STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675433	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Huntsville	1302 Nottingham St Huntsville, TX 77340

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on observations, interviews, and record review, the facility failed to consult with the resident's physician when there was a need to alter treatment for 1 of 7 residents (Resident #23) reviewed for notification of changes. The facility failed to notify and consult with the physician about the changes in Resident #23's high blood sugar readings. This failure could place residents at the risk of not receiving appropriate medical interventions, which could result in severe illness or hospitalization . Findings included: Record review of an Admission Record for Resident #23 dated 4/16/2024 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of Alzheimer's with late onset (occurs when someone is [AGE] years or older and the brain changes leading to memory loss), hypothyroidism (abnormally low activity of the thyroid gland), COPD (a group of lung diseases that affect breathing), and Type 2 diabetes (a problem in the way the body regulates and uses sugar as a fuel). Record review of a Quarterly MDS for Resident #23 dated 2/14/2024 indicated she had moderate impairment in thinking with a BIMS score of 11. She required partial set up or clean up assistance. During the 7 days look back period, she received 7 days of insulin injections. Record review of a care plan for Resident #23 dated 1/23/2023 and revised on 4/18/2023 indicated she was at risk for frequent infections, hyper/hypoglycemia (low blood sugar/high blood sugar), renal failure (kidney failure), cognitive/physical impairment/skin desensitized to pain, or pressure related to diabetes mellitus, and used insulin. Interventions included: diabetes medication as ordered by the doctor. Monitor/document for side effects and effectiveness. Monitor/document/report PRN any s/s of hyperglycemia. Record review of active physician orders for Resident #23 dated 4/16/2024 indicated an order with a start date of 1/24/2024 for insulin Lispro (1 Unit Dial) Subcutaneous (under the skin) Solution Pen-injector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 450 = 10 units; 451 - 500 = 12 units Call APN of above 500, subcutaneously before meals and at bedtime for DM II. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of active physician orders for Resident #23 dated 4/16/2024 indicated an order with a start date of 1/16/2024 for Lantus subcutaneous solution 100 unit/ml inject 15 unit subcutaneously at bedtime for diabetes. Record review of Resident #23's MAR dated 2/1/2024-2/29/2024 revealed a high blood sugar over 500 on the following days and times: 506 on 2/27/2024 at 7:00 AM and 544 on 2/28/2024 at 7:00 AM documented by LVN D. Record review of Resident #23's progress notes dated February 2024 did not reveal any notes regarding blood sugars over 500 that were reported to the physician or NP. During an observation and interview on 04/15/24 at 09:37 AM, Resident #23 was in bed awake and dressed. She said her blood sugars have improved because she gave her candy away to her roommate. She said her blood sugars had been high in the past but was not able to recall how high they were. During a phone interview on 4/16/2024 at 12:22 PM, the NP said she visited the facility 3-4 times a week. She said Resident #23 had a history of hypothyroidism, COPD, Hypertension, and diabetes. She said Resident #23 was on sliding scale insulin for diabetes and her blood sugars were uncontrolled due to meals being brought in by her family of foods that she cannot have. She said Resident #23 was on a long-acting insulin and took it at bedtime. She said the facility had notified her of Resident #23 having an elevated blood sugar over 500 sometime last month, March 2024 but not any time before that she could recall. She said a nurse notified her that day in March 2024 and she visited the facility and gave the nurse an order to recheck Resident #23's blood sugar. She said Resident #23 snacked a lot and was not dietary compliant. When the State Surveyor asked her if there had been any other times that she was notified of Resident #23's blood sugars being over 500, she stated that she had not. She said if a resident had an elevated blood sugar that was over 500, usually she would give an order to administer more insulin and reevaluate. She said the nurse could have given the 12 units of insulin that was ordered to give, then notify the MD, and then she would give any additional orders if needed. During an interview on 4/16/2024 at 12:33 PM, LVN D said she was the nurse who checked the blood sugars for Resident #23 on 2/6/24, 2/27/24, and 2/28/24. She said she was taught if there were any readings outside of parameters, she was instructed to place a 4 in the MAR to indicate vitals being outside of parameters for administration. She said for Resident #23 if her blood sugar was above 500, the orders were to contact the MD. She said they notified the NP of things before 5 pm Monday-Friday and after hours then would contact the primary physician. She said residents could be at risk for strokes, heart attacks, and a coma if hyperglycemia was not treated. She said they usually notified the physician or NP by phone. She did not have any explanation as to why the MAR for Resident #23 did not show that insulin of 12 units was given to her if her blood sugar was greater than 500. She stated she notified the physician of the blood sugars being over 500. Record review of late entry progress notes dated 4/16/2024 for Resident #23 dated 4/16/2024 at 1:32 PM indicated LVN D entered a progress note for 2/27/24 and 2/28/2024 to indicate 12 units of insulin were administered and the MD was notified (after state surveyor intervention). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/2024 at 3:00 PM, the DON and the Administrator said the charge nurses were responsible for notifying the physicians immediately of any change in condition. The DON said anything that the orders said to report such as changes in vital signs or a change in condition needed to be reported to the physician. The DON said altered mental status or any change from the resident's normal baseline should be reported. The DON said the charge nurses were to complete a change in condition assessment, call the MD, and then enter the orders that were given. Both the Administrator and the DON said going forward, they would monitor for changes in condition during the morning meetings and conduct audits to ensure changes were being notified. Both said residents could potentially have a risk of decline, hospitalization s, and affect care if not being treated. Both said Resident #23 has had elevated blood sugars over 500 in the past and was given orders by the physician to increase insulin. Both stated the blood sugars would fluctuate between high and low but was not aware of the dates in question where there was not any documentation reporting blood sugar over 500 to the MD. Record review of a facility policy titled Administration Procedures for all Medications revised date of 8/2020 indicated, .Medications will be administered in a safe and effective manner. The guidelines in this policy apply to all medications. IV. Administration 13. Notify the attending physician and/or prescriber of: b. Held medications for pulse, blood pressure, low or high blood sugar, or other abnormal test results or vital signs resulting in medication being held .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on interviews and record reviews, the facility failed to ensure an accurate MDS was completed for 1 of 6 residents (Residents #12) reviewed for MDS assessment accuracy. The facility failed to code Resident #12 as being on hospice services on her MDS assessments. This failure could place residents at risk for not receiving the appropriate care and services to maintain the highest level of well-being. Findings included: Record review of an Admission Record for Resident #12 dated 4/16/2024 indicated she admitted to the facility on [DATE] and was a [AGE] year-old female with diagnoses of dementia, adult failure to thrive, hypertension, and chronic atrial fibrillation. Record review of active physician orders for Resident #12 dated 4/16/2024 indicated an order to admit to hospice dated 6/1/2023. Record review of a Quarterly MDS for Resident #12 dated 12/9/2023 indicated she had moderate impairment in thinking with a BIMS score of 11. She required partial/moderate assistance to set up or clean up assistance with ADL's. Special treatments, procedures, and programs while a resident during the 14 days look back period did not indicate the resident had hospice care. Record review of an Admission MDS for Resident #12 dated 6/8/2023 indicated she had moderate impairment in thinking with a BIMS score of 11. She required extensive assistance with ADLs with one-person physical assist. Special treatments, procedures, and programs while not a resident or while a resident during the 14 days look back period did not indicate the resident had hospice care. Record review of a care plan for Resident #12 dated 6/2/2023 indicated she had a terminal diagnosis related to malnutrition/failure to thrive and was on hospice services. During an interview on 4/16/2024 at 3:44 PM, the MDS Coordinator said she had been employed at the facility since May 2023 and was responsible for completing the MDS assessments. She said Resident #12 admitted to the facility on [DATE] on hospice services from home. She said the Admission MDS assessment dated [DATE] and the Quarterly MDS dated [DATE] for Resident #12, should have indicated she was on hospice services. She said she completed a modification of both assessments to indicate the resident was on hospice. She said the DON signed the assessments after they were completed. She said the DON looked over them to make sure they were accurate. She said she thinks that for those two assessments she was probably in a hurry. She said her goal was to have everything as accurate as possible. Resident #12 was on hospice, and if the assessments were not accurate there was a risk that it would not paint a picture of what was going on with the residents. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/2024 at 3:00 PM, the DON and the Administrator both said the MDS Coordinator was responsible for completing the assessments for the residents, but the DON signed them. The DON said she spot checked the assessments for accuracy. The DON said Resident #12 admitted to the facility on hospice and the Admission MDS assessment and the Quarterly MDS Assessment should have indicated the resident was on hospice. The DON said the residents could be at risk of not being provided appropriate care. The DON said she would make sure the MDS Coordinator was more mindful of the demographic information and ensure the assessments were accurate. Record review of a facility policy titled MDS Completion Accuracy and Timeliness revised 11/15/2023 indicated, .The purpose of this policy is to ensure accuracy and timeliness of MDS completion. 1. Each facility must follow most updated MDS RAI rules and regulations for completing each MDS accurately and timely. 2. Each facility must also utilize most updated Texas TAC rules for MDS accuracy .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273 Based on observations, interviews, and record review, the facility failed to develop a person-centered comprehensive care plan to address medical needs for 2 of 6 residents (Resident #15 and Resident #39) reviewed for comprehensive care plans. The facility failed to ensure Resident #15's and Resident #39's care plans were revised to reflect current transfer status of requiring mechanical lift transfer. This failure could place residents requiring mechanical lift transfer at increased risk of falls, injuries, and a decreased quality of life. Findings included: Record review of a facility face sheet dated 4/16/24 for Resident #15 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of closed fracture with routine healing (a broken bone that does not penetrate the skin). Record review of a Comprehensive MDS assessment dated [DATE] for Resident #15 indicated that she had a BIMS score of 11, which indicated that she had moderately impaired cognition. Functional abilities section indicated that she was dependent with transfers. Record review of a Comprehensive Care Plan dated 2/3/21 for Resident #15 indicated that she had an ADL self-care performance deficit and indicated that she required extensive assistance of 1 person for transfers. The Care plan did not address the use of mechanical lift transfers with assistance of 2 persons. Record review of a Physician Order Summary Report dated 4/16/24 for Resident #15 indicated that she did not have a physician order for mechanical lift transfers. Record review of a facility face sheet dated 4/16/24 for Resident #39 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of sequelae of cerebral infarction (complications after having a stroke) and dysphagia (difficulty swallowing food or liquid). Record review of an Annual MDS assessment dated [DATE] for Resident #39 indicated that he had a BIMS score of 10, which indicated that he had moderately impaired cognition. Functional abilities section indicated that he was dependent with transfers. Record review of a Comprehensive Care Plan dated 4/22/22 for Resident #39 indicated that he had an ADL self-care performance deficit and required extensive assistance of 2 persons for transfers but did not indicate that he required mechanical lift transfers with assistance of 2 persons. Record review of a Physician's Order Summary Report dated 4/16/24 for Resident #39 indicated that he did not have a physician order for mechanical lift transfers. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 4/15/24 at 9:27 am Resident #39 was observed sitting up in wheelchair in his room. Hoyer (mechanical lift) transfer pad was observed underneath him in his chair. He had right sided weakness and said he could not move his right arm. He had garbled speech and was hard to understand but said yeah when asked if staff used a mechanical lift to transfer him to his chair. During an observation and interview on 4/17/24 at 10:33 am Resident #15 was observed in the dining room participating in activities. She had a mechanical lift pad underneath her in her wheelchair. She said that staff used a mechanical lift to transfer her to her wheelchair. During an interview on 4/17/24 at 10:40 am CNA C said she had been employed at the facility since 2001. She said she did not transfer Resident #15 or Resident #39 today or yesterday, but if she needed to know their transfer status, she would look at the Kardex (resident information sheet that pulls over from the care plan). During an interview on 4/17/24 at 11:30 am the DON said that CNAs should look at the Kardex to get needed resident information such as level of assistance needed for transfers. She said if information was not on the care plan, the CNAs may not know that a resident required a mechanical lift transfer, and the resident could suffer a fall. She said going forward she would ensure that care plans would reflect accurate resident status. During an interview on 4/17/24 at 11:25 am the MDS nurse said she was responsible for care plans. She said other staff would update them as well, whenever needed. She said she would get communications during the morning meetings if there was something about a resident that needed to be updated on the care plan. She said she also does reviews quarterly and after each MDS assessment such as a change of condition. She said if all needed information was not included in the plan of care, staff may not know what level of assistance a resident needed, and they could fall. During an interview on 4/17/24 at 12:00 pm the DON said the facility did not have a policy or procedure for mechanical lift transfers. Record review of a facility policy titled Comprehensive Care Plan dated 1/20/21 read .The Care Plan is revised every quarter, significant change of condition, annual or as the resident condition changes on an individualized basis .

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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 16 resident reviewed for ADLs. (Resident #15) The facility failed to remove Resident #15'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 4/16/2024 for Resident #15 indicated she admitted to the facility on [DATE] and was a [AGE] year-old female with diagnoses of mixed receptive expressive language disorder (difficulty understanding and expressing language to produce words or complete sentences), vascular dementia (decline in thinking skins caused by blocked or reduced blood flow in the brain), major depressive disorder (persistent feeling of sadness and loss of interest), and Alzheimer's disease (progressive disease that destroys memory). Record review of a care plan dated 2/3/2021 for Resident #15 indicated she had an ADL self-care performance deficit related to the disease processes of CVA (stroke) with hemiplegia (paralysis on one side). Interventions included to bath/shower three times a week and as necessary. The resident required extensive assistance by staff. Record review of a Significant Change MDS for Resident #15 dated 2/8/2024 indicated she had moderate impairment in thinking with a BIMS score of 11. She required substantial/maximal assistance with ADL's. During an observation and interview on 4/15/2024 at 2:51 PM, Resident #15 was in bed awake, dressed, and had black facial hair noted to her upper lip and chin. The chin hair was approximately 2-3 cm in length She did not remember how long it had been since the last time they shaved her face and said she did not like it. During an observation on 4/16/2024 at 9:20 AM, Resident #15 was in bed awake, black facial hair noted to her upper lip and chin with the chin hair being approximately 2-3 cm in length. During an observation and interview on 4/17/2024 at 8:50 AM in room of Resident #15. CNA G had just finished giving Resident #15 a bed bath and had shaved her upper lip and chin. She said she checked the residents for facial hair each time they received their baths or showers. She said the aides were supposed to shave the women and men in the facility if they did not refuse. She said she had been employed at the facility since March 2023. Resident #15 was in bed awake, dressed, and said she felt much better that her face was shaved. CNA G said she had received training with skill checkoffs and with the baths, shaving was one of the tasks to be completed. (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 4/17/2024 at 11:05 AM, CNA J said she had been employed at the facility for 3 years. She said the aides were supposed to shave every time the residents received a bath. She said Resident #15's hair grew back fast but she never refused for anyone to shave her. She said it would make her feel sad or like she was turning into a man if she had facial hair and she was dependent on staff to shave it for her. She said the ADON conducted check offs with the aides and shaving was part of the tasks with bathing. Record review of tasks for Resident #15 indicated she was scheduled to receive her bath on Monday, Wednesday, and Fridays but it did not include to shave. During an interview on 4/17/2024 at 11:10 AM, the ADON said she had been employed at the facility since September 2021 and was responsible for conducting skills check offs with the staff. She said she did check offs quarterly that included incontinent care but did hand washing and PPE all the time. She said the last skills check off with staff was conducted in January 2024. She said shaving the residents was a task that should be completed on shower days. She said residents could be at risk of dignity issues. She said going forward she would continue to train staff and conduct random checks with incontinent care. During an interview on 4/17/2024 at 3:00 PM, the DON and the Administrator both said the CNAs were responsible for ensuring the residents were shaved on their shower days and when needed. She said shaving was part of the task for them to provide to the residents. The DON said residents could feel embarrassed if they had unwanted facial hair. Both said going forward, they would make sure showers were done and add the task of shaving to the task for ADL's. A policy regarding ADL care was requested, both the Administrator and DON said the facility did not have a policy.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273 Based on observations, interviews, and record review, the facility failed to ensure the residents' environment remained as free of accident hazards as possible for 2 of 6 residents reviewed for accident hazards (Resident #15 and Resident #39). The facility failed to develop and implement a policy and procedure including interventions to inspect the Hoyer sling for signs of damage before each use. The facility failed to remove damaged mechanical lift slings from service. The facility failed to obtain physicians orders for Hoyer lift transfers. This deficient practice could result in a loss of quality of life due to injuries if the damaged lift sling broke during transfer for residents that use a Hoyer lift for transfers and inappropriate use of Hoyer (mechanical lift) for transfers if an order was not obtained by the physician. Findings included: Record review of a facility face sheet dated 4/16/24 for Resident #15 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of a closed fracture with routine healing (a broken bone that does not penetrate the skin). Record review of a Comprehensive MDS assessment dated [DATE] for Resident #15 indicated that she had a BIMS score of 11, which indicated that she had moderately impaired cognition. Functional abilities section indicated that she was dependent with transfers. Record review of a Comprehensive Care Plan dated 2/3/21 for Resident #15 indicated that she had an ADL self-care performance deficit and indicated that she required extensive assistance of 1 person for transfers. Care plan did not address the use of mechanical lift transfers with assistance of 2 persons. Record review of a Physician Order Summary Report dated 4/16/24 for Resident #15 indicated that she did not have a physician order for mechanical lift transfers. Record review of a facility face sheet dated 4/16/24 for Resident #39 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of sequelae of cerebral infarction (complications after having a stroke) and dysphagia (difficulty swallowing food or liquid). Record review of an Annual MDS assessment dated [DATE] for Resident #39 indicated that he had a BIMS score of 10, which indicated that he had moderately impaired cognition. Functional abilities section indicated that he was dependent with transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Comprehensive Care Plan dated 4/22/22 for Resident #39 indicated that he had an ADL self-care performance deficit and required extensive assistance of 2 persons for transfers but did not indicate that he required mechanical lift transfers with assistance of 2 persons. Record review of a Physician's Order Summary Report dated 4/16/24 for Resident #39 indicated that he did not have a physician order for mechanical lift transfers. During an observation and interview on 4/16/24 at 3:15 pm Resident #39 was observed lying in his bed with his wheelchair at the foot of his bed. A blue mesh mechanical lift pad was observed in his wheelchair. The loops had no color left, they were all white. There were multiple loose seams and strings observed around the edging of the lift pad. There were ripped areas observed to the white backing along the top back of the lift pad. Resident was unsure if that was the lift pad that was used to put him into bed. During an observation on 4/17/24 at 10:33 am Resident #15 was observed in her wheelchair in the dining room with a lift pad underneath her with faded colors on the strap loops. The colors were observed to be almost completely faded and almost white in color. Label on lift pad was crinkled and almost unreadable. During an interview on 4/16/24 at 3:40 pm the DON immediately removed the lift pad and said she would take it out of service. She said it must have slipped through. She said CNAs should check for wear and tear before using the pads for residents. She said that residents could be at risk for falls and accidents if lift pads with visible wear and tear were used to transfer residents. During an interview on 4/17/24 at 10:30 am Laundry Aide said she had been here approximately 6 months. She said she inspected lift pads for stains and tears and color fading. She said if she found any, she would put them aside not to be used, and report them to Administrator. She said they were not washed with bleach. She said if pads that were worn out or have tears were used to transfer residents, she would think they could rip, and the resident could fall. During an interview on 4/17/24 at 10:40 am CNA C said she had been here since 2001. She said she would check lift pads before using them and if she saw any loose seams or tears, she would take them to the Administrator. She said using worn out lift pads could cause residents to fall. During a joint interview on 4/17/24 at 11:00 am the DON and the Administrator both said that CNAs and nurses should always inspect mechanical lift pads prior to use and if they were damaged or worn, bring them to the DON or Administrator. The DON said she was ordering all new lift pads and would be inspecting them regularly to be sure they were taken out of service when they were worn or no longer safe to use. She said she had in-serviced nursing staff and would be continuing to educate staff on the safe use of mechanical lifts and inspection of the lift pads. She said residents could be at risk of falls if unsafe lift pads were used to transfer residents. During an interview on 4/17/24 at 11:30 am the DON said she was unaware that she needed a physician order for mechanical lift transfers and that going forward she would ensure that a physician order was obtained for all residents that needed lift transfers. Mechanical lift policy was requested on 4/17/24 at 12:00 pm. the DON said that the facility did not have a policy for mechanical lift transfers. (continued on next page)

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	675433	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Huntsville	1302 Nottingham St Huntsville, TX 77340

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Full Body Slings- Medline, Instructions for use www.medline.com accessed 4/17/24 reflected .Always inspect slings prior to each use. Signs of rips, tears, or frays indicate sling wear which is unsafe and could result in injury. Signs of color fading, bleached areas, or permanent wrinkles on the straps indicate improper laundering which is unsafe and could result in injury. Any slings with signs of wear or improper laundering should be immediately removed from use .

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273 Based on observations, interviews, and record review, the facility failed to ensure each resident received and the facility provided food prepared in a form designed to meet individual needs for 2 of 2 (Residents #3 and #39) residents reviewed for puree diets. The facility failed to prepare the pureed diet to the consistency required for Resident #3 and Resident #39. This failure could place residents who received pureed meat and vegetables at risk of not having nutritional needs met by consuming foods that could cause choking and decreased meal intakes. Findings included: Record review of a facility face sheet dated 4/17/24 for Resident #3 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of traumatic subdural hemorrhage (bleeding inside your head) and feeding difficulties. Record review of a Quarterly MDS assessment dated [DATE] for Resident #3 indicated that he had a BIMS score of 6, which indicated that he had severe cognitive impairment. Section GG indicated that he required supervision assistance for eating. Record review of a Comprehensive Care Plan dated 2/21/24 for Resident #3 indicated that he was at risk for nutritional impairment, and he received a pureed diet. Record review of a Physician's Order Summary Report dated 4/17/24 for Resident #3 indicated that he had an order for regular diet, pureed texture with start date of 8/1/23. Record review of a facility face sheet dated 4/16/24 for Resident #39 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of sequelae of cerebral infarction (complications after having a stroke) and dysphagia (difficulty swallowing food or liquid). Record review of an Annual MDS assessment dated [DATE] for Resident #39 indicated that he had a BIMS score of 10, which indicated that he had moderately impaired cognition. Section GG indicated that he required supervision assistance for eating. Record review of a Comprehensive Care Plan dated 1/19/24 for Resident #39 indicated that he received a puree diet. Record review of a Physician's Order Summary Report dated 4/16/24 for Resident #39 indicated that he had an order for pureed texture diet with start date of 2/1/24. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/15/24 at 12:03 Resident #39 was observed sitting up in his bed with his head of bed elevated and was served a lunch tray by a staff member. His lunch tray consisted of pureed turkey that appeared to have small chunks still visible. He was not observed to have any difficulty in eating. During an observation on 4/16/24 at 12:30 pm pureed turkey on the state surveyors' test tray was observed to be chewy and not a smooth, pudding-like consistency. During an observation on 4/16/24 at 5:30 pm pureed pizza on the state surveyors' test tray was observed to be chewy with chunks in it and not a smooth, pudding-like consistency. During an observation and interview on 4/16/24 at 5:40 pm with the Dietary Manager and the DON, they also sampled the pureed pizza and agreed that it was not the correct texture. During an interview on 4/17/24 at 9:52 am with the Dietician, she said that she would get a variety of textures to check when she was in the facility. She said that she had received a puree test tray at the end of March, and it was a smooth, pudding-like texture. She said residents could be at risk of choking or swallowing difficulties if they do not receive the correct consistency of foods. During an interview on 4/17/24 at 10:43 am with the Dietary Manager, he said that it was his responsibility to ensure the correct puree texture was achieved and that the nurses would also check the trays to make sure residents received the correct diet and texture. He said the dietician would usually come twice monthly. He said she would always request a mechanical soft tray to check textures. He does not remember her requesting a puree to sample the texture. He said if residents received the incorrect texture they could possibly choke. During a joint interview on 4/17/24 with the DON and the Administrator, they both said that residents could be at risk for aspiration if they were served foods that were not the correct texture. The DON said that she would ensure the nurses were also checking the trays going forward to ensure residents received the correct texture. The Administrator said she expected her kitchen staff to serve the proper consistency food to the residents. She said she had in-serviced kitchen staff on proper pureeing and would be continuing to educate the staff. Record review of a facility policy titled Preparation of Foods dated 4/2022 reflected .Food will be cut, chopped, ground, or pureed to meet individual needs of the resident and served according to menu .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 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 #15) and 2 of 5 staff (CNA E and CNA G) reviewed for infection control. CNA E did not change gloves, sanitize/wash hands between glove changes, and touched clean items with dirty gloves when providing incontinent care on 4/15/2024. CNA G failed to properly bag soiled linens and towels after giving Resident #15 a bed bath on 4/17/2024. These failures could place residents at risk of exposure to communicable diseases and infections. Findings included: Record review of an Admission Record dated 4/16/2024 for Resident #15 indicated she admitted to the facility on [DATE] and was a 64-year- old female with diagnoses of mixed receptive expressive language disorder (difficulty understanding and expressing language to produce words or complete sentences), vascular dementia (decline in thinking skins caused by blocked or reduced blood flow in the brain), major depressive disorder (persistent feeling of sadness and loss of interest), and Alzheimer's disease (progressive disease that destroys memory). Record review of a care plan dated 2/3/2021 for Resident #15 indicated she had an ADL self-care performance deficit related to the disease processes of CVA (stroke) with hemiplegia (paralysis on one side). Interventions included to bath/shower three times a week and as necessary. The resident required extensive assistance by staff. Record review of a Significant Change MDS for Resident #15 dated 2/8/2024 indicated she had moderate impairment in thinking with a BIMS score of 11. She required substantial/maximal assistance with ADL's. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/15/2024 at 2:25 PM, CNA E and CNA J were in the room of Resident #15 to provide incontinent care. CNA E donned (put on) gloves and pulled down the brief between Resident #15's thighs. CNA J was in the room and had gloves on both hands. CNA E opened a package of disposable wipes and pulled out some wipes. CNA E wiped down the left groin, folded over the wipes, and with clean side of wipes she wiped down the right groin. CNA E pulled out more wipes from the package and wiped from the front down the middle of the resident's peri area. CNA J rolled the resident to her right side. CNA E pulled out more wipes from the package with the same gloves. CNA E took the wipes and wiped the rectal area multiple times and the wipes had feces on them. CNA E then without changing gloves rolled the brief underneath the resident's buttocks and it was removed and placed in the trash. CNA E then placed a clean brief underneath Resident #15 and opened the nightstand drawer. CNA E removed her gloves after CNA J instructed her to and placed them in the trash. CNA E exited the room and said she had to get gloves. She removed gloves from her scrub top pocket and placed them on both hands. Resident #15 was rolled onto her left side by CNA J and the brief was secured. CNA E removed her gloves and trash and placed them in the bin that was outside in the hallway. CNA E reentered the room and washed her hands in the bathroom. CNA J removed her gloves and placed them in the trash and washed her hands in the bathroom. During an interview on 4/15/2024 at 2:40 PM, CNA E said she had been working at the facility for 6 months. She said she worked a different hall in the facility and came in to work on her day off today. She said during the incontinent care observed for Resident #15, she should have had wipes in the room, did not have anything to place on the resident's buttocks, and before starting and after care hands should be washed or sanitized. She said she should have removed her gloves when she went from dirty to clean after wiping the resident's buttocks and not touch the clean brief or nightstand. She said she should have washed her hands before putting on gloves to finish providing care. She said she had skills check off with someone but does not remember how long ago it was. She said if staff did not change their gloves or wash their hands, residents could be at risk for infections. Record review of a competency evaluation conducted by the ADON dated 12/12/2023 for CNA E indicated she was competent with incontinent care for a female resident. During an observation on 4/17/2024 on 8:50 AM in room of Resident #15. CNA G was present and had dirty linens and towels in her gloved hands touching her scrub top walking to the door to place them in a plastic trash barrel. There were linens observed on the floor. CNA G said she had just finished giving Resident #15 a bed bath. She said the dirty linens and towels should have been placed in a plastic bag. She picked up the other linens that were on the floor and placed them in the plastic barrel. She said she had plastic bags in her pants pocket and did not know why she placed the linens on the floor. She said residents could be at risk of slipping or falling if linens were placed on the floor. Record review of a competency evaluation conducted by the ADON on 9/29/2023 for CNA G indicated she was competent with incontinent care and placing soiled linens in a plastic bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/17/2024 at 11:10 AM, the ADON said she had been employed at the facility since September 2021 and was responsible for conducting skills check offs with the staff. She said she did the check offs quarterly that included incontinent care but did hand washing and PPE all the time. She said the last skills check off with staff was conducted in January 2024. She said hand hygiene with incontinent care should be done before and after care, between care and when going from dirty to clean. She said gloves should be changed when going from dirty to clean. She said dirty linens should be put in a plastic bag and placed in the barrel and should not be on the floor. She said residents could be at risk of infections. She said going forward she would continue to train staff and conduct random checks with incontinent care. During an interview on 4/17/2024 at 3:00 PM, the DON and the Administrator said that the DON and ADON were responsible for conducting skills check offs and at a minimum they were conducted annually and quarterly for hand hygiene and PPE. They said they always conducted peri care all the time and as needed. Both said dirty linens should be placed in a bag and barrel and never placed on the floor. The DON said the residents could be at risk of infections. The DON said hand hygiene should be performed before and after care provided and anytime gloves were removed and gloves changed when going from dirty to clean. Going forward she would in-service staff more with teaching and training and would do a spot check daily until improved. The Administrator said they would increase awareness and make several rounds daily. Record review of a facility policy revised on 10/24/2022 titled Hand Hygiene 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 (hand washing or the use of an ABHR) after contact with bodily fluids, such as urine . Record review of a facility policy titled Laundry and Bedding, Soiled revised October 2018 indicated, .Soiled laundry/bedding shall be handled, transported, and processed to best practices for infection prevention and control. 1. All used laundry is handled as potentially contaminated until it is properly bagged and labeled for appropriate processing. a. Soiled laundry and bedding (e.g., personal clothing, gowns, bed sheets, blankets, pillows, towels, etc.) contaminated with blood or other potentially infectious materials is handled as little as possible and with a minimum of agitation. b. Laundry that is contaminated with blood or body substances is placed in leak-proof bags or containers .