:15 AM during observation of puree meal preparation: After pureeing mixed veggies, [NAME] A took processor bowl and lid to 3-compartment sink and cleaned it. [NAME] A shook water off processor bowl and took the processor bowl to the prep table and placed upright on the prep table. Observation of liquid on sides and bottom of processor bowl. [NAME] A prepared puree ham and pineapple. [NAME] A took processor bowl and lid to the 3-compartment sink washed and placed it in drainer. [NAME] A placed sweet potato casserole in processor bowl and placed processor bowl on processor base. Puree sweet potato casserole. Removed processor bowl from processor base and took processor bowl with puree sweet potato casserole in processor bowl to 3-compartment sink and added water to processor bowl. [NAME] A returned processor bowl to processor base and pureed. [NAME] A removed processor bowl from processor base and took processor bowl with puree sweet potato casserole in processor bowl back to 3-compartment sink and added water to processor bowl. [NAME] A took processor bowl back to the processor base and pureed. [NAME] A removed processor bowl and poured puree sweet potato casserole into pan on steam table and covered with parchment paper. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 10:48 AM with the DM, she stated all food items in the refrigerator needs to be dated and in a sealed container. She stated the individual cheese slices were to be portioned out and wrapped with plastic wrap and dated. She stated all staff were responsible for dating all food placed in the refrigerator. She stated the reason for the no dates and the cheese not being wrapped was the staff get lazy. She stated the potential negative outcome would be you do not know when the food needs to be thrown away or how long it had been in the refrigerator. She stated, you could be serving expired food to residents that could make them sick. She stated the processor bowl should have been placed upside down in the dish drainer at end of 3-compartment sick and allowed to air dry. She stated staff have been trained to allow time to air dry processor bowls between each food item. She stated the potential negative outcome could be chemical in the processor bowl mixing with the food due to not allowing it to dry. She stated food should not leave the prep table. She stated the water should have been added using a separate container. She stated staff have been educated on how to add liquid to the puree. She stated the potential negative outcome could be cross contamination of food and making the residents sick. During an interview on [DATE] at 01:20 PM with the ADON, she stated all kitchen staff have been in-serviced on dating food in the refrigerator. She stated the potential negative outcome could be serving expired food to residents. She stated taking food from the prep area to the 3-compartment sink could cause cross contamination and bacteria in food. Record review of the facility policy, titled Food Preparation and Services, dated revised [DATE] revealed the following: Policy Statement: Food and nutrition services employees prepare, distribute, and serve food in a manner that complies with safe food handling practices . General Guidelines . 2. Cross-contamination can occur when harmful substances, i.e., chemicals or disease-causing microorganisms are transferred to food by hands (including gloved hands), food contact surfaces, sponges, cloth towels, or utensils that are not adequately cleaned. Cross contamination can also occur when raw food touches or drips onto cooked or ready-to-eat foods . Food Preparation Area . 2. Equipment is arranged to facilitate food preparation, based on input from appropriate individuals including food and nutrition services staff. 3. Areas for cleaning dishes and utensils are located in a separate area from the food service line to assure that a sanitary environment is maintained . 4d. cleaning and sanitizing work surfaces (including cutting boards) and food-contact equipment between uses, following food code guidelines . Record review of the facility policy, titled Food Receiving and Storage, dated revised [DATE] revealed the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Statement - Foods shall be received and stored in a manner that complies with safe food handling practices . Refrigerated/Frozen Storage 1. All foods stored in the refrigerator or freezer are covered, labeled, and dated (use by date) . 7. Refrigerated foods are labeled, dated, and monitored so they are used by their use-by date, frozen or discarded .

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49927 Based on observation, interview, and record review, the facility failed to maintain and ensure safe and sanitary storage of residents' food items for 5 of 5 refrigerators reviewed for food safety (room [ROOM NUMBER], 208, 216, 217, and 220) in that: The refrigerator located in room [ROOM NUMBER] did not have an up-to-date temperature log present nor did it have a thermometer inside of the refrigerator. The refrigerator contained perishable food items such as deli lunch meats, protein shakes and pickles. The refrigerator located in room [ROOM NUMBER] did not have a temperature log present nor did it have a thermometer inside of the refrigerator. The refrigerator contained perishable food items such as canned sodas and cottage cheese. The refrigerator located in room [ROOM NUMBER] did not have a temperature log present nor did it have a thermometer inside the refrigerator. The refrigerator contained perishable food items such as ice cream, yogurt, and cans of soda. The refrigerator located in room [ROOM NUMBER] did not have an up-to-date temperature log present for the refrigerator. The refrigerator contained cans of soda and perishable snack items. The refrigerator located in room [ROOM NUMBER] did not have an up-to-date temperature log present nor did it have a thermometer inside the refrigerator. The refrigerator contained perishable food items such as yogurt. These failures could place residents at risk for food borne illnesses. Findings include: Observations during the duration of the survey (10/15/2024 - 10/17/2024) revealed the following: room [ROOM NUMBER], on 10/15/2024 at 10:12 AM, Observed a personal refrigerator. There was not an up-to-date log present. There was no thermometer present. The refrigerator contained perishable food items such as deli lunch meats, protein shakes and pickles. room [ROOM NUMBER], on 10/15/2024 at 10:15 AM, Observed a personal refrigerator. There was no log present. There was no thermometer present. The refrigerator contained perishable food items such as canned sodas and cottage cheese. room [ROOM NUMBER], on 10/15/2024 at 4:51 AM, Observed a personal refrigerator. There was no log present. There was no thermometer present. The refrigerator contained perishable food items such as ice cream, yogurt, and cans of soda. room [ROOM NUMBER], on 10/15/2024 at 10:41 AM, Observed a personal refrigerator. There was not an up-to-date log present. The refrigerator contained cans of soda and perishable snack items. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER], on 10/15/2024 at 10:06 AM, Observed a personal refrigerator. There was not an up-to-date log present. The refrigerator contained perishable food items such as yogurt. During an interview on 10/17/2024 at 10:35 PM, the ADON stated the housekeeping staff was responsible for checking the temperatures of the residents' personal refrigerators and logging them daily. The ADON stated the housekeeping staff should have ensured the residents' refrigerators had valid thermometers, and they should have reported to administration if there was no thermometer. The ADON stated it was important to check temperatures of the residents' personal refrigerators because food could have spoiled, and residents could have gotten sick. During an interview on 10/17/2024 at 10:45 AM, the DON said she was unsure of how often the residents' refrigerators should have been checked for adequate temperatures or how often the temperatures should have been logged. The DON stated the housekeeping staff was responsible for ensuring the logs were current. The DON stated she was unsure of the last training staff received regarding residents' personal refrigerators. The DON stated housekeeping staff should have ensured the refrigerators had a valid thermometer. The DON stated it was important for staff to check temperatures on residents' personal refrigerators because residents could have gotten sick from food that was not at an appropriate temperature, and residents could have gotten food poisoning. Record review of the facility's policy titled Nutritional Policies and Procedures, Guidelines for Personal Resident Refrigerators, revised 5/1/2015, revealed: When a patient/resident requests a personal refrigerator in his or her room, the following guidelines are provided to assure the avoidance of practices that could result in foodborne illness. Expectations of Resident/Family - a patient/resident or the patient's/resident's family shall do the following: 1. Purchase a thermometer for the refrigerator to ensure that the unit maintains a temperature of 41 F or lower. Expectations of the Facility - the Facility shall do the following: 1. Nursing or housekeeping personnel will record temperatures of personal refrigerators daily. Record review of the facility's policy titled Nutritional Policies and Procedures, Guidelines for Residents' Use of Personal Refrigerators, revised 5/1/2015, revealed: The storage of perishable and non-perishable foods in resident rooms pose the risk and danger for spreading of infection and disease as well as the potential for another resident to consume foods not intended for him or her, which foods may be outside of their nutritional plan. The use of personal refrigerators in the Facility is at the Facility's discretion and subject to the following: o All refrigerators must be purchased by the resident or his/her legal representative and must be equipped with a thermometer to ensure that the unit maintains a temperature of 41 F or lower; o Facility staff will monitor temperatures of the refrigerator on a daily basis and discard any items deemed unsafe/hazardous by Facility staff;

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49305 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 3 (Residents #20, #42 and #45) of 3 residents and 3 of 3 staff (LVN A, LVN B, CNA A) reviewed for infection control. 1. The facility failed to implement EBP (Enhanced Barrier Precautions) for Resident #20 and Resident #42 who each required indwelling urinary catheters. 2. The facility failed to implement EBP (Enhanced Barrier Precautions) for Resident #20 and Resident #45 who had wounds which required a dressing. These failures could place residents at risk for cross contamination, spread of infection and sepsis. Findings included: 1. Resident #20 Review of Resident #20's face sheet revealed an [AGE] year-old male with an admitted [DATE] with the following diagnoses: Respiratory Failure (condition in which the blood does not have enough oxygen), Atherosclerotic Heart Disease (buildup of plaque in the artery walls), Congestive Heart Failure (inadequate pumping of the heart), Chronic Kidney Disease (kidney damage), Dysphagia (difficulty swallowing), Hypertension (high blood pressure), Urinary Retention (difficulty completely emptying the bladder), Neuromuscular Dysfunction of the Bladder (bladder does not fill or empty correctly). Record review of Resident #20's annual MDS dated [DATE] revealed a BIMS score of 05, indicating the resident had severe cognitive impairment. Section H - Bladder and Bowel, revealed Resident #20 had an indwelling catheter. Record review of Resident #20's comprehensive care plan, dated 06/18/24, revealed resident #20 required an indwelling catheter related to neurogenic bladder (lack of bladder control). Record review of Resident #20's current Physician Orders dated 07/11/24 revealed an order to monitor indwelling catheter for complications. In an observation on 10/15/24 at approximately 10:30 AM, Resident #20's room lacked EBP signage, and no PPE was noted at or near the entrance to the resident room. Resident #42 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #42's face sheet revealed an [AGE] year-old male with an admitted [DATE] with the following diagnoses: Thrombosis of Aorta (blood clot blocking the artery that carries blood from the heart), Chronic Obstructive Pulmonary Disease (airflow blockage and breathing-related problems), Gastroesophageal Reflux Disease (digestive condition), Hypertension (high blood pressure), Benign Prostatic Hyperplasia - BPH (enlargement of prostate gland). Record review of Resident #42's annual MDS dated [DATE] revealed a BIMS score of 06, indicating the resident had severe cognitive impairment. Section H - Bladder and Bowel, revealed Resident #42 had an indwelling catheter. Record review of Resident #42's comprehensive care plan, dated 10/09/24, revealed resident #42 required an indwelling catheter related to BPH. Record review of Resident #42's current Physician Orders dated 09/20/24 revealed an order for an indwelling catheter. In an observation on 10/15/24 at approximately 10:39 AM, Resident #42 had an indwelling urinary catheter. Resident #42's room lacked EBP signage, and no PPE was noted at or near the entrance to the resident room. In an observation on 10/16/24 at 02:52 PM, CNA A entered the room of Resident #42 without sanitizing her hands. CNA A then washed her hands and put on gloves and performed catheter and incontinent care on Resident #42. CNA A did not put on a gown prior to performing catheter care on Resident #42. 2. Resident #20 Record review of Resident #20's comprehensive care plan, dated 08/14/24, revealed resident #20 had a pressure ulcer to his coccyx (tailbone), that required a dressing, per physician's orders. Record review of Resident #20's comprehensive care plan, dated 08/14/24, revealed resident #20 had a pressure ulcer to his right heel, that required a dressing, per physician's orders. Record review of #20's current Physician Orders dated 08/26/24, revealed an order to cleanse the wound to the coccyx (tailbone), and apply wound dressing, per physician's orders. Record review of #20's current Physician Orders dated 10/14/24, revealed an order to cleanse the wound to the right heel, and apply wound dressing, per physician's orders. In an observation on 10/15/24 at approximately 10:30 AM, Resident #20's room lacked EBP signage, and no PPE was noted at or near the entrance to the resident room. Resident #45 Review of Resident #45's face sheet revealed a [AGE] year-old female with an admitted [DATE] with the following diagnoses: Open wound to right hip, Infection of right hip, Chronic Obstructive Pulmonary Disease (airflow blockage and breathing-related problems), Gastroesophageal Reflux Disease (digestive condition), Hypertension (high blood pressure), Diabetes Mellitus (disease involving abnormally high levels of glucose in the blood), and Dementia (loss of cognitive functioning) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #45's annual MDS dated [DATE] revealed a BIMS score of 13, indicating the resident was cognitively intact. Section M -Skin Conditions revealed Resident #45 had a pressure ulcer. Record review of Resident #45's comprehensive care plan, dated 10/06/24, revealed resident #45 had a right hip wound, requiring daily dressing, per physician's orders. Record review of Resident #45's current Physician Orders dated 10/15/24 revealed an order to cleanse and apply a dressing to the pressure ulcer on the right hip, per physician's orders. In an observation on 10/16/24 at 09:52 AM, Resident #45's room lacked EBP signage, and no PPE was noted at or near the entrance to the resident room. In an observation on 10/16/24 at 09:55 AM, LVN B entered the room of Resident #45 to perform wound care and failed to sanitize her hands before entering. LVN B then washed her hands and put on gloves and performed wound care to the pressure ulcer on Resident #45's right hip. LVN B did not don (put on) a gown prior to performing wound care. In an interview on 10/17/24 at 11:27 AM, LVN B stated she did not sanitize her hands prior to entering the room of Resident #45 to perform wound care. She stated she did not put on a gown prior to performing wound care on Resident #45. She stated she did not know what EBP was and did not know the requirements for EBP. She stated she had not been trained on EBP at the facility. LVN B could not state a potential negative outcome for failure to observe EBP on at-risk residents. In an interview on 10/17/24 at 11:30 AM, LVN A stated she did not know the requirements for EBP, and she had not been trained on EBP at the facility. LVN A stated she had not observed EBP on at-risk residents in the facility. LVN A stated a potential negative outcome for failure to implement EBP on at-risk residents would be infection. In an interview on 10/17/24 at 11:36 AM, CNA A stated she had not been trained on EBP at the facility. She stated she had not observed EBP on at-risk residents in the facility. She stated PPE had not been made available to her for use with residents who may have required EBP. CNA A was unable to state a potential negative outcome for failure to observe EBP on at-risk residents. In an interview on 10/17/24 at 01:38 PM with the DON, she stated she was the Infection Preventionist. She stated she was not familiar with the requirements for EBP. She stated nursing administration was made aware of the pending requirements of EBP around January 2024, but the requirement was not yet implemented. She stated nursing administration failed to follow-up and implement EBP when it later became a requirement. She stated nursing administration was responsible for monitoring infection control in the facility, which was done through reviewing infection control practices and reviewing resident's infection data, and by conducting rounds in the facility. The DON stated nursing staff had not been trained on EBP and proper PPE had not been made available to direct care staff. She stated a potential negative outcome for failure to implement EBP for at-risk residents would be the spread of infection. Record review of the facility-provided memorandum from Centers for Medicare and Medicaid with a subject of Enhanced Barrier Precautions in Nursing Homes, dated 03/20/24 revealed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Memorandum Summary . EBP recommendations now include use of EBP for residents with chronic wound or indwelling medical devices during high-contact resident care activities . GUIDANCE Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of [NAME] to staff hands and clothing. EBP are indicated for residents with any of the following: . Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a [NAME]. Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (e.g., Band-Aid) or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies . EBP should be used for any residents who meet the above criteria, wherever they reside in the facility. . For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: Dressing Bathing/showering Transferring Providing hygiene (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Changing linens Changing briefs or assisting with toileting Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator Wound care: any skin opening requiring a dressing . Facilities should ensure PPE and alcohol-based hand rub are readily accessible to staff. . Effective Date: April 1, 2024.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 41480 Based on observation, interview, and record review the facility failed to maintain an effective pest control program so that the facility was free of pests in the kitchen and dining room reviewed for physical environment, in that: The facility failed to provide an effective pest control program for flies and insects in the facility. These failures could place residents at risk for vector-borne diseases. The findings include: During an observation on 10/15/24 at 09:15 AM, during initial tour of the kitchen, a fly was seen crawling on the steam table and three flies were crawling on the refrigerator across from the steam table. During an observation on 10/15/24 at 11:15 AM, during observation of puree, a fly was seen crawling on the steam table and on floor in front of prep table. During an observation on 10/15/24 at 12:10 PM of the dining room revealed a resident was swatting flies at the table using her napkin. During an observation on 10/16/24 at 12:00 PM, observed dietary aide swatting flies off food cart while taking residents plates to dining room. Observed four flies crawling on the refrigerator across from steam table. During an observation on 10/17/24 at 10:45 AM, revealed a fly crawling on drink carts in front of steam table and four flies crawling on fridge across from the steam table. During an observation on 10/18/24 at 10:47 AM, revealed a fly crawling on the steam table and on the door beside the steam table. During an interview on 10/18/24 at 10:48 AM with the DM, she stated flies have been a problem. She stated they try to keep the kitchen doors closed. She stated she was trying to get someone to spray the kitchen. She stated [name of pest control company] was providing services every 2 -3 months, but they have not come because the bill has not been paid. She stated she did not know the last time [name of pest control company] was in the building. She stated maintenance was responsible for pest control in the kitchen and dining area. She stated she tried calling the [name of pest control company] representative, but he told her there was nothing he could do until the bill was paid. She stated she was aware of the fly issue and the kitchen staff try to keep food covered. She stated the potential negative outcome could be having to throw out food because flies carry disease and if they land on the food, they must throw it all out. She stated the residents could get sick from flies landing on the food. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/18/24 at 11:00 AM with the maintenance man, he stated they were currently working with a company to get a contract for pest control. He stated [name of pest control company] has not been to the facility since he has been there. He stated he has sprayed the building for insects a couple of times but does not remember the dates. During an interview on 10/18/24 at 11:05 AM with the maintenance supervisor, he stated they currently do not have a contract for pest control. He stated they were spraying the building inside and out. He stated [name of pest control company] was no longer coming to the facility due to lack of payment. During an interview on 10/18/24 at 01:15 PM with the BOM, she stated all bills were paid through corporate. During an interview on 10/18/24 at 01:20 PM with the ADON, she stated the currently do not have a contract with pest control. She stated she was working with a company to get a contract and maintenance was spraying facility and outside as needed until she obtained a contract with a pest control company. She stated the potential negative outcome could be flies getting on residents' food. She stated flies carry bacteria and can cause food borne illness. On 10/18/24 at 01:54 PM call placed to corporate, voice mail left. Record review of the last service report from [name of pest control company] dated 11/17/23. Record review of the facility's Pest Control policy dated revised May 2008 revealed the following: Policy Statement - Our facility shall maintain an effective pest control program. Policy Interpretation and Implementation 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents . 6. Maintenance services assist, when appropriate and necessary in providing pest control services.