STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675398	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care of Center	501 Timpson Center, TX 75935

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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 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** 46436 Based on observations, interviews, and record reviews the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 1 of 12 residents (Resident #58) reviewed for call lights. The facility failed to ensure Resident #58's call light was within reach on 5/13/2024 and 5/14/2024. This could affect residents who used their call light or desire to use the call light and place them at risk of not being able to notify staff of their needs. Findings include: Record review of a facility face sheet dated 5/13/2024 indicated Resident #58 was [AGE] years old and admitted to the facility on [DATE] with diagnosis of intervertebral disc degeneration (break down of the bones in the back). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #58 had a BIMS of 12 indicating intact cognition and required assistance with ADL's. Record review of a comprehensive care plan dated 4/24/2024 indicated Resident #58 had a history of falls and to ensure call light was within reach. During an observation on 05/13/24 at 10:31 am Resident # 58 was in the bed awake and alert and call light was hanging on a monitor attached to the wall on the other side of the room. During an observation on 05/13/24 at 2:17 pm Resident #58's call light remained hanging on the monitor on the other side of room. During an interview on 05/13/24 at 2:18 pm Resident # 58 said she used her call light to ask for help and was not sure where her light went. She said she would have to yell for help if she needed it. During an observation on 05/14/24 at 8:26 am Resident #58 was in the bed asleep and her call light was hanging across a monitor on the other side of room. (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	During an interview on 5/14/2024 at 9:50 am CNA E stated she had been a CNA for [AGE] years and at the facility 6 years. She said that all call lights should be always within reach, and it was everyone's responsibility to check with their rounds. She said the CNA's are mostly responsible because they were in the rooms the most. She said Resident #58 used her call light at times and was not aware her light was across the room. She said she had been trained on call light placement and if a resident could not reach their light they could fall or become injured. During an interview on 5/14/2024 at 2:00 pm LVN A said that all staff should check that the call light was in place each time care was provided. She said management has had in-services regarding call light placement and if a call light was not in reach a resident could not call for help or could have a fall. During an interview on 5/14/2024 at 3:05 pm the DON said she was responsible for oversight of the facility and all staff have been trained on keeping the call lights in reach. She said that she expected that every resident could reach their call light to avoid a negative outcome to the resident. During an interview on 5/14/2024 at 4:02 pm the administrator said all staff should be checking the call lights with each encounter of care. She said that staff were trained regularly on call light placement and expected every resident to have access to their call light to prevent a negative outcome. She said the facility did not have a specific policy for call light placement.

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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** 46436 Based on observation, interview, and record review, the facility failed to provide comfortable and safe temperature levels for 1 of 12 residents (Resident #1) reviewed for comfortable environment. The facility failed to prevent the temperature from being 67 F in Resident #1's room on 5/13/2024. This failure placed the residents at risk for harm by a diminished quality of life and discomfort. Findings: Record review of a facility face sheet dated 5/13/2024 indicated Resident #1 was [AGE] years old and admitted to the facility on [DATE] with diagnosis of Alzheimer's. Record review of a quarterly MDS assessment dated [DATE] indicated Resident #1 had a BIMS of 8 indicating moderate cognitive impairment and was independent with ADL's. Record review of a comprehensive care plan dated 01/30/2024 indicated Resident #1 had behaviors related to disturbed sleep and to monitor for safe environment. During an interview on 05/13/24 at 1:50 pm Resident # 1 said her room was too cold. She was upset and said they must stop turning the air down so low. She said she doesn't know what the facility has changed but when she wakes up now her room is so cold, and she did not like it that cold. During an observation and interview on 05/13/2024 at 1:58 pm the maintenance director came to Resident #1's room to check the room temperature. Thermostat on hall read 71 degrees and temperature per portable thermometer on resident side of room read 67 degrees Fahrenheit. The door was opened, and the air vent was closed. The maintenance director stated the temperature should be 71-81 degrees and they would adjust the air and monitor the temperature until the temperature was above 71 degrees Fahrenheit. He said the temperature should be maintained between those ranges for resident health. During an interview on 5/13/2024 at 2:05 pm Resident # 1 said she was going back to bed and cover up until the room warmed up. Record review of a facility temperature log dated 5/13/2024 for Resident #1's room indicated at 2:00 pm the room temperature was 69.3 degrees and then 70 degrees Fahrenheit. Every 1-hour checks completed until 3:00 pm and temperature in Resident #1's room was 74 degrees. During an observation and interview on 05/14/24 at 7:45 am Resident #1 was in her room asleep. The room temperature was comfortable and the temperature on the hall thermostat stated 72 degrees. The maintenance director increased the temperature back to 74 degrees and locked the thermostat cover. He stated the temperature should be 71-81 degrees Fahrenheit and he had placed signs on the thermostat, but staff would adjust the temperature up and down themselves. He said if a resident voiced they were hot the staff would move the temperature down without thinking about other residents being cold. He said that temperatures should be maintained per the regulation for resident comfort and safety. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/14/2024 at 9:50 am CNA E said that the temperature was controlled by management, but some staff would adjust the temperature on their own if a resident voiced being too hot or too cold. She said she was not aware that a facility had to maintain a certain temperature range but could see how that would be necessary. She said if a resident was too cold it could cause them to get sick. During an interview on 5/14/2024 at 3:45 pm the administrator said that the maintenance department was responsible for maintaining the correct temperatures in the facility, but the staff did adjust the temperature as needed for spikes and drops in temperatures. She said that she was not aware that Resident #1's room was getting too cold but would continue to monitor and place a thermometer in the room to monitor. She said that if temperature ranges were not maintained per the regulation there could be a potential for a negative resident outcome. Record review of a facility policy titled Quality of Life-Homelike Environment dated May 2017 indicated, . comfortable and safe temperatures of 71F-81F .

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46436 Based on interviews and record reviews the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 2 of 7 residents (Resident #58 and #61) reviewed for baseline care plans. The facility failed to complete a baseline care plan within 48 hours of admission on Resident # 58 and provide a care plan summary to the resident or representative. The facility failed to complete a baseline care plan within 48 hours of admission on Resident # 61 and provide a care plan summary to the resident or representative. This failure could place residents at risk of not receiving correct and/or necessary care/treatment. Findings included: 1. Record review of a facility face sheet dated 5/13/2024 indicated Resident #61 was [AGE] years old and admitted to the facility on [DATE] with diagnosis of encephalopathy (brain changes). Record review of an admission MDS assessment dated [DATE] indicated Resident #61 had a BIMS of 99 indicating Resident #61 was not able to complete the interview. Record review of a baseline care plan for Resident # 61 indicated he was admitted on [DATE] and baseline care plan was not completed until 12/27/2023. 2. Record review of a facility face sheet dated 5/13/2024 indicated Resident #58 was [AGE] years old and admitted to the facility on [DATE] with diagnosis of intervertebral disc degeneration (changes in the bones in the back). Record review of an admission MDS assessment dated [DATE] indicated Resident #58 had a BIMS of 13 indicating intact cognition and required supervision with ADL's. Record review indicated Resident # 58 admitted to the facility on [DATE] and her baseline care plan was not completed until 10/15/2023. During an interview on 05/14/24 at 2:40 pm LVN A said that when a resident was going to be admitted the RN opened the baseline care plan, the admitting nurse entered the information into the assessment, then the RN reviewed and finalized the care plan. She said a copy of the summary was given to the resident or representative by the RN once completed and the process should be completed within 48 hours of admission. She said that if the baseline care plan was not completed timely it could cause missed resident care. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/14/2024 at 2:45 pm the clinical reimbursement coordinator said that the admitting nurse was to enter the information into the baseline care plan, she then reviewed the information, and the DON finalized the care plan. She said that if a resident was admitted after hours or weekends the DON or RN supervisor was responsible for the task. She said once completed the family or resident should receive a copy of the summary and all should be done within 48 hours of admission. She said that failure to complete baseline care plans timely could cause care delays. During an interview on 5/14/2024 at 2:55 pm the DON said that baseline care plans should be done on admission by the admitting nurse, the MDS nurse should review them and then she finalized the care plan. She said the baseline should be completed within 48 hours, but she was behind. She said the weekend RN supervisor helped as well but she had been the supervisor on the weekends recently. She said once the care plan was completed the resident and family should receive a copy of the summary. She said if the baseline care plan was not completed per the regulation could be a potential for inaccurate care. During an interview on 5/14/2024 at 3:30 pm the administrator said the DON was responsible for ensuring the baseline care plan was completed and the family received a copy of the summary. She said that the baseline care plan should be completed within 48 hours of admission and if not done could lead to care delays. She said there was not a specific policy for base line care plans and the nurse was to follow the admission checklist. Record review of an undated facility admission checklist indicated, .must initiate baseline care plan and give summary to resident and resident representative.

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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** 43994 Based on observations, interviews, and record review, the facility failed to provide the necessary services to maintain personal hygiene for 1 of 6 resident reviewed for ADLs. (Resident #62) The facility failed to remove Resident #62's unwanted facial hair. This failure could place residents who required assistance from staff for ADLs at risk of not receiving care and services to meet their needs which could result in feelings of poor self-esteem, lack of dignity, and health. Findings included: Record review of an Admission Record dated 5/14/2024 for Resident #62 indicated she admitted to the facility 1/3/2024 and was [AGE] years old with diagnoses of Alzheimer's Disease (a brain disorder that causes memory loss, thinking problems and personality changes), major depressive disorder (persistent sadness or loss of interest), and hypertension (high blood pressure). Record review of a Quarterly MDS dated [DATE] for Resident #62 indicated she had severe impairment in thinking with a BIMS score of 5. She required set up or clean up assistance with personal hygiene including combing hair, shaving, applying makeup, washing/drying face and hands. Record review of a care plan dated 1/16/2024 for Resident #62 indicated she had ADL self-care performance deficits related to disease processes. For personal hygiene she required set-up assist and verbal cues of one staff with personal hygiene and oral care. During an observation and interview on 5/13/2024 at 10:05 AM, Resident #62 was sitting up on the side of her bed, alert to person with confusion noted. She was dressed and had facial hair on her chin. During an observation and interview on 5/13/2024 at 1:55 PM, Resident #62 said she had asked someone to help her shave her face. Facial hair was noted to her chin and top of lip. She said she picked at the hair and did not like it. She said they shaved it once or twice since being admitted . During an observation on 5/14/2024 at 8:06 AM, Resident #62 was sitting up on the side of her bed, dressed, facial hair on her upper lip and chin. During an observation and interview on 5/14/2024 at 3:15 PM, Resident #62 was standing up in her room by her bed and said she did not get a shower today and thought it was yesterday 5/13/24, she still had facial hair on her face. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/14/2024 at 3:20 PM, CNA H said she had been employed at the facility since October 2023 full time and worked the hall where Resident #62 resided. She said Resident #62 was able to do everything for herself, but they assisted. She said the resident had a shower this morning. She said usually on shower days the aides were required to change the linens, wash their hair if needed and if they had facial hair to remove it if they would allow it. She said she did not notice that Resident #62 had facial hair this morning because the resident washed her own face. She said she should have had the facial hair removed during her shower. She said if she had unwanted facial hair, she would not like it. Record review of tasks for Resident #62 indicated she was scheduled to receive her bath on Tuesday, Thursday, and Saturdays but it did not include to shave. During an interview on 5/15/2024 at 10:00 AM, the DON said the nurse aides were supposed to shave residents on their assigned shower days. She said she was not aware on yesterday 5/14/2024 that Resident #62 had facial hair, but it had been taken care of. She said shaving was part of the nurse aide's tasks and Resident #62 had never refused care that she was aware of. She said having facial hair would make her feel uncomfortable. She said she would in-service the nurse aides about resident care. She said they did not have a policy on ADL care. She said she expected care to be provided to all of the residents to make them comfortable and look appropriate. During an interview on 5/15/2024 at 10:20 AM, the Administrator said that nursing services were responsible for ADL care being provided to the residents. She said the nursing staff should be checking to ensure the nurse aides were doing what they were supposed to. She said nursing services should be making daily rounds to ensure residents were showered and shaved. She said having unwanted facial hair would make her feel uncomfortable. She said going forward they would monitor more closely during daily rounds that the residents had the care they needed. She said the facility did not have a policy on ADL Care.

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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** 43994 Based on observations, interviews, and record review, the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and offered a therapeutic diet when there was a nutritional problem, and the healthcare provider orders a therapeutic diet for 1 of 3 residents (#33) reviewed for weight loss and nutrition. The facility failed to provide Resident #33 with nutritional supplements as indicated by the physician orders for health shakes. These failures could place residents at risk for unplanned weight loss, malnutrition, and failure to thrive. The findings included: Record review of an Admission Record dated 5/14/2024 for Resident #33 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of acute chronic respiratory failure with hypoxia (not enough oxygen in the blood that causes breathing problems), hypertension (high blood pressure), type 2 diabetes, and COPD (lung disease that causes obstructed airflow from the lungs). Record review of active physician orders for Resident #33 dated 5/13/2024 indicated an order for dietary supplements for a house shake with meals for weight loss for poor oral intake for 90 days with a start date of 3/11/2024. Record review of a Quarterly MDS assessment dated [DATE] for Resident #33 indicated she had moderate impairment in thinking with a BIMS score of 11. She required set up or clean up assistance with eating. She had a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months and was not on a physician-prescribe weight-loss regimen. Record review of a care plan revised on 3/11/2024 for Resident #33 indicated she may have nutritional deficits with weight loss related to diagnoses, meds, diet, and appetite. Interventions included add one house shake BID x60 days related to weight loss. 3/11/2024-increase to TID x90 days. Record review of a progress note dated 3/21/2024 by the RD indicated, Resident #33 has unstageable pressure injury to right heel measuring that resolved on 3/15/24 weekly wound assessment. Weight 106.2# with BMI 20.1 WNL for height. Medication reviewed; furosemide (fluid medication) ordered. Diet: Carb Controlled, Regular texture, Regular consistency with majority of PO intake 51-100% of meals. Supplements: House shake BID and Active Liquid Protein 30 ml BID. GOAL: Provide adequate nutrition for weight maintenance, promote wound healing, and prevent dehydration. Intervention: Continue diet and Active Liquid Protein as ordered. Change House shakes from BID to TID x 90 days. Encourage fluids to prevent dehydration: 6-7 cups fluid daily. Monitor weight, skin, and PO intake. Record review of a Nutrition Recommendation to Physician by the RD dated 3/8/2024 indicated an order to change house shake from bid to TID x90 days related to weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Nutrition Recommendation to Physician by the RD dated 2/9/2024 indicated an order to add one house shake bid x60 days related to weight loss. Record review of weight logs for Resident #33 revealed: 5/9/2024 11:53 107.0 Lbs Standing 4/5/2024 19:07 106.0 Lbs Wheelchair 3/11/2024 09:42 106.2 Lbs Wheelchair 3/8/2024 16:35 104.5 Lbs Wheelchair 2/8/2024 15:16 110.0 Lbs Mechanical Lift 1/28/2024 14:53 110.0 Lbs Standing 1/25/2024 17:27 116.0 Lbs Standing 1/15/2024 15:01 118.5 Lbs Wheelchair 1/8/2024 18:57 118.5 Lbs Wheelchair 1/5/2024 19:49 118.5 Lbs Wheelchair During an observation on 5/13/2024 at 12:10 PM, Resident #33 was eating in the dining room and her tray card read house shake x90 days ending 6/9/2024: house shake at breakfast, lunch, and dinner. There was not a health shake on her tray. During an observation and interview on 5/13/2024 at 1:51 PM, Resident #33 was in her room sitting in a wheelchair and said she did not get a health shake at lunch today and had only been getting them at breakfast and supper. Record review of Dietary Sticker Sheet for Residents that were to receive shakes undated indicated Resident #33 was listed for AM and Supper. There was not a sticker for lunch. During an interview on 5/14/2024 at 3:20 PM, CNA H said she had been employed at the facility since October 2023 fulltime and worked the hall where Resident #33 resided. She said Resident #33 was supposed to get health shakes twice a day with meals. She said sometimes the health shakes were not on the trays and would have to go to the kitchen to get one. She said Resident #33 usually ate in her room and this morning she had a health shake on her morning and lunch tray. She said on yesterday 5/13/2024 she was not aware that the resident did not get a health shake at lunch in the dining room. She said it depended on who was working in the dining room to ensure the residents received them with their meals. She said the dietary staff do not usually put them on the trays and the staff had to get health shakes for the residents. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/2024 at 9:28 AM, Dietary Aide said she worked at the facility for over a year part time. She said she helped set up trays for meals and placed health shakes on the trays. She said Resident #33 received a health shake for breakfast and lunch but was not sure about supper and was on the list of residents who were to receive health shakes. She said she did not work on Monday 5/13/2024. She said some residents were given health shakes if they did not eat. She said she did not know what could happen if a resident did not get their shake. During an interview on 5/15/2024 at 9:35 AM, the DM said Resident #33 was supposed to get a health shake three times a day. She said the RD sends a copy of the recommendations and when she received the communication form from the DON, she would make changes to the orders in the dietary system. She said she was told not to change anything with the orders until a communication form was received from the DON. She said residents could be at risk for weight loss if they did not get their ordered supplements such as health shakes. She said the Dietary aides were responsible for putting the shakes on the trays. She said on 5/13/2024, Resident #33 was just missed at lunch. She said she had a system in place already that included stickers to help the dietary staff visualize who needed health shakes. During an interview on 5/15/2024 at 10:00 AM, the DON said the RD visited the facility monthly and saw people based on risk factors. She said the RD reviewed the report twice a month and would send recommendations to her. She said Resident #33 triggered for a 10.5% weight loss in April 2024 and an order was given to put her on health shakes. She said her weight has stabilized now and the health shakes have been increased to TID and before it was BID. She said the dietary staff were responsible for placing the health shakes on the meal trays and the nurses were supposed to check the diet orders and tray cards to ensure the residents were getting what was ordered. She said there was a risk for weight loss. Going forward she would talk to the DM and have her pull the order from the computer to ensure it matched the tray cards along with in-service nursing staff to make sure they are looking for the shakes. During an interview on 5/15/2024 at 10:20 AM, the Administrator said the dietician sent recommendations to the DON and the DM. She said then the DON talked to the physician and received approval for the order, would put the order in the system and would write a communication form for dietary to let them know and then the DM would then enter the orders in the dietary system She said she was not aware that Resident #33 was not receiving her ordered health shakes. She said going forward she would retrain nursing to read the tray cards and retrain dietary staff. She said there was a risk of not getting the nutritional value the residents needed if they did not receive their supplements. She said the facility did not have a policy on dietary orders or recommendations.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 43994 Based on interview and record review the facility failed to review the work of each Certified Nurse Assistant (CNA) at least once every 12 months, for 1 of 6 (CNA G) reviewed for annual competency evaluations. The facility failed to complete a performance review of CNA G and conduct inservices based on the results of the review. This deficient practice could affect residents and place them at risk of not receiving consistent, appropriate interventions necessary to meet the residents' needs. Findings included: Record review of a personnel file review for CNA G indicated she was hired at the facility on 1/17/2023, with no evidence of a competency evaluation in the past 12 months. Last evaluation was on 1/17/2023. During an interview on 5/15/2024 at 9:50 AM, the ADON said she was responsible for conducting the competency evaluations for staff in the facility. She said skill check offs were conducted annually in December. She said CNA G was not conducted at that time because the facility had an outbreak of COVID in November 2023 and some did not get theirs done. She said there could a risk for cross contamination, infections, safety issues, falls and injuries if staff did not have a competency evaluation. During an interview on 5/15/2024 at 10:00 AM, the DON said the ADON was responsible for conducting the competency evaluations yearly. She said the facility had not completed the nurse aide evaluations this year. She said they had a set month to do competency evaluations and would try to keep the same month yearly. She said she had not seen any increased infections or any negative outcomes from not having them completed. She said they had QAPI and if they noticed any increased risk areas, they would take it to them. She said there was always a potential risk for infections and cross contamination. During an interview on 5/15/2024 at 10:20 AM, the Administrator said nursing was responsible for ensuring staff received their competency evaluations. She said they were to be done on hire and yearly thereafter. She said she was made aware of CNA G not having an annual evaluation done. She said CNA G changed from a part time position to prn and the facility had a COVID outbreak in November 2023 and the ADON had to shift focus and did not get a change to get hers done. She said there was a risk of staff not remembering the proper way to perform tasks if they did not have a competency evaluation. She said the facility did not have a policy on competency evaluations.

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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 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. 40124 Based on interviews and record review the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and follow a policy to provide pharmacy services in accordance with State and Federal laws or rules of the Drug Enforcement Administration for 2 of 12 months (January 2024 and February 2024) reviewed for pharmacy services. The facility failed to document the required number of witness signatures for the drug destruction on 01/10/2024 and 02/06/2024. This failure could put residents at risk for misappropriation and drug diversion. Findings include: Record review of facility drug destruction records for the last 12 months revealed that on 01/10/2024 and 02/06/2024, the cover page was only signed by one witness and the consultant pharmacist (Drug destruction cover sheet was not signed by two witnesses as required by regulation). During an interview 05/14/24 2:06 at pm the ADON said that she usually witnesses the drug destruction as the second witness when the pharmacist performs a destruction at the facility. She said the Pharmacist and DON usually complete the destruction and she will witness if needed. She said she did not witness the January and February destruction because the second witness line was blank. During an interview on 05/15/24 at 9:00 am the Administrator said the DON is responsible for ensuring compliance with drug destruction and obtaining two witnesses' signature during the destruction process. The Administrator said there was a risk of a drug diversion of procedures were not followed as required per regulation. During a phone interview on 05/15/24 at 10:00 am the consultant pharmacist said drug destruction should always be witnessed by herself and two other witnesses. She said the ADON usually assists her with destruction. She said not following regulation increased the risk of drug diversion. During an interview on 05/15/24 at 11:00 am the DON said she is responsible for ensuring compliance with drug destruction and obtaining two witnesses' signature during the destruction process. The DON said there was a risk of a drug diversion of procedures were not followed as required per regulation. Record Review of a PHARMSCRIPT policy, Controlled Substance Disposal Policy# 5.1 Effective Date I 09-2018 Revision Date(s) I 08-2020 Medications classified as controlled substances by the Drug Enforcement Administration (DEA) are subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with federal and state laws and regulations. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procedures 8. The Director of Nursing, in collaboration with the consultant pharmacist, is responsible for the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized, licensed nursing and pharmacy personnel have access to controlled medications. 2. When a dose of a controlled substance is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It is destroyed in the presence of two licensed nursing personnel, and/or in accordance with facility policy and state regulations, and the disposal is documented on the accountability record on the line representing that dose. The same process applies to the disposal of unused partial tablets and unused portions of single-dose ampules and doses of controlled substances wasted for any reason. 3. All controlled substances remaining in the facility after a resident has been discharged or an order discontinued are disposed of: a. In the facility by the Director of Nursing and consultant pharmacist (or other licensed personnel as permitted by state regulations), or b. By returning to the Drug Enforcement Administration (DEA), or c. By retaining for destruction by an agent of the DEA, or d. By sending to the appropriate state agency, as directed by state laws, regulations, and/or by the DEA. 4. Disposition is documented on the facility's Drug Destruction log or similar form. For emergency kit controlled substances disposal, the bottom portion of the accountability record is completed. Controlled drugs given via intravenous/infusion therapy may be accounted for on a separate type of controlled drug record, and disposition of any remaining drug is documented on that form. Empty containers and tubing used in administration of controlled drugs via intravenous/infusion therapy are disposed of in the same manner as containers and tubing for any other intravenous/infusion drug. See facility policies and procedures for intravenous/infusion therapy. 5. The licensed nurse(s) and pharmacist witnessing the destruction ensure that at a minimum, the following information is entered on the facility's Drug Destruction log or similar form. a. Date of destruction b. Resident's name c. Name and strength of medication d. Prescript ion number e. Amount of medication destroyed (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. Signature of witnesses . 6. Accountability records for controlled substances that are disposed of or destroyed are maintained with the unused supply until it is destroyed or disposed of and then stored for two years or per applicable law and regulation. 7. A controlled substance may be returned to the provider pharmacy only if it is refused at the time of delivery. 8. Unless otherwise directed in a facility policy, when a fentanyl patch is removed from a resident the patch is folded in half with the adhesive attaching to the adhesive and the patch is placed in inert material such as cat litter to render the mixture unusable in the presence of 2 licensed personnel. The disposal is documented per facility policy.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40124 Based on observations, interviews, and record review the facility failed to ensure drugs and biologicals used in the facility were labeled and stored in accordance with currently accepted professional principles and the expiration date when applicable for 2 of 4 medication carts (500 hallway medication cart and 600 hallway medication cart) were reviewed for labeling and storage. The facility failed to properly label 3 vials of glucometer strips with an opened date. The facility failed to discard expired high and low glucose check solutions. This failure could place residents who receive medications at risk for receiving outdated medications and could result in residents not receiving the intended therapeutic effects of their medications and health decline. Findings included: During an observation and interview on [DATE] at 08:00 am of the Medication cart for 500-hallway, glucometer strips, 3 vials are open with no date opened. Expiration date [DATE]. Interview with LVN A said the nurses have received training to date the glucometer strips when opened they are to perform a high and a low check when they open a new package of strips and document in the glucometer logbook at the nurses' station. She said the resident's glucose reading per glucometer could not be accurate if the test strips were not used by the recommended use by date after opening. LVN A was not sure how long the strips were good after opening. During an interview on [DATE] at 1:53 PM the ADON said the facility recently started a new process for the glucose strips on the electronic medication administration record when the resident requires a new vial of strips, they are opened, a quality control check of high and low solutions which expire 90 after opening, is performed by the opening nurse and documented. The ADON said the opening nurse is responsible for labeling the new vial with the date opened. The ADON said all licensed staff had received training on the new process by herself and the DON. She said that not labeling the glucose strips with an open date could cause the strips to be used beyond the use date intended by the manufacturer. During an interview and observation on [DATE] 07:50 AM of the 600-hallway medication cart, G2 glucose control solutions high and low labeled with date opened [DATE]. LVN B, she said she had worked at the facility for 2 years. She said that the facility had recently implemented a new process for checking the glucometers with high and low solutions and did not use a central log anymore. She said the controls are to be checked when a new vial of strips was opened and recorded on the electronic medication administration record. She said she did not know how long the solutions were good for once opened. LVN B said she had not received training on how long the glucose high and low solutions were good, she thought 30 days. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on [DATE] at 08:00 AM of the 200-hallway medication cart there were no glucose hi and low solutions on the cart. LVN C said he had only worked at the facility for 2 days. LVN C said that all test strips should be dated when opened. He said he had not received any training on testing the glucometer with high and low solutions when new vials were opened. He said he did not know how long strips or control solutions were to be used before discarding. LVN C said using expired solutions or test strips could result in inaccurate glucose testing results. During an interview on [DATE] 09:00 AM the Administrator said the DON is responsible for training nursing staff and ensuring compliance with glucometer checks including discarding expired solutions and dating of opened test solutions. The Administrator said that using expired solutions or test strips could result in inaccurate glucose testing results. During an interview on [DATE] at 2:00PM the DON said she is responsible for training nursing staff and ensuring compliance with glucometer checks including expired solutions and dating of opened test solutions. The DON said that using expired solutions or test strips could result in inaccurate glucose testing results. Record review of a package insert of glucose control solutions indicated discard any unused control solution 90 days after first opening or after the expiration date. Record review of a package insert for glucose strips indicated the strips are good for 6 months after opening or the expiration date. Record review of an undated facility competency checklist for Glucometer checks indicated: Ensure date/time is set accurately on meter. If opening a new bottle of test strips, record 'opened date' on outside of bottle. Test strips should be discarded 6 months after date of opening according to manufactures guidelines. Record review of an undated glucometer controls out of range guide: Check that solution has not expired. Recheck solution. Use another glucometer-replace.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46436 Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions in 1 of 1 kitchen observed for kitchen sanitation. The kitchen floor, walls, and handles of the refrigerator had buildup of a sticky substance on [DATE]. There was a fan in use in the kitchen with dark thick substance on the fan blades and fan cover on [DATE]. The drink dispenser located in the kitchen had undated boxes of concentrate liquid and the orange liquid concentrate was on the floor and connected to the machine on [DATE]. The coffee dispenser had undated boxes of coffee concentrate connected to the machine and the machine had dried dark brown substance on the inside on [DATE]. The kitchen refrigerator stored unlabeled and expired objects on [DATE]. These deficient practices could place residents who ate food from the kitchen at risk for foodborne illness. Findings include: During an observation on [DATE] at 9:03 am the kitchen had buildup on the floors, walls, and handles of refrigerator of a dark sticky substance. There was a fan present in the prep area with dark thick buildup on blades and outside cover. The drink dispenser in the kitchen had 3 concentrated juices attached. The 3 containers were undated and the bag with an orange liquid concentrate was laying on the floor. The coffee dispenser in the dining room had 2 boxes of coffee concentrate and neither were dated and inside of the machine had a dark brown dried liquid substance on the inside. The refrigerator had 2 containers of cottage cheese container with best by date of [DATE], cranberry sauce in a reusable container dated to use by [DATE], an unlabeled meat link in a plastic bag, a bottle of red sauce dated as opened [DATE] and the directions read to use within 5 days of opening, an unlabeled yellow thick substance in a reusable container, and an unlabeled green pea substance in a reusable container. During an observation on [DATE] at 9:20 am of a coffee dispenser located in the dining room had a cleaning schedule located on the inside of the door that indicated a daily rinsing schedule and a weekly sanitizing schedule per manufacturer recommendations. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 9:26 am Cook F said that everyone was responsible for checking the refrigerator daily for unlabeled and expired items. She said that items should be labeled and dated and disposed of within 3 days or per the label or directions. She said she was not sure on the drink dispensers and if the boxes needed to be dated or not and was not aware of a cleaning schedule for the dispensers or the kitchen. She said she cleaned as she cooked. She said she had been trained on properly storing items and did the best she could, but other workers had to do their part when they were working. She said that an unsanitary kitchen and improper storage of foods could cause illness. During an interview on [DATE] at 9:40 am the DM said she was responsible for all duties in the kitchen and dining room and the kitchen staff should be cleaning daily, labeling, and storing food appropriately and all items should be dated. She said the staff had been trained on maintaining the kitchen in a sanitary condition. She said there was a cleaning schedule and the staff had been signing off that cleaning had been done. She said the drink dispensers were wiped down but the company that provided them were to deep clean them. She said she was not aware of the manufacturer weekly cleaning schedule listed inside the drink dispensers but would check into it. She said that by not maintaining kitchen sanitation it could lead to contamination and illness. During an interview on [DATE] at 4:00 pm the administrator said the dietary manager was responsible for oversight of the kitchen and she expected the kitchen to be cleaned and items stored in a sanitary manner. She said the staff had been trained on proper cleaning of the kitchen and how to label and store foods but would oversee more training was done. She said that an unsanitary kitchen could lead to illness and expected the kitchen to be maintained in a sanitary condition. Record review of a monthly kitchen cleaning schedule log indicated full cleaning performed in [DATE], February 2024, [DATE], and [DATE]. Record review of an in-service training dated [DATE] titled Dating and Labeling and cleaning indicated staff had been trained. Record review of an in-service training dated [DATE] titled deep cleaning kitchen and dating and labeling indicated staff had been trained. Record review of a facility policy titled Food Storage dated [DATE] indicated' .4. foods are stored at least 6 inches off the floor, 6. food removed from its original packaging will be labeled .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 46436 Based on observations, interviews, and record reviews the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 4 residents (Resident #29 and Resident #39) and 2 of 5 staff (CNA D and CNA H) reviewed for infection control. CNA D did not change gloves and sanitize/wash hands when providing incontinent care to Resident #29 on 5/13/2024. CNA H did not sanitize or wash her hands after changing gloves when providing incontinent care to Resident #39 on 5/14/2024. These failures could place residents at risk of exposure to communicable diseases and infections. Findings include: 1.Record review of a facility face sheet dated 5/13/2024 indicated Resident #29 was [AGE] years old and admitted to the facility on [DATE] with diagnosis of cerebral infarction (lack of blood to the brain). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #29 had a BIMS of 4 indicating severe cognitive impairment and was always incontinent of bowel and bladder and required maximum assistance with toileting. Record review of a comprehensive care plan dated 3/22/2024 indicated Resident #29 had ADL self-performance deficit and required extensive assistance with toileting. During an observation on 05/13/24 at 10:05 AM Resident # 29 was receiving care from CNA D. CNA D had gloves on, Resident #29's brief was opened and pulled down forward, CNA D wiped front to back with stool present. Resident #29 turned self on right side, CNA D wiped stool from buttocks using wipes. CNA D placed soiled brief in a bag, and wiped buttocks until clean. She placed soiled wipes in bag. Without changing gloves and performing hand hygiene, CNA D applied barrier clean to buttocks and placed clean brief under Resident #29. Resident #29 rolled back over, and CNA D continued to apply skin barrier to front peri-area and pulled clean brief into place. Wearing same soiled gloves, CNA D placed pillow under Resident #29's right arm and adjusted linen on bed. CNA D then removed gloves and washed her hands before leaving room. During an interview on 05/13/24 at 10:15 AM CNA D said she had been a CNA for [AGE] years. She said she had received training on incontinent care recently and was checked off. She said she was nervous and should have changed her gloves from dirty to clean to prevent infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a competency evaluation for hand hygiene indicated CNA D was last evaluated for competency on 11/12/2023. 2. Record review of an Admission Record for Resident #39 dated 5/14/2024 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnosis of major depressive disorder (persistent sadness or loss of interest), diastolic heart failure (condition in the heart that causes the heart to become stiff and unable to fill properly) , morbid obesity (overweight), and hypertension (high blood pressure). Record review of a Quarterly MDS Assessment for Resident #39 dated 2/15/2024 indicated she did not have any impairment in thinking with a BIMS score of 14. She required substantial/maximal assistance with toileting. She was always incontinent of bladder and bowel. Record review of a care plan for Resident #39 revised on 9/30/2023 indicated she was incontinent of bladder and bowel with interventions to monitor for incontinence every 2 hr/prn, change promptly. During an observation on 5/14/2024 at 11:05 AM in the room of Resident #39, CNA H was present to provide incontinent care. She removed gloves from her scrub top pocket and placed them on her hands without washing or sanitizing them. She opened the brief of Resident #39 and pulled it down between the resident's thighs. She removed wipes and wiped the resident's lower abdomen and then wiped down the left inner thigh and placed the wipe in the trash. She removed a wipe and wiped down the right inner thigh and placed it in the trash. She removed a wipe and wiped down the middle of peri area from front to back. She rolled the resident onto her left side and removed her gloves and placed them in the trash. She removed gloves from her pocket and placed them on her hands without washing or sanitizing them. She removed wipes and wiped the resident's rectal area from front to back. She rolled the brief underneath the resident's buttocks. She opened a clean brief and placed it underneath the dirty brief and removed the dirty brief. She rolled the residents onto her back and secured the brief. She removed her gloves and placed them in the trash. She went to the resident's closet and picked out a dress for the resident to wear. She said she had to leave the room to get the mechanical lift to transfer the resident from the bed to her wheelchair and did not wash or sanitize her hands. During an interview on 5/14/2024 at 3:20 PM, CNA H said she had been employed at the facility since October 2023 and was full time and worked the hall where Resident #39 resided. She said during the incontinent care provided to Resident #39, she did not wash her hands before care was started, during or after the care provided. She said when she thought about sanitizing her hands it was too late. She said she did not have her sanitizer in her pocket like normal because she was wearing a different jacket. She said her gloves should have been in a plastic bag and not stored in her pocket. She said she recently had a skills check off by the ADON last month April 2024. She said residents could be at risk for infections if staff did not wash or sanitize their hands when providing care. Record review of a Hand Hygiene Competency Check Off Audit Form dated May 2024 conducted by the ADON indicated CNA H was checked on 5/2/2024 for hand hygiene and passed. Record review of a competency skills evaluation for CNA H dated 12/10/2023 indicated she was satisfactory with providing incontinent to a female resident that included hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/14/24 at 1:37 PM the DON said that CNA D had been trained on proper hygiene and had been a CNA for many years. She said she expected all staff to follow proper hand hygiene when providing care. She stated the risk of improper incontinent care could lead to infections and negative resident outcomes. During an interview on 5/14/2024 at 3:33 pm the administrator said that nurse management was responsible for oversight of resident care like incontinent care and hand hygiene. She said CNA D had been a CNA for many years and expected all staff to follow proper hand hygiene and incontinent care. She said that the CNA not performing correct peri care and hand hygiene could cause cross contamination. During an interview on 5/15/2024 at 9:50 AM, the ADON said she was the IP and responsible for training staff on hand hygiene. She said she conducted quarterly check offs with staff on hand hygiene. She said CNA H was present on 5/2/2024 when she had a training on hand hygiene. She said staff should perform hand hygiene before starting care, between care, and before exiting the room. She said residents could be at risk of cross contamination and infections if they did not wash or sanitize their hands. During an interview on 5/15/2024 at 10:00 AM, the DON said staff should wash or sanitize their hands before starting care, when going from dirty to clean, and before leaving the room. She said the ADON was responsible for training staff on hand hygiene, and it was done quarterly. She said going forward, they would continue training staff on hand hygiene with check offs. She said there was a risk of cross contamination and infections if staff did not wash or sanitize their hands. During an interview on 5/15/2024 10:20 AM, the Administrator said hand hygiene should be done before care was started, when changing gloves, between dirty to clean procedures, at the end of care, and any time hands were visibly soiled. She said the ADON was the IP and had been doing hand hygiene competencies quarterly and as needed. She said residents could be at risk for infections if staff did not perform hand hygiene. Record review of a facility policy titled Perineal Care dated 10/01/21 indicated, .to prevent infections and skin irritation;11. remove gloves and discard, wash hands, 12. reposition bed covers . Record review of a facility policy titled Hand Hygiene dated 8/4/21 indicated, .Hand hygiene is used to prevent the spread of pathogens in healthcare settings. 1. You should always perform hand hygiene: before applying and after removing personal protective equipment (e.g., gloves), before and after providing any type of care; 2. You must perform hand hygiene (handwashing or the use of an ABHR) after contact with bodily fluids, such as urine .

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on interview and record review, the facility failed to develop, implement, and maintain an effective training program for 5 of 14 employees (Administrator, Director of Resident Support Service, Director of Life Enrichment, DM, and CNA J) reviewed for training. The facility failed to ensure the Administrator was trained on restraint reduction annually. The facility failed to ensure the Director of Resident Support Service was trained on restraint reduction annually. The facility failed to ensure the Director of Life Enrichment was trained on restraint reduction annually. The facility failed to ensure the DM was trained on fall prevention and restraint reduction annually. The facility failed to ensure CNA J was trained on fall prevention annually. These failures could place residents at risk of not receiving care to attain or maintain their highest practicable physical, mental, and psychosocial well-being due to lack of staff training. Findings include: Record review of a facility assessment dated [DATE] and reviewed on 3/11/2024 indicated Training: Upon initial new hire (all staff) receive training on Resident Rights, Abuse policy, Blood borne pathogens, Infection Control. Competencies should be completed annually. Regular training in services are used to complete new hire orientation and annually (HIV, Abuse, Falls, Dementia, Restrain Free environment, Ethics). Required in-service training for CNA and CMA: Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year. Record review of the personnel file for the Administrator indicated she hired at the facility on 6/21/2022 and did not have an annual training on restraints. Record review of the personnel file for the Director of Support Service indicated she hired at the facility on 11/3/2022 and did not have an annual training on restraints. Record review of the personnel file for the Director of Life Enrichment indicated she hired at the facility on 7/26/2021 and did not have an annual training on restraints. Record review of the personnel file for the DM indicated she hired at the facility on 10/13/2022 and did not have an annual training on fall prevention and restraints. Record review of the personnel file for CNA J indicated she hired at the facility on 10/4/2022 and did not have an annual training on fall prevention. (continued on next page)

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	675398	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care of Center	501 Timpson Center, TX 75935

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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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/14/2024 at 11:30 AM, the BOM said the facility did not have a person in house that was designated for HR duties. She said corporate was responsible for all of the required trainings for new and existing staff. She said she was responsible for completing the orientation of new hires. During an interview on 5/14/2024 at 2:34 PM, the HR Business Partner said the facility was fairly new to her and she acquired it at the end of January 2024. She said on hire the required trainings should be done at orientation in the facility. She said some of the facilities used the monthly electronic version and others still used paper documentation for the trainings. She said when trainings were sent out to the facilities, they were sent via email by the Director of Clinical Education. She said then the facility should be completing them accordingly. She said if someone was not present at the time of the monthly in-service training, when that staff returned to work, they should follow-up to ensure they received the training. She said the trainings for on hire included: Abuse, Dementia Care, HIPAA, Human Immunodeficiency Virus (HIV), Texas House [NAME] 300, Restraints, and Slips, Trips, and Falls. During an interview on 5/15/2024 at 8:36 AM, the Director of Clinical Education said she was responsible for the trainings for staff on hire and annually. She said the facility had a centralized onboarding with new hires with corporate. She said the on boarding started with corporate and new hires received training on Abuse, Dementia Care, HIPAA, Human Immunodeficiency Virus (HIV), Texas House [NAME] 300, Restraints, and Slips, Trips, and Falls on hire and annually. She said the facility was in the process of ensuring the orientation and on boarding with staff included the additional education on trainings that included behavioral health, compliance and ethics and QAPI. She said every month she sent the facilities a different topic for training and included who the training should be given to. She said if staff were not present at the time of the trainings, then education should be provided to that staff member when they returned to work. She said the facilities could provide training as much as they needed to. She said if staff did not receive the required training, they could potentially have a knowledge deficit. She said the facility did not have a policy on trainings for staff. She said there was an oversight issue with the email on the restraint training that was sent out to the facility because it did not include all staff to be trained and only said for nursing staff. Record review of an email dated June 2, 2023, by the Director of Clinical Education indicated a monthly education for June 2023 to include training on restraint for all nursing staff. All nursing staff includes any nurse, medication aide, certified nurse aide, restorative aide, and uncertified aide. During an interview on 5/15/2024 at 10:00 AM the DON said she was responsible for the trainings that was sent by the Director of Education. She said the Director of Education sent the facility a monthly list of trainings and it told them who gets what and they scheduled the training with staff. She said they just went by the list that was sent and the Director of Education was responsible for ensuring the facility received the required trainings. She said going forward they would ensure the staff received any missing trainings. She said there was a risk of staff not knowing how to do their jobs. She said all of the state required trainings came from corporate. (continued on next page)

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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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/15/2024 at 10:20 AM, the Administrator said the trainings were split between the DON and herself. She said she received an email monthly for what trainings were needed. She said corporate would send the trainings and it would indicate who needed the training. She said they have always just gone by what corporate sent to them. She said she thought that the trainings that were sent out to the facilities were being done correctly. She said there was a risk of staff not knowing how to handle situations if they did not receive training. She said the facility did not have a policy on the required trainings.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on interview and record review, the facility failed to provide the mandatory training on standards, policies, and procedures for an infection prevention and control program for 1 of 14 staff (CNA J) reviewed for training. The facility failed to ensure infection prevention and control training was provided CNA J on hire. This failure could place residents at risk of the spread of illness due to lack of staff training. The findings were: Record review of the personnel file for CNA J indicated she hired at the facility on 3/5/2024 and did not have training on infection control on hire. During an interview on 5/14/2024 at 11:30 AM, the BOM said the facility did not have a person in house that was designated for HR duties. She said corporate was responsible for all of the required trainings for new and existing staff. She said she was responsible for completing the orientation of new hires. During an interview on 5/14/2024 at 2:34 PM, the HR Business Partner said the facility was fairly new to her and she acquired it at the end of January 2024. She said on hire the required trainings should be done at orientation in the facility. She said some of the facilities used the monthly electronic version and others still used paper documentation for the trainings. She said when trainings were sent out to the facilities, they were sent via email by the Director of Clinical Education. She said then the facility should be completing them accordingly. She said if someone was not present at the time of the monthly in-service training, when that staff returned to work, they should follow-up to ensure they received the training. During an interview on 5/15/2024 at 8:36 AM, the Director of Clinical Education said she was responsible for the trainings for staff on hire and annually. She said the facility had a centralized onboarding of new hires with corporate. She said the on boarding started with corporate and new hires received training on Abuse, Dementia Care, HIPAA, Human Immunodeficiency Virus (HIV), Texas House [NAME] 300, Restraints, and Slips, Trips, and Falls on hire and annually. She said the facility was in the process of ensuring the orientation and on boarding with staff included the additional education on trainings that included behavioral health, infection control, compliance and ethics and QAPI. She said every month she sent the facilities a different topic for training and included who the training should be given to. She said if staff were not present at the time of the trainings, then education should be provided to that staff member when they returned to work. She said the facilities could provide training as much as they needed to. She said if staff did not receive the required training, they could potentially have a knowledge deficit. She said the facility did not have a policy on trainings for staff. (continued on next page)

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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 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/2024 at 10:00 AM the DON said she was responsible for the trainings that was sent by the Director of Education. She said the Director of Education sent the facility a monthly list of trainings and it told them who gets what and they scheduled the training with staff. She said they just went by the list that was sent and the Director of Education was responsible for ensuring the facility received the required trainings. She said going forward they would ensure the staff received any missing trainings. She said there was a risk of staff not knowing how to do their jobs. She said all of the state required trainings came from corporate. During an interview on 5/15/2024 at 10:20 AM, the Administrator said the trainings were split between the DON and herself. She said she received an email monthly for what trainings were needed. She said corporate would send the trainings and it would indicate who needed the training. She said they have always just gone by what corporate sent to them. She said she thought that the trainings that were sent out to the facilities were being done correctly. She said there was a risk of staff not knowing how to handle situations if they did not receive training. She said the facility did not have a policy on the required trainings. Record review of a facility assessment dated [DATE] reviewed on 3/11/2024 indicated Training: Upon initial new hire (all staff) receive training on Resident Rights, Abuse policy, Blood borne pathogens, Infection Control. Competencies should be completed annually. Regular training in services are used to complete new hire orientation and annually (HIV, Abuse, Falls, Dementia, Restrain Free environment, Ethics). Required in-service training for CNA and CMA: Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year. Record review of a facility policy titled Infection Control revised 10/25/22 indicated, .This communities' infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. 5. All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter .

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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 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. 43994 Based on interview and record review, the facility failed to provide the required compliance and ethics training for 1 of 14 employees (CNA J) reviewed for training. The facility failed to ensure compliance and ethics training was provided to CNA J. This failure could affect residents and place them at risk of staff not being aware of facility standards/policies due to lack of staff training. Findings included: Record review of the personnel file for CNA J indicated she hired at the facility on 3/5/2024 and did not have training on compliance and ethics training. During an interview on 5/14/2024 at 11:30 AM, the BOM said the facility did not have a person in house that was designated for HR duties. She said corporate was responsible for all of the required trainings for new and existing staff. She said she was responsible for completing the orientation of new hires. During an interview on 5/14/2024 at 2:34 PM, the HR Business Partner said the facility was fairly new to her and she acquired it at the end of January 2024. She said on hire the required trainings should be done at orientation in the facility. She said some of the facilities used the monthly electronic version and others still used paper documentation for the trainings. She said when trainings were sent out to the facilities, they were sent via email by the Director of Clinical Education. She said then the facility should be completing them accordingly. She said if someone was not present at the time of the monthly in-service training, when that staff returned to work, they should follow-up to ensure they received the training. She said the trainings for on hire included: Abuse, Dementia Care, HIPAA, Human Immunodeficiency Virus (HIV), Texas House [NAME] 300, Restraints, and Slips, Trips, and Falls. During an interview on 5/15/2024 at 8:36 AM, the Director of Clinical Education said she was responsible for the trainings for staff on hire and annually. She said the facility had a centralized onboarding with new hires with corporate. She said the on boarding started with corporate and new hires received training on Abuse, Dementia Care, HIPAA, Human Immunodeficiency Virus (HIV), Texas House [NAME] 300, Restraints, and Slips, Trips, and Falls on hire and annually. She said the facility was in the process of ensuring the orientation and on boarding with staff included the additional education on trainings that included behavioral health, compliance and ethics and QAPI. She said every month she sent the facilities a different topic for training and included who the training should be given to. She said if staff were not present at the time of the trainings, then education should be provided to that staff member when they returned to work. She said the facilities could provide training as much as they needed to. She said if staff did not receive the required training, they could potentially have a knowledge deficit. She said the facility did not have a policy on trainings for staff. (continued on next page)

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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 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/2024 at 10:00 AM the DON said she was responsible for the trainings that was sent by the Director of Education. She said the Director of Education sent the facility a monthly list of trainings and it told them who gets what and they scheduled the training with staff. She said they just went by the list that was sent and the Director of Education was responsible for ensuring the facility received the required trainings. She said going forward they would ensure the staff received any missing trainings. She said there was a risk of staff not knowing how to do their jobs. She said all of the state required trainings came from corporate. During an interview on 5/15/2024 at 10:20 AM, the Administrator said the trainings were split between the DON and herself. She said she received an email monthly for what trainings were needed. She said corporate would send the trainings and it would indicate who needed the training. She said they have always just gone by what corporate sent to them. She said she thought that the trainings that were sent out to the facilities were being done correctly. She said there was a risk of staff not knowing how to handle situations if they did not receive training. She said the facility did not have a policy on the required trainings.