STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675418	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor at Seagoville	2416 Elizabeth LN Seagoville, TX 75159

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47690 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames to meet residents' mental and psychosocial needs, for 1 (Resident #32) of 4 residents reviewed for comprehensive care plans. The facility failed to develop a comprehensive person-centered care plan to address Resident #32's dialysis access in the left forearm fistula. This failure could affect residents by placing them at risk for not receiving necessary care and services. Findings included: 1. Review of Resident #32's face sheet dated 10/03/24 revealed the resident was a [AGE] year-old male admitted on [DATE] with diagnoses including hypertension (High blood pressure), Renal insufficiency, renal failure, or End stage renal disease (ESRD) (is a medical condition in which the kidneys can no longer adequately filter waste products .), and hyperkalemia (elevated potassium level in the blood). Review of Resident#32's MDS assessment dated [DATE] revealed Resident #32 had a BIMS score of 14 indicating he was cognitively intact. Review of Resident #32's Physician's Order Sheet dated 05/17/23 revealed check dialysis site every shift for thrill, bleeding, and & s&s (signs and symptoms) of infection. Location of access site=left forearm. Notify MD of any abnormality. (1) Auscultate [is a method used to listen to the sound of arteries (blood vessels) using a stethoscope] and palpate (is to examine by touch .) dialysis AV fistula (a connection between blood vessel (artery and vein) to support dialysis.) on left forearm for bruit/thrill (signs that an arteriovenous (AV) fistula, such as one used for hemodialysis, is working properly), notify MD of any abnormality . Review of Resident #32's Comprehensive care plan, dated 09/19/22 last reviewed, did not reveal dialysis AV fistula on left forearm listed as a care area and/or problem. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/01/2024 at 11:01 AM revealed Resident #32 had a dialysis AV fistula on the left forearm, the site looked dry, clean, and intact . An interview on 10/03/24 at 1:48 PM with the MDS coordinator revealed residents' care plans were updated by her, the unit manager, and the ADON. The MDS coordinator stated the importance of care plan was for the staff to know what kind of care to render to the residents. The MDS coordinator stated if there was an order from the MD, and the staff were following the order there was no implication on the resident care, and she was going to update Resident#32's care plan. Interview over the phone on 10/03/24 at 12:42 PM with the DON revealed Resident #32's care plan should be updated to reflect dialysis AV fistula (AVF) access on the left forearm. The DON stated if the resident's care plan was not updated it can affect the resident's care. The DON stated it was the responsibility of the MDS nurse coordinator to update residents' care plan. Review of facility policy titled Care Plan, Comprehensive Person-Centered, revised March 2022, revealed, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48560 49427 Based on observation, interview, and record review, the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 3 (Residents #34, #11, and #64) of 6 residents reviewed for quality of life. The facility failed to ensure: 1. Resident #34 had her fingernails cleaned and trimmed. 2. Resident #11 had her fingernails cleaned and trimmed. 3. Resident #64 had her fingernails cleaned and trimmed. These failures could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections, and a decreased quality of life. Findings included: 1. Review of Resident #34's Admission MDS assessment dated [DATE] reflected Resident #34 was a [AGE] year-old female with initial admitted to the facility on [DATE]. Her diagnoses included Deep vein thrombosis (blood clot within veins of the leg), Hypertension (high blood pressure), Atrial fibrillation (irregular heart rhythm), Renal insufficiency (poor kidney function), Cognitive communication deficit (communication is affected related to disruption in cognitive abilities). Resident #34 had a BIMS score of 03 which indicated Resident #34 had severe cognitive impairment. Resident #34 required moderate assistance with personal hygiene. Review of Resident #34's Comprehensive Care Plan dated 08/29/2024 reflected, Problem: [Resident #34] ADL functions. Goal: Will maintain a sense of dignity by being clean, dry, odor free, and well-groomed over next 90 days. Interventions: set-up, assist, give shower, shave, oral, hair, nail care schedule and as needed. In an observation and interview on 10/01/2024 at 10:09 AM with Resident #34 revealed her nails on both hands were approximately 1.0 centimeter in length extending from the tip of his fingers and had black areas underneath the nails. Resident #34 stated she had weak eyesight that precluded her from performing ADL care by herself. She stated she would like the staff to trim and clean her nails, however it was not offered during her stay at the facility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/3/24 at 12:05 PM LVN B stated he had worked in the facility for almost 3 years. He stated that CNAs were responsible for cleaning and clipping fingernails for residents. LVN B stated that nurses were responsible for clipping fingernails for diabetics, after they were notified by the CNAs. He stated that he was not aware that Resident #34 needed her fingernails cleaned or trimmed; since he thought the CNA that was assigned to the hall would take care of it. LVN B stated that ADL's were monitored daily and the risk to the resident for failure to provide ADL including nail care was increased risk of infection. In an interview and observation on 10/02/2024 at 2:20 PM CNA C stated that she had worked in the facility for last 2 months. She stated that she currently helped with light duty at the facility. She explained light duty work included helping with resident grooming, facial hair trimming, nail care, setting up beds and helping with activities. She observed Resident #34's nails and stated that they needed to be trimmed and cleaned. She stated that CNAs were responsible for trimming and cleaning nails during bathing and as needed. She stated that the risk of not cleaning/ trimming fingernails could be increased risk of infection and loss of dignity. 2. Review of Resident #11's Quarterly MDS, dated [DATE], reflected she was a [AGE] year-old old female admitted to the facility on [DATE]. She had a BIMS score of 8 (moderately impaired cognition) and the diagnoses of arthritis (joint inflammation), Alzheimer's disease (loss of cognition), and high blood pressure. Section E, Behavior, reflected she did not reject Activities of Daily Living (ADL) care and Section GG, Functional Abilities and Goals, reflected she required moderate assistance for personal hygiene. Review of Resident #11's care plan, dated effective 12/06/2023 and printed on 10/02/2024, reflected she had short term memory impairment; interventions included .Use cues to enhance participation in self care. Report any decline in ability to participate/perform ADL care . In an observation and interview on 10/02/2024 at 10:11 AM, with Resident #11 revealed her nails on both hands were approximately 1.0 centimeter in length extending from the tip of her fingers and both index fingers had a dark red and brown substance underneath the nails. Resident #11 stated that her nails were long and would like them to be trimmed, and she was unable to recall when they were last trimmed. 3. Review of Resident #64's Quarterly MDS, dated [DATE], reflected she was a [AGE] year-old female admitted to the facility on [DATE]. She had a BIMS score of 8 (moderately impaired cognition) and the diagnoses of stroke, cirrhosis (damaged liver), Section E, Behavior, reflected she did not reject Activities of Daily Living (ADL) care. Review of Resident #64's care plan, dated effective 06/13/2024 and printed on 10/02/2024, reflected she had a history of stroke with right sided weakness and interventions included .assist with ADL's and comfor [sic] measures as needed . In an observation and interview on 10/02/2024 at 9:16 AM revealed CNA C was exiting Resident #64's room and stated she had just finished trimming Resident #64's nails. She stated had not gotten to Resident #11's nails yet and was not sure when she last trimmed her nails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 10/02/2024 at 9:20 AM with Resident #64 and CNA G revealed Resident #64's nails on the left hand were trimmed with pointed ends and sharp, jagged corners, a dark substance under the middle finger, and the ring fingernail was trimmed short past the nail bed. Her nails on the right hand were approximately 1.0 centimeter in length and extended from the tip of her fingers with a dark substance underneath her nails. Resident #64 stated she would like her nails trimmed and was not able to remember when someone last trimmed her nails. In an interview on 10/02/2024 at 9:22 AM CNA G stated that it did not look like Resident #64's right nails were trimmed on the right hand that had pointed, jagged, sharp edges, and length of nails. CNA G observed Resident #11's nails and stated they were also long and should have been trimmed and cleaned of debris from her index fingers. CNA G stated not trimming nails and ensuring edges and surfaces were smooth posed a risk to a resident's health because they could scratch themselves and cause skin tears or injury to their eyes. In an interview on 10/02/2024 at 9:48 AM with LVN H revealed he was unaware that Resident #64 or Resident #11 needed fingernail trimming or cleaning and that CNA C was on light duty and was responsible for cleaning and trimming nails. He stated nurses were responsible for clipping fingernails for diabetics, after they were notified by the CNAs. He stated the risk to the residents for failing to provide nail care was infection or injury. In an interview on 10/02/2024 at 1:41 PM the ADON stated that CNAs were responsible for cleaning/trimming fingernails. She stated that CNAs provided ADL care during shower days or as needed. She stated that the risk of long, dirty nails was increased infections and skin breakdown. She stated that as an ADON in the facility, she conducted multiple daily rounds on residents to ensure ADL's were provided to all residents. In a phone interview on 10/03/2024 at 12:42 PM with the DON revealed his expectation was that nail care and ADL care should be provided as needed, especially during shower time. He stated that both CNAs and nurses were responsible for doing nail care. He also stated that as the DON, either himself or ADON conducted daily routine rounds and check 24-hour reports for monitoring resident ADL's to ensure quality of life was maintained. The DON stated that residents having long, and dirty fingernails could be an infection control issue and cause skin breakdown. Record review of the facility nail care policy titled Fingernails/Toenails, Care of, revised February 2018, reflected, Purpose: the purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infection.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49837 Based on observation, interview, and record review the facility failed to ensure that residents who needed respiratory care are provided such care, consistent with professional standards of practices for 1 of 6 residents (Resident #27) reviewed for respiratory care. The facility failed to have a physician's order for Resident #27's oxygen use. This failure could affect residents by placing them at risk for not receiving the appropriate care and treatment services. Findings included: Review of Resident #27's face sheet, dated 10/02/24, reflected she was an [AGE] year-old woman admitted to the facility on [DATE]. Her diagnoses included cerebral infarction (stroke), type 2 diabetes mellitus (a chronic condition when the body does not produce enough insulin resulting in persistently high blood sugar levels) and unspecified diastolic heart failure (a long-term condition that happens when the heart does not pump well enough to give your body a normal supply). Review of Resident #27's MDS assessment dated [DATE] reflected she had a BIMS score of 12 indicating she was cognitively intact. The MDS did not reflect she was on oxygen therapy while at the facility. Review of Resident #27's Comprehensive Care Plan last updated 08/07/24 reflected no care plan for oxygen therapy. Review of Resident #27's consolidated physician's orders revealed no physician's order for oxygen use. Record review of Resident #27's nurse progress notes dated 09/30/24 by LVN E reflected. At about 1800 (6:00 p.m). nurse noted this resident congested, adequate vital signs of temp (temperature) 97.3, blood sugar 125, RR (respiratory rate) 16, BP (blood pressure) 106/58, pulse 60, O2 (oxygen) SAT-85. Notified DR received ordered for chest Xray. Order carried out. There was no documentation in the records Resident #27 was administrated oxygen on 09/30/24. Observation on 10/01/24 at 10:53 a.m. revealed Resident #27 was in bed on oxygen via nasal cannula with the oxygen concentrator next to her bed. The concentrator was observed on with the oxygen being infused through the nasal cannula. The LPM was not captured. Resident #27 was asked when she was first administered oxygen. Resident #27 stated it was either last night, 09/30/24 or this morning. Observation on 10/2/24 at 1:11 p.m. revealed Resident #27 no longer had the nasal cannula in her nose. Resident #27 stated LVN A took it away. Resident #27 stated she believed he took it because she did not need it anymore. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LVN E on 10/02//2024 at 1:59 p.m. revealed he put the concentrator and nasal cannula in Resident #27's room just in case Resident #27 needed it. He denied he administered the oxygen to Resident #27. He stated every nurse knew that they needed a physician's order to provide treatment to Resident #27. Interview with the DON on 10/03/24 01:12 p.m. revealed he expected the oxygen to have physician's order and nurses were responsible for making sure there was one prior to the oxygen being administered. He stated the only time a physician's order is not required is if there was an emergency that put Resident #27 at risk for sepsis (a life-threatening complication of an infection) shock, or death. He stated a crash cart (oxygen prepared tank) is used in situations such as that. He stated his expectations are for the nurses to make sure Resident #27 had a physician's order prior to the oxygen being administered. He stated the risk to Resident #27 is not getting the correct oxygen dose. Review of facility's policy Physician Orders revised 01/2020 reflected It is the policy of this facility that physician orders are maintained per state and federal regulations .Procedures: 1. All physicians' orders shall be recorded on the patients' medical record and must be signed electronically by the attending/prescribing physician. 2. Verbal or telephone orders are considered to be in writing when dictated by the attending physician and later signed by him/her electronically once the licensed nurses enter the order into the EMR. 3. Medications, diets, therapy, or any treatment may not be administered to the patient without a written order from the attending physician. Review of facility's policy Oxygen Administration revised 10/2020 reflected under preparation to verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47690 Based on observations, interviews, and record review the facility failed to label drugs and biologicals used in the facility in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 (300 hall nurses' medication cart) of 2 medication carts reviewed for pharmacy services. The facility failed to ensure the 300 Hall medication cart had 2 medications Valproic acid (as sodium salt) 250 mg/5 mL (5 mL) oral solution in a 16 oz bottle, and Levetiracetam 500 mg/5 mL (5 mL) oral solution in a 16 oz bottle for Resident#3 were dated when there were opened. This failure could affect residents resulting in diminished effectiveness, and not receiving the therapeutic benefits of the medications. The findings included: Record review of Resident #3's MDS, dated [DATE], revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including hypertension (High blood pressure), seizure disorder or epilepsy (a chronic brain disease that causes seizures, which are episodes of abnormal electrical activity in the brain), schizophrenia (Is a serious mental health condition that affects how people think, feel and behave. It may result in a mix of hallucination .), type 2 diabetes mellitus (elevated blood sugar), and hyperlipidemia (too many lipids and fats in the blood), and dementia (loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain). She had a BIMS score of 03 indicating her cognition was severely impaired. Record review of Resident #3's physician's orders dated 08/08/2024 revealed an order for 1-valproic acid (as sodium salt) 250 mg/5 ml (5ml) oral solution, 25 ml oral three times daily; And 2-levETRAcetam 500 mg/5 ml (5ml) oral solution, 7.5 ml=750 mg Oral Two Times Daily. Observation on 10/03/24 at 08:14 AM revealed the 300-Hall nurse's medication cart had a 16 oz bottle of valproic acid (as sodium salt) 250 mg/5 ml (5ml) oral solution, and a 16 oz bottle of levETRAcetam 500 mg/5 ml (5ml) oral solution for Resident #3, that were open and used without the open date on them. Interview on 10/03/24 at 09:38 AM, LVN E stated the two medications solution bottles that belonged to Resident #3 had no open date. LVN E stated she give the Resident#3 her ordered dose of valproic solution and levetracetam solution this morning. She stated she did not check the solutions for an expiration date. LVN E stated the purpose of the open date every four weeks was for expiration purposes because the liquid medication solutions were only good for 28 days after opening. She stated giving expired medications may not be effective the way it should be. She further stated she received and in-service on medications pass every end of the month by the pharmacist. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/03/24 at 10:03 AM, the ADON stated the liquid medication solution, once opened, needed to be dated because medication solutions should be removed from the carts and replenished after 28 days from the open date. The ADON further stated if the medication solution was used after the expiration date, it could lose its effectiveness. The ADON stated she did random checks of the medication carts for monitoring, and the pharmacist checked the carts monthly and reeducated the staff responsible for medications pass. Interview over the phone on 10/03/24 at 12:42 PM, the DON stated the liquid medications supposed to be dated, and labeled by whoever opened the medication, and it should be done by any of the nurses on the floor, or the ADON. The DON stated the impact on the residents, the potency of the medication could not be effective after the expiration date. The DON further stated the expectation were the medication carts should be checked every shift to make sure the medication had been dated, and no expired medications were in the carts. Record review of the facility's policy titled Medication Labeling & Storage, dated February 2023, revealed in part .3. If the facility has ., outdated .medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items .8. If medication containers have missing, incomplete, improper, or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items .

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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** 48560 Based on observations, interviews and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's only kitchen in that: 1. The facility failed to ensure food items in the facility walk-in freezer were covered, labeled, and dated with the expiration date. 2. The facility failed to discard expired food items in the facility walk-in refrigerator. These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness, and food contamination. Findings included: Observation on [DATE] at 9:18 AM in the facility's walk-in freezer revealed an unopened bag of cauliflower florets did not have expiration date on it. Observation on [DATE] at 9:19 AM in the facility's walk-in freezer revealed an unopened bag of diced yellow squash did not have expiration date on it. Observation on [DATE] at 9:20 AM in the facility's walk-in freezer revealed a bag of diced chicken was left uncovered. Observation on [DATE] at 9:23 AM in the facility's walk-in refrigerator revealed tomato sauce in a covered container that was dated [DATE]. In an interview on [DATE] at 12:47 PM with the Dietary Manager, he stated that his expectation was all food items in the facility kitchen needed to be dated, labeled, and covered. He stated everyone in the kitchen including dietary aides, cooks and himself were responsible for dating and labeling food items. He also stated all food items needed to adhere to facility food storage guidelines. He stated that the vegetables in the facility freezer were taken out of the original box and the individual bags should had been marked with a expiry (sic, expiration) date on it. He stated the frozen diced chicken should have been covered appropriately. He revealed that tomato sauce in the walk-in refrigerator was dated [DATE] and had a shelf life of 7 days and should had been discarded. He stated that failure to cover, label and date food items or not discarding expired foods could cause food borne illness in residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview [DATE] at 01:46 PM with the [NAME] A stated everyone in the kitchen including cooks, dietary aides and dietary manager were responsible for dating, labeling, and covering all food items. She stated if frozen foods were out of their original box than it needed to be dated with , expiration date and labeled. She stated all foods should be covered appropriately to prevent the food from cross contamination and freezer burn. She stated the tomato sauce was leftover and stored in the refrigerator had shelf life of 7 days and should had been discarded promptly. She stated the risk of not dating, labeling, and covering food items or discarding expired food items was residents could get sick. Record Review of the facility policy titled Food Storage undated reflected, . 15. Refrigeration . Refrigerated foods should be stored upon delivery and careful rotation procedures should be followed.16. Frozen Foods: Foods should be covered, labeled, and dated. Record Review of the facility policy titled Food storage undated did not mention what kind of date should the facility have on the food products. Review of the Food and Drug Administration Food Code, dated 2022, reflected, XXX,d+[DATE].12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food, or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food ,d+[DATE]. 11 Food Storage.(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety Review of the Food and Drug Administration Food Code, dated 2022, reflected, XXX,d+[DATE] Preventing contamination from the premise,d+[DATE].11 Food Storage (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675418	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor at Seagoville	2416 Elizabeth LN Seagoville, TX 75159

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - 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** 49837 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 1 of 6 residents (Resident #18) reviewed for infection control. CNA D failed to wear personal protective equipment during incontinence care with Resident #18, when Resident #18 was on enhanced barrier precautions. This failure could place residents at risk for cross contamination, infection, and illness. The findings include: Record review of Resident #18's significant change in status assessment, dated 07/11/24, reflected a [AGE] year-old female with an admitted [DATE]. Resident #18 BIMS score was 3 which indicated Resident #18 to be severely cognitively impaired. Active diagnoses included severely impaired vision (completely blind) hypertension, gastroesophageal reflux disease (stomach contents move up into the esophagus), end-stage renal disease (chronic kidney disease), hyperlipidemia, anxiety disorder, and depression. Observation and interview on 10/02/24 at 1:32 p.m. revealed CNA D performed incontinent care for Resident #18 without wearing personal protective equipment (a gown) before or during incontinent care. CNA D advised the surveyor not to go into Resident #18's room due to CNA D having to change Resident #18. CNA D stated the room smelled bad because Resident #18 had ripped off her ostomy (an opening between the large intestine (colon) and the abdominal wall) bag and feces was everywhere. CNA D stated he had to clean Resident #18 and change her clothing. CNA D was observed entering Resident #18's room with gloves on but no gown to provide incontinent care on Resident #18. CNA D was observed in Resident #18's room for at least 15 minutes or more. In an interview with CNA D on 10/03/24 at 9:11 a.m. he stated Resident #18 was blind and had an ostomy bag. He stated Resident #18 ripped the ostomy bag off her and had feces everywhere. He stated he provided Resident #18 incontinent care and forgot to gown up. He stated the expectations was for CNAs to use personal protective equipment with residents who were on enhanced barrier precautions. He stated the risk of not using personal protective equipment was infections to Resident #18 and others. In an interview with the ADON on 10/03/24 at 10:52 a.m. she revealed her expectations was for CNAs to follow enhanced barrier precaution guidelines. She stated EBP was to be used when Resident #18 is provided with incontinent care, toileting, or when Resident #18 ostomy bag is to be changed. She stated the risk of not following protocols was infection to residents and staff. In an interview with the DON on 10/03/24 at 1:12 p.m. he revealed his expectations was for CNAs to follow the enhanced barrier precaution guidelines. He stated the risk of not following protocols was infection to residents and staff. (continued on next page)

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	675418	A. Building B. Wing	10/03/2024

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Personal Protective Equipment (PPE) Competency Validation dated July 13, 2024, reflected CNA D's competency on Donning (putting on) and Doffing (taking off) .Standard Precautions and Transmission Based Precautions. Record review of the facility's policy titled Continuing Care Network Patient Care Management System 8 Infection Control dated November 2017, reflected, 1. The facility must establish an infection prevention and control program (IPCP) that must include: A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all Patients, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment. Record review of the facility's policy and procedure on Enhanced Barrier Precautions (Revised 3/2024) reflected in part: Enhanced Barrier Precautions is an infection control intervention designed to reduce the transmission of multidrug-resistant organisms and employs targeted gown and glove use during high-contact resident care activities for targeted residents. Enhanced Barrier Precautions (EBP) are used in conjunction with standard precautions and expands the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs 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 MDRO . Examples of indwelling medical devices: central lines, urinary catheters, feeding tubes, and tracheostomies . When EBP are indicated, EBP should be employed for the following high-contact resident care activities: Dressing, bathing/showering, transferring, providing hygiene, changing briefs, assisting with toileting .