STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675434	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Pines Nursing and Rehabilitation Center	503 Old Austin Highway Bastrop, TX 78602

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30633 Based on observation, interviews and record review the facility failed to ensure each resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility for two (Resident #57 and Resident #66) out of seven residents reviewed for dignity. 1.The facility failed to treat Resident #57 with respect and dignity by providing privacy during care when Resident #57 was left exposed after a fall and incontinent episode. 2.The facility failed to treat Resident #66 with respect and dignity when he was left with long untrimmed fingernails which could cause skin breakdown, damage and become a source of infection. This failure could place residents needing assistance at risk for diminished quality of life, loss of dignity, and self-worth. Findings included: Review of the Face Sheet for Resident #57 reflected he was admitted on [DATE] with diagnosis of: COPD, a single Pulmonary Nodule, Atrial Fibrillation, Heart Failure, Type 2 Diabetes, Morbid Obesity, Major Depressive disorder, Acute and Chronic respiratory Failure with Hypoxia, and Obstructive Uropathy. Review of the MDS assessment for Resident #57 dated 3/18/24 reflected a BIMS score of 15 indicating normal cognitive function. His physical assessment reflected he required supervision or one person assistance for all ADLs. He was assessed as occasionally incontinent of bowel and had a Foley catheter in place. Review of the Care Plan for Resident #57 reflected interventions were in place for: drug allergies, DNR status, ADL self-performance deficit r/t Dementia, limited mobility d/t heart failure, refusing to wear BiPAP breathing assist, Diabetes, fall risk, foley catheter, behavior of insomnia, rash to right back r/t herpes zoster (shingles), oxygen therapy, (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation at 10:47 am on 5/21/24 revealed Resident #57 had fallen from his bed to the floor. He was face down on the floor with his brief around his ankles. His catheter remained in place, draining clear yellow urine. LVN C and a NA were at bedside attempting to assist him, and LVN E entered the room. LVN C stated Resident #57 was confused and had become more confused since yesterday. He stated Resident #57 had gone out to hospital for a Shingles infection this weekend and they also diagnosed a UTI. He was receiving antibiotics for both. The Resident stated he had slipped in water at bedside attempting to reach pants on his bedside table. No pants were visible on the bedside table. Resident argued with staff some, as they put down towels to soak up water. In an interview on 5/21/24 at 11:10 am LVN C stated he was summoned to Resident #57's room by a housekeeper who stated he had fallen. LVN stated he had not worked with Resident #57 for a while, but he was definitely more confused than normal. He stated Resident #57 indicated he was not hurt in the fall. LVN C stated Resident #57 was able to sit up and then sat in his wheelchair to transfer back to bed. LVN C stated Resident #57 had cardiac and respiratory problems which limited his ability to perform ADLs. LVN C stated Resident #57 may need to return to the hospital for evaluation. Review of Progress Notes for Resident #57 reflected on 5/23/24 he demonstrated increased level of confusion. On 5/21/24 the resident was sent to the hospital after fall without injury. He was observed by staff on the floor face down, and his brief was around his ankles. Resident #57 stated he had turned off his oxygen concentrator because a doctor was in the room talking to him. Resident #57 was previously sent to the hospital on 5/18/24 for confusion and shaking. In an interview on 5/23/24 at 8:55 am Resident #57 stated he was unsure why he had removed his clothing and his brief prior to his fall. Resident #57 stated he did not recall the fall. He stated his confusion could be related to his UTI or his Shingles outbreak. In an interview on 5/23/24 at 9:30 am LVN D stated Resident #57 had a history of removing his briefs. She stated she was not sure if the behavior was related to his dementia or his recent UTI. In an interview on 5/23/24 at 9:35 am the DON stated the facility had been actively watching Resident #57. She stated he was sent to the hospital the first time for a UTI, but the antibiotics prescribed did not yield the desired effect. She stated he was sent out a second time on 5/21/24 after he fell from bed. The DON stated Resident #57 was monitored because he had a Foley catheter. The DON stated his behavior could be added to care plan pointing out his fall was the first incident of #57 removing his brief she had found. In an interview on 5/23/24 at 11:50 am the Administrator stated Resident #57 came down with a UTI on 5/18/24 and was sent out to hospital. She stated interventions could have been added to deal with his confusion, disrobing behaviors, and other symptoms of the UTI. She stated other than the fall on 5/21/24 no other falls were noted for Resident #57. This state surveyor pointed out he was listed as a high fall risk. The Administrator stated when Resident #57 was observed with his brief down around his ankles or incontinent of bowel, staff should have taken action to protect his dignity. She stated the door should have been closed during care, curtains pulled, and the resident covered. The State Surveyor stated after Resident #57 fell three staff were in the room (C, [NAME], A) and no one took measures to protect the resident's dignity. She stated staff should have responded to the situation wholly. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Face Sheet for Resident #66 reflected he was admitted on [DATE] with diagnosis of: Congestive Heart Failure, Prostate Cancer, Kidney cancer, Schizophrenia, HTN, Glaucoma, and dependence on supplemental Oxygen. Review of the Annual MDS assessment for Resident #66 dated 4/13/24 reflected a BIMS score of 10 or moderate cognitive impairment. His physical assessment reflected he required supervision or one person assistance for most ADLs. Resident #66 was unable to walk, he utilized an electric wheelchair. He was assessed as occasionally incontinent of bowel and bladder. Review of the Care Plan for Resident #66 reflected interventions were in place for: Schizophrenia, Non-compliance with rules and regulations regarding VA contract, ADL self-care deficit, verbally aggressive toward staff, Congestive Heart Failure, fall, risk, and oxygen therapy. In an interview on 5/22/24 at 1:07 pm LVN A stated Residents on hall 100 should have their nails trimmed. She stated Resident #66 had a history of Schizophrenia and could say almost anything. She did not know why his fingernails were long and untrimmed. She stated aides should be trimming resident nails unless otherwise directed. In an interview on 5/22/24 at 10:37 am CNA H stated she was unsure why Resident #66 had long untrimmed fingernails and toenails. She stated she worked mainly on memory care and she stated nails are normally trimmed on shower day. In an interview on 5/22/24 at 3:40 pm the DON stated Resident #66 would refuse to have his fingernails cut and would refuse showers. No progress notes to verify refusing showers or nail cutting were found by the DON as she reviewed records on the facility computer. The behaviors reported by the DON were not found in the care plan. Review of the facility policy Promoting/Maintaining Resident Dignity dated 1/13/23 reflected all staff were involved in providing care to residents and to promote and maintain resident dignity, respect, and resident rights. Staff to maintain resident privacy.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48314 Based on observations, interviews, and record review, the facility failed to provide maintenance services necessary to maintain a safe, orderly, and comfortable homelike environment for five (room [ROOM NUMBER], 451, 460, 461, and 463) of twelve rooms reviewed in the facility's secure unit for environmental conditions. The facility failed to cut down and cap the two mounting bolts that secure the toilet's base to the floor, which ensures that the toilet does not move or leak in room [ROOM NUMBER], 451, 460, and 463. The facility failed to ensure that room [ROOM NUMBER]'s bathroom walls were painted after having two portions of drywall repaired. These failures could place residents at risk of living in an unsafe, unhomelike, and uncomfortable environment. Findings included: Observation on 05/21/2024 at 10:09 AM, room [ROOM NUMBER]'s bathroom toilet had the two base mounting bolts exposed, uncut, and not capped. Observation on 05/21/2024 at 10:19 AM, room [ROOM NUMBER]'s bathroom toilet had the two base mounting bolts exposed, uncut, and not capped. Observation on 05/21/2024 at 10:39 AM, room [ROOM NUMBER]'s bathroom walls had two sections of the drywall that had been repaired but were not repainted to match the rest of the bathroom's paint color. Observation on 05/21/2024 at 10:41 AM, room [ROOM NUMBER]'s bathroom toilet's two base mounting bolts were rusted, exposed, uncut, and not capped. Observation on 05/21/2024 at 12:30 PM, room [ROOM NUMBER]'s bathroom toilet's two base mounting bolts were rusted, exposed, uncut, and not capped. Observations on 05/23/2024 from 8:00 AM through 8:02 AM revealed that room [ROOM NUMBER] and #463's toilet bowl mounting bolts remained exposed, uncut, and not capped, and room [ROOM NUMBER]'s drywall repairs had not been painted. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and observation on 05/23/2024 at 9:38 AM, the Maintenance Director stated that she was responsible for all building maintenance, which included patches, painting, and toilets. The Maintenance Director stated that she has no additional staff under her that assist with maintenance. At 9:44 AM, the Maintenance Director entered the bathroom of room [ROOM NUMBER] and stated that the walls should have been painted after the drywall was patched. The Maintenance Director stated that she repaired and patched the dry wall sections approximately two weeks ago and should have painted them to maintain a homelike environment. At 9:46 AM, the Maintenance Director entered the bathroom of room [ROOM NUMBER] and stated that the exposed toilet mounting bolts should have been cut and covered to prevent residents from hurting themselves on the exposed bolts. Interview and observation on 05/23/2024 at 9:48 AM, the Administrator stated that it was her expectation that the interior and exterior of the facility be safe and maintained in a homelike manner. The Administrator stated that the Maintenance Director was responsible for the overall care of the grounds and resident rooms. At 9:51 AM, the Administrator entered the bathroom of room [ROOM NUMBER] and stated that the toilet mounting bolts should have been cut and covered to prevent resident contact and possible injury. At 9:53 AM, the Administrator entered the bathroom of room [ROOM NUMBER] and stated the dry wall patches should have been painted as soon as they dried to maintain a homelike environment. Review of the facility's undated General Housekeeping Policies revealed, The facility provides sufficient housekeeping and maintenance personnel, equipment, and supplies to maintain the interior and exterior of the facility in a safe, clean, orderly, and attractive manner. Nursing personnel are not assigned to routine housekeeping duties. Review of how-to install a toilet through https://www.[NAME].com/n/how-to/replace-a-toilet revealed, make sure the nuts are firm but don't tighten them too much; the bowl could crack. Then use a [NAME] saw to cut off the excess bolt. Snap on the caps. Further review revealed, toilet bolt caps cover up rusted or protruding toilet floor bolts, which will help update the look of the bathroom and secure safety of your family.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48314 Based on interviews and record review, the facility failed to ensure a resident's assessment was completed within 7 and 14 days, and electronically transmit encoded, accurate, and complete MDS data to the CMS system for a subset of items upon a resident's discharge from the facility for one (Resident #88) of eight residents reviewed for encoding and transmitting resident assessments. The facility failed to complete, encode, and submit a Discharge MDS Assessment for Resident #88. This failure to place discharged residents at risk of not having a proper discharge and not receiving services post discharge. Findings included: Closed record review of Resident #88's Face Sheet, dated 05/23/2024 reflected a [AGE] year-old male admitted to the facility on [DATE] and discharged from the facility on 02/19/2024 with the following diagnoses: Alzheimer's Disease (brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks) and Vascular Dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain). Closed record review of Resident #88's Care Plan initiated on 01/04/2024 revealed, Problem [Resident #88] has a terminal prognosis. admitted to [Hospice Provider] on 1/2/24 Dx: Alzheimer's Disease. Closed record review of Resident #88's undated MDS Assessment list revealed, accepted Entry MDS on 12/22/2023 and an accepted Admission MDS on 1/3/2024. Resident #88's MDS Assessment list did not contain a Discharge MDS Assessment at any stage in the preparation, submission, or acceptance process. Closed record review of Resident #88's Discharge Plan and Summary dated 02/19/2024 revealed that Resident #88 was discharged from the facility at his family's request under hospice care of [Hospice Provider] on 02/19/2024. In an interview on 05/23/2024 at 2:53 PM, the Assessment Nurse stated that she was responsible for MDS Assessments and submissions for residents in the facility. The Assessment Nurse stated that they were required to complete a Discharge MDS Assessment within 14 days of a resident's discharge from the facility. The Assessment Nurse reviewed the electronic MDS records for Resident #88 and stated that it was not accurate. The Assessment Nurse stated that she should have completed and submitted it within 14 days as a Discharge Without Expected Return MDS Assessment for Resident #88. The Assessment Nurse stated that Resident #88's Discharge MDS Assessment was missed. The Assessment Nurse stated that the MDS Assessment and submissions were necessary to ensure that TMHP (Texas Medicaid and Healthcare Partnership) was aware of the resident's status as well as for billing and patient needs documentation. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/23/2024 at 3:00 PM, the DON stated that the Assessment Nurse was responsible for the MDS Assessments and that she signs off on them. The DON stated that she believed the MDS submissions needed to be completed within five days but would need to look up the information to be certain. The DON stated that when a resident was discharged from the facility they must complete and submit a Discharge MDS Assessment. The DON stated that failure to properly and accurately report MDS Assessments could result in billing issues. In an interview on 05/23/2024 at 3:03 PM, the Administrator stated that MDS Assessments must be completed and reported to provide an accurate picture of the resident and for billing purposes. The Administrator stated that the Assessment Nurse was responsible for MDS reporting and that Discharge MDS Assessments should be completed within seven days. The Administrator reviewed the MDS Assessment list for Resident #88 and stated they failed to submit a Discharge MDS Assessment for Resident #88 and should have done so. Review of the facility's Assessment Frequency / Timeliness policy dated 10/24/2022 revealed, Policy: The purpose of this policy is to provide a system to complete standardized assessments in a timely manner, according to the current RAI Manual. Policy Explanation and Compliance Guidelines: 1. The MDS/RAI Coordinator will be responsible for tracking due dates for all MDS assessments, including OBRA and Medicare PPS assessments. 6. An OBRA discharge assessment will be completed within 14 days of the discharge date .

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49099 Based on interviews and record review, the facility failed to ensure all PASARR- Level I positive residents diagnosed with mental illness were provided with a PASARR- Level II Screening for 1 of 3 residents (Resident #70) reviewed for mental illness, intellectual disability, or developmental disability. The facility failed to ensure Resident #70 received a PASARR Level 2 evaluation. This failure could place residents at risk for not receiving necessary mental health services and causing a possible decline in mental health. Findings included: Record review of Resident #70's face sheet dated 05/23/24 revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of nontraumatic intracerebral hemorrhage-unspecified (also known as intracranial bleed is bleeding within the skull), hemiplegia (one sided paralysis) and hemiparesis (partial weakness on one side of the body) following unspecified cerebrovascular disease (a group of conditions that affect blood flow and the blood vessels in the brain) affecting left dominant side, and bipolar disorder-unspecified (a mental health condition that causes extreme mood swings between emotional highs and lows). Record review of Resident #70's MDS assessment dated [DATE] revealed a BIMS score of 13 suggesting cognition intact. Section I of the MDS assessment reflected active diagnosis of anxiety disorder, depression, and bipolar disorder. Record review of Resident#70's care plan reflected: [Resident #70] uses psychotropic medications related to anxiety, insomnia, depression, bipolar disorder, and hallucinations. Initiated 11/12/22, last revised 11/22/23. The relevant interventions were Administer psychotropic medications as order by physician. Monitor for side effects and effectiveness every shift. Consult with pharmacy, MD to consider dosage reduction when clinically appropriate at least quarterly. Discuss with MD, family ongoing need for the use of medication. Review behaviors/ interventions and alternate therapies attempted and their effectiveness as per facility policy. Educate the resident/ family/ caregivers about risks, benefits, and the side effects and/ or toxic symptoms of psychotropic medication drugs being given. Initiated 11/15/22. Record review of Resident #70's PASARR-Level 1 screening dated 11/15/22 read in part, is there evidence or an indicator this is an individual that has a Mental Illness? The answer was: Yes. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/23/24 at 01:02 PM with the Assessment Nurse, she stated that after looking for Resident #70's PASARR level 2 assessment she determined that the level 2 assessment was not completed for Resident #70. The Assessment Nurse said it would have been her responsibility to ensure that the level 2 assessment was completed to determine if Resident #70 would have qualified for additional services. The Assessment Nurse stated she would complete and submit the appropriate documentation in order for a QMHP to come evaluate Resident #70 and determine if she qualified for additional services. In an interview on 05/23/24 at 02:00 PM with the DON, she stated it was her expectation that PASARR screenings were completed on admission and that positive level 1 screenings have a level 2 completed. The DON stated it was the responsibility of the Assessment Nurse to complete the PASARR screenings and ensure accuracy. She stated a potential negative outcome could be residents would miss additional mental health services. In an interview on 05/23/24 at 02:15 PM with the Administrator, she stated it was her expectation that PASARR level 1 screenings were done upon admission and that residents were referred the same day for a level 2 screening if positive on the level 1. The Administrator stated it was the responsibility of the Assessment Nurse to ensure level 2 screenings were completed. She stated a negative outcome to not completing a PASARR would be the potential for a resident to not have additional needed services. The facility PASARR policy was requested 05/23/24 at 03:00 PM and The Administrator stated there was not a PASARR policy.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30633 Based on observations, record review, and interviews the facility failed to update one (Resident #57) out of seven residents reviewed for care plan in relation to changes in health, changes in behavior and significant changes. The facility failed to update Resident #57's care plan and adjust it r/t physician orders or behaviors. The deficient practice could affect residents by delaying treatment, care, and services that could result in residents not attaining or maintaining their highest practicable physical, mental, and psychosocial well-being. Findings included: Review of the Face Sheet for Resident #57 reflected he was admitted on [DATE] with diagnosis of: COPD, a single Pulmonary Nodule, Atrial Fibrillation, Heart Failure, Type 2 Diabetes, Morbid Obesity, Major Depressive disorder, acute and chronic respiratory failure with hypoxia, and obstructive uropathy. Review of the MDS assessment for Resident #57 dated 3/18/24 reflected a BIMS score of 15 indicating normal cognitive function. His physical assessment reflected he required supervision or one person assistance for all ADLs. He was assessed as occasionally incontinent of bowel and had a Foley catheter in place. Review of the Care Plan for Resident #57 reflected interventions were in place for: drug allergies, DNR status, ADL self-performance deficit r/t Dementia, Limited mobility d/t heart failure, Refusing to wear BiPAP breathing assist, Diabetes, Fall Risk, Foley catheter, behavior of Insomnia, Rash to right back r/t Herpes zoster (Shingles), Oxygen therapy. No changes related to diagnosis of UTI, Antibiotics or confused behaviors. Review of Progress Notes for Resident #57 reflected on 5/23/24 he demonstrated increased level of confusion. On 5/23/24 the Nurse Practitioner changed the antibiotic for the UTI to Cipro 500 mg twice a day. On 5/21/24 the resident was sent to hospital after a fall without injury. He was observed by staff on the floor face down and his brief was around his ankles. Resident #57 stated he had turned off his oxygen concentrator because a doctor was in the room talking to him. On 5/20/24 the resident was continued on Keflex antibiotic 500 mg every 12 hours and Valacyclovir 500 mg every 8 hours for Shingles. On 5/19/24 Resident #57's antibiotic was changed to Keflex 500 mg every 12 hours for UTI. Resident #57 was previously sent to hospital on 5/18/24 for confusion and shaking. On 5/21/24 at 9:25 Resident#57 was observed lying in bed incontinent of stool with his brief pulled down exposing his buttocks. Resident did not respond to voice. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation at 10:47 am on 5/21/24 revealed Resident #57 had fallen from his bed to the floor. He was face down on the floor with his brief around his ankles. His catheter remained in place, draining clear yellow urine. Two staff were at bedside attempting to assist him. LVN C and a NA, Charge Nurse/ LVN E entered the room. He stated Resident #57 was confused and had become more confused since yesterday. He stated Resident #57 had gone out to hospital for a Shingles infection this weekend and they also diagnosed a UTI, he was receiving antibiotics for both. The Resident stated he had slipped in water at bedside attempting to reach pants on his bedside table. No pants were visible on the bedside table. Resident argued with staff some as they put down towels to soak up water. The charge nurse stated Resident #57 may need to return to hospital for evaluation. In an interview on 5/21/24 at 11:10 am LVN C stated he was summoned to Resident #57's room by a housekeeper who stated he had fallen. LVN C stated he had not worked with Resident #57 for a while, but he was definitely more confused than normal. He stated Resident #57 indicated he was not hurt in the fall. LVN C stated Resident #57 was able to sit up and then sat in his wheelchair to transfer back to bed. LVN C stated Resident #57 had cardiac and respiratory problems which limited his ability to perform ADLs. In an interview on 5/23/24 at 8:55 am Resident #57 stated he was unsure why he had removed his clothing and his brief prior to his fall. Resident #57 stated he did not recall the fall; he stated his confusion could be related to his UTI or his Shingles outbreak. Observation revealed his Foley catheter was draining clear yellow urine. Resident #57 was receiving a breathing/nebulizer treatment at the time of the interview. In an interview on 5/23/24 at 9:30 am LVN A stated Resident #57 had a history of removing his briefs. She stated she was not sure if the behavior was related to his dementia or his recent UTI. In an interview on 5/23/24 at 9:35 am the DON stated the facility had been actively watching Resident #57. She stated he was sent to hospital the first time for a UTI, but the antibiotics prescribed did not yield the desired effect. She stated he was sent out a second time on 5/21/24 after he fell from bed. The DON stated Resident #57 was monitored because he had a Foley catheter. The DON stated his behavior could be added to care plan pointing out his fall was the first incident of #57 removing his brief she had found. The DON stated staff should have followed policy and covered Resident #57 to protect his dignity. In an interview on 5/23/24 at 11:50 am the Administrator stated Resident #57 came down with a UTI on 5/18/24 and was sent out to hospital. She stated interventions could have been added to deal with his confusion, disrobing behaviors and other symptoms of the UTI. She stated other than the fall on 5/21/24 no other falls were noted for Resident #57, the surveyor pointed out he was listed as a high fall risk. The Administrator stated when Resident #57 was observed with his brief down around his ankles or incontinent of bowel staff should have taken action to protect his dignity. She stated the door should have been closed during care, curtains pulled, and the resident covered. Surveyor stated after Resident #57 fell three staff were in the room (C, [NAME], A) and no one took measures to protect the resident's dignity. She stated staff should have responded to the situation wholly. Review of the Facility's Care Plan Development Policy dated October 2022 reflected the care plan must be updated within 7 days of a comprehensive MDS assessment. The facility's rational for proceeding with care planning will be evidenced in the clinical record (such as a change in condition).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675434	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Pines Nursing and Rehabilitation Center	503 Old Austin Highway Bastrop, TX 78602

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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** 30633 Based on observations, record review, and interviews the facility failed to update the Resident's (#57) care plan in relation to changes in health, changes in behavior and significant changes for one (Resident #57) out of 8 residents reviewed. The facility failed to update Resident #57's care plan and adjust it in relation to physician orders. The deficient practice could affect residents by delaying treatment, care, and services that could result in residents not attaining or maintaining their highest practicable physical, mental, and psychosocial well-being. Findings included: Review of the Face Sheet for Resident #57 reflected he was admitted on [DATE] with diagnosis of: COPD, a single Pulmonary Nodule, Atrial Fibrillation, Heart Failure, Type 2 Diabetes, Morbid Obesity, Major Depressive disorder, acute and chronic respiratory failure with hypoxia, and obstructive uropathy. Review of the MDS assessment for Resident #57 dated 3/18/24 reflected a BIMS score of 15 indicating normal cognitive function. His physical assessment reflected he required supervision or one person assistance for all ADLs. He was assessed as occasionally incontinent of bowel and had a Foley catheter in place. Review of the Care Plan for Resident #57 reflected interventions were in place for: drug allergies, DNR status, ADL self-performance deficit r/t Dementia, Limited mobility d/t heart failure, Refusing to wear BiPAP breathing assist, Diabetes, Fall Risk, Foley catheter, behavior of Insomnia, Rash to right back r/t Herpes zoster (Shingles), Oxygen therapy. No changes related to diagnosis of UTI, Antibiotics or confused behaviors. Review of Progress Notes for Resident #57 reflected on 5/23/24 he demonstrated increased level of confusion. On 5/23/24 the Nurse Practitioner changed the antibiotic for the UTI to Cipro 500 mg twice a day. On 5/21/24 the resident was sent to hospital after a fall without injury. He was observed by staff on the floor face down and his brief was around his ankles. Resident #57 stated he had turned off his oxygen concentrator because a doctor was in the room talking to him. On 5/20/24 the resident was continued on Keflex antibiotic 500 mg every 12 hours and Valacyclovir 500 mg every 8 hours for Shingles. On 5/19/24 Resident #57's antibiotic was changed to Keflex 500 mg every 12 hours for UTI. Resident #57 was previously sent to hospital on 5/18/24 for confusion and shaking. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview at 10:47 am on 5/21/24 revealed Resident #57 had fallen from his bed to the floor. He was face down on the floor with his brief around his ankles. His catheter remained in place, draining clear yellow urine. Two staff were at bedside attempting to assist him. LVN C and a NA, LVN E entered the room. He stated Resident #57 was confused and had become more confused since yesterday. He stated Resident #57 had gone out to hospital for a Shingles infection this weekend and they also diagnosed a UTI, he was receiving antibiotics for both. The Resident stated he had slipped in water at bedside attempting to reach pants on his bedside table. No pants were visible on the bedside table. Resident #57 argued with staff some as they put down towels to soak up water. In an interview on 5/21/24 at 11:10 am LVN C stated she was summoned to Resident #57's room by a housekeeper who stated Resident #57 had fallen. LVN C stated he had not worked with Resident #57 for a while, but he was definitely more confused than normal. He stated Resident #57 indicated he was not hurt in the fall. LVN C stated Resident #57 was able to sit up and then sat in his wheelchair to transfer back to bed. LVN C stated Resident #57 had cardiac and respiratory problems which limited his ability to perform ADLs. The LVN C stated Resident #57 may need to return to hospital for evaluation. In an interview on 5/23/24 at 8:55 am Resident #57 stated he was unsure why he had removed his clothing and his brief prior to his fall. Resident #57 stated he did not recall the fall; he stated his confusion could be related to his UTI or his Shingles outbreak. Observation revealed his Foley catheter was draining clear yellow urine. Resident #57 was receiving a breathing/nebulizer treatment at the time of the interview. In an interview on 5/23/24 at 9:30 am LVN A stated Resident #57 had a history of removing his briefs. She stated she was not sure if the behavior was related to his dementia or his recent UTI. In an interview on 5/23/24 at 9:35 am the DON stated the facility had been actively watching Resident #57. She stated he was sent to hospital the first time for a UTI, but the antibiotics prescribed did not yield the desired effect. She stated he was sent out a second time on 5/21/24 after he fell from bed. The DON stated Resident #57 was monitored because he had a Foley catheter. The DON stated his behavior could be added to care plan pointing out his fall was the first incident of #57 removing his brief she had found. The DON stated staff should have followed policy and covered Resident #57 to protect his dignity. In an interview on 5/23/24 at 11:50 am the Administrator stated Resident #57 came down with a UTI on 5/18/24 and was sent out to hospital. She stated interventions could have been added to deal with his confusion, disrobing behaviors and other symptoms of the UTI. She stated other than the fall on 5/21/24 no other falls were noted for Resident #57, the surveyor pointed out he was listed as a high fall risk. The Administrator stated when Resident #57 was observed with his brief down around his ankles or incontinent of bowel staff should have taken action to protect his dignity. She stated the door should have been closed during care, curtains pulled, and the resident covered. Surveyor stated after Resident #57 fell three staff were in the room (C, [NAME], A) and no one took measures to protect the resident's dignity. She stated staff should have responded to the situation wholly. Review of the Facility's Care Plan Development Policy dated October 2022 reflected the care plan must be updated within 7 days of a comprehensive MDS assessment. The facility's rational for proceeding with care planning will be evidenced in the clinical record (such as a change in condition).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on observations, interviews, and record review, the facility failed to have all residents receive treatment and care in accordance with professional standards of practice, the comprehensive care plan, for 1 of 3 (Resident # 54) residents reviewed for edema care. The facility failed to follow physician orders, the comprehensive care plan, and provide treatment for Resident #54's edema. This failure could place residents at risk for untreated medical issues and diminished quality of care. Findings included: Record review of Resident # 54's face sheet dated 05/22/2024 reflected a [AGE] year-old-female admitted on [DATE] and readmitted on [DATE] with a diagnoses of pain in the right foot (a localized or generalized unpleasant bodily sensation or complex of sensations that causes mild to severe physical discomfort), need for assistance with personal care (anything that a person needs to maintain hygiene, well-being, self-esteem, and dignity), essential hypertension (is often due to obesity, family history, and an unhealthy diet), and hemiplegia unspecified affecting right dominant side (paralysis or the right side of the body after injury to the brain or spinal cord). Record review of Resident #54's Quarterly MDS assessment dated [DATE] reflected Resident #54 had a BIMS score of 9, which indicated moderately impaired cognition. Resident #54 was assessed for not rejecting care. She required assistance with ADLs such as: personal hygiene, toileting, showers, upper and lower body dressing, putting on/taking off footwear, transfers, and oral hygiene. Record review of Resident #54's Comprehensive Care Plan revised on 05/14/2024 reflected Resident #54 had ADL self -care performance deficit related to impaired balance and limited mobility. Intervention: resident required assistance with bathing, bed mobility, dressing, eating, personal hygiene, toileting, and transfers. Resident #54 had hypertension and was at risk for hypotensive (blood pressure suddenly becomes low) or hypertensive crisis (blood pressure suddenly becomes high). Intervention: give medications as ordered. Monitor for and document any edema. Resident #54 was assessed to require diuretic therapy related to edema. Interventions: Administer diuretic medications as ordered. Compression socks one time a day for BLE edema (date initiated on 03/21/2024). Observation on 05/21/2024 at 9:50 AM revealed Resident #54 was lying in bed in her room. She kept pointing to her feet. Resident's right foot and right leg had edema. In an interview on 05/21/2024 at 9:52 AM Resident #54 stated yes when asked if her leg felt swollen. Resident #54 would only respond to yes/ no type questions. She stated no when asked if she was in pain. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on 05/21/2024 at 11:05 AM of Resident #54's Physician Orders last review date of 05/08/2024 reflected Resident #54 had edema with a start date of 12/13/2023. She also had a physician order for compression socks -Large, 10mmHG compression- on in the AM, off in the PM (start date 03/02/2024). Record review on 05/21/2024 at 11:15 AM of Resident #54's Skilled Administration Record in the electronic medical record dated 05/01/reflected Resident #54 was scheduled to have compression socks (large, 10mmHG compression -in the AM, off in the PM. One time a day for BLE edema and remove per schedule. Apply 7:00 AM and Remove 7:00 PM start date 03/02/2024. It was documented on 5/21/2024 a nurse applied compression socks on Resident #54 at 7:00 AM. Observation on 05/21/2024 at 11:24 AM revealed Resident #54 was sitting outside on the front porch. She had on bright yellow non-skid house sock on her right leg. She was not wearing compression socks on her left or her right leg. Resident #54's right leg was swollen and was propped on the wheelchair leg rest. Resident #54 will respond to yes/no type questions. However, she does not elaborate on any of her responses. In an interview on 05/21/2024 at 11:26 AM Resident #54 stated no when asked if she was wearing her hose/socks to prevent her legs from swelling. She also stated no when asked if she refused to wear the compression socks or did someone take the compression socks off of her earlier in the day. She did not respond to any other questions about the staff or her compression socks. Observation on 05/21/2024 at 1:53 PM Resident #54 revealed she was sitting in her wheelchair on the front porch. The activity director was asking Resident #54 if she wanted to attend bingo. Resident #54 was wearing a bright yellow nonskid sock on her right leg. Resident #54's right leg was swollen. In an interview on 05/21/2024 at 1:55 PM the Activity Director stated the sock Resident #54 was wearing on her right leg was a non-skid sock to keep her from falling. Observation on 05/21/2024 at 3:55 PM revealed Resident #54 was sitting in her wheelchair on the front porch wearing bright yellow non-skid sock on her right leg. Observation and interview on 05/22/2024 at 7:15 AM revealed Resident #54 was in bed and kept pointing to her feet. She was not wearing her compression socks. Resident #54 stated no when asked if she was in pain. She also stated yes when asked if she wore special hose for her feet and legs to help with the swelling. She stated no when asked if the staff placed the hose on her every day. Resident #54 did not respond to other questions about the hose or how many days she did not wear the compression socks. She stated no when asked if she was wearing the hose yesterday. Observation and interview on 05/22/2024 at 8:05 AM revealed Resident #54 was in bed and pointed to her feet. She was not wearing her compression socks. Her right leg was swollen. Resident #54 stated no when asked if she was in pain. She stated no when asked if anyone offered to place the socks on her feet to keep them from swelling. Resident #54 stated yes when asked if she wore special compression socks. She stated yes when asked if the compression socks were white. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on 5/22/2024 at 9:10 AM of Resident #54's Skilled Administration Record in the electronic medical record dated 05/2024 reflected Resident #54 was scheduled to have compression socks (large, 10mmHG compression -in the AM, off in the PM. One time a day for BLE edema and remove per schedule. Apply 0700 AM and Remove 1900 PM start date 03/02/2024. A nurse did not document compression socks were applied to Resident #54's right and left legs. Observation and interview on 05/22/2204 at 9:15 AM revealed Resident #54 was lying in bed and was not wearing compression socks. Resident #54 stated no when asked if anyone came in her room to offer to place her compression socks on her feet to help with her feet and legs from swelling. She smiled and stated, no no no. When asked her what color the socks were to keep her feet from swelling, she stated white. Resident #54 stated no when asked if she refused today not to wear the compression socks. Observation and interview on 05/22/2024 at 9:47 AM revealed Resident #54 was lying in bed. She was not wearing compression socks. Resident #54's right leg was swollen. She stated no when asked if she was in pain. Resident #54 stated no when asked if anyone attempted to place her socks on her feet to keep them from swelling. She also stated white when asked the color of the socks the nurses placed on her feet to prevent her feet from swelling. Observation and interview on 05/22/2024 at 10:53 AM revealed Resident #54 was sitting outside in her wheelchair. Her right foot was propped on the wheelchair leg rest. Resident #54 was wearing a bright pink non-skid sock. Resident #54 stated no when asked if this was the sock the nurses put on to keep her feet from swelling. She stated color white when asked what color the socks were, that she wore to keep feet and legs from swelling. Resident #54 stated no when asked if anyone had attempted to put the white color socks on her feet prior to placing the pink sock on her right foot. Record review on 05/22/2024 at 12:30 PM of Resident #54's reflected Skilled Administration Record in the electronic medical record dated 05/24/2024 reflected Resident #54 was scheduled to have compression socks (large, 10mmHG compression -in the AM, off in the PM. One time a day for BLE edema and remove per schedule. Apply 0700 AM and Remove 7:00 PM start date 03/02/2024. It was documented on 5/22/2024 LVN A applied compression socks on Resident #54 at 7:00 AM. Observation and interview on 05/22/2024 at 12:50 PM Resident #54 was sitting outside on the front porch in her wheelchair. Her right foot was not propped on the wheelchair leg rest. Her right foot was swollen, and she had an indention in her right leg where the top of the non-skid sock was located on her leg (approximately 6 inches above her right ankle). Resident #54 stated no when asked if she was in pain. She stated no when asked if anyone attempted to place the white socks to prevent her legs from swelling on her feet today. She also stated no when asked if she refused wearing the white socks yesterday or today. Observation and interview on 05/22/2024 at 1:00 PM LVN A observed Resident #54 (sitting on the front porch) feet and legs. She stated the pink sock was a non-skid sock the residents wear to prevent falls. LVN A stated Resident #54 wore these socks frequently. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/22/2024 at 1:04 PM LVN A stated Resident #54 was expected to wear compression socks on both feet. She stated Resident #54's order was to place the compression socks on both feet at 7:00 AM and remove the compression socks at night. LVN A stated she did not observe Resident #54 prior to documenting she applied the compression socks on 05/22/2024. She also stated she did not know whether Resident #54 had the compression socks on her feet or not when she documented on the electronic medical form. LVN A stated she was required to observe Resident #54 and place the compression socks on her feet. LVN A stated she became busy and forgot to go observe Resident #54 and documented she had the compression socks on her feet. LVN A stated it was her responsibility to place the compression socks on Resident #54. She also stated she made a mistake, and she was responsible for Resident #54 not having the compression socks on both feet. LVN A also stated Resident #54's right leg was swollen and there was an indent in her right leg at the top of where the nonskid sock was located on the right leg. LVN A stated if Resident #54 did not wear compression socks there was a possibility her leg may become more swollen, she may develop a wound, and/or she may have severe pain. LVN A stated Resident #54 may need to be transferred to the hospital for further evaluation. She also stated if Resident #54 had compression socks on the staff would not remove the socks without consulting with her. She stated no one had reported to her they applied the compression socks or removed the compression socks. LVN A stated Resident #54 did not have on the compression socks. She also stated she was not aware of Resident #54 refusing to wear compression socks. She stated if a resident refused care it would be documented in the nurses' notes, on their care plan, and on the MAR or the skilled administration record. LVN A also stated Resident #54 loved to sit outside and she did not always keep her right foot on the wheelchair footrest. She stated with Resident #54 sitting outside and not wanting to leave her foot on the footrest. This was also an issue due to Resident #54's feet and legs become more swollen and the compressed socks would help prevent her legs from swelling. LVN A stated she did not follow Resident #54's physician order or care plan on 5/22/2024. She stated the compression socks color was white. In an interview on 05/22/2024 at 1:46 PM the Assessment Nurse stated all nurses were required to follow physician orders. She stated if Resident #54 had a physician order to wear compression hose on BLE the nurses were expected to follow the physician order. She also stated if it was on the skilled administration record to apply the compression hose at 7:00 AM, the nurse was expected to apply the compression socks at the following times between 6:00 AM and 9:00 AM. She stated the nurse had an hour before and hour after 7:00 AM to apply the compression socks. She also stated if Resident #54 was not wearing her compression socks there was a potential Resident #54 may develop a wound or may have redness on the skin of her legs and feet. Assessment Nurse also stated if Resident #54 refused to wear the compression socks it would be documented in the nurses' notes, care plan, and the skilled administration record. She stated she was not aware of Resident #54 refusing to wear compression socks. She stated anytime a resident refused any type of care including compression socks it would be discussed during the morning meeting. She stated she would document on Resident #54's care plan she refused to wear compression socks. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/22/2024 at 2:20 PM The Director of Nurses stated her expectations were all nurses to follow the physician orders at all times. She stated LVN A was expected to observe Resident #54 prior to documenting anything on the skilled administration record if the compression socks had been applied to Resident #54. She stated it was her expectation for the nurse to apply the compression socks to Resident #54. The Director of Nurses also stated LVN A did not follow the physician orders or the care plan. She stated it was imperative for all Residents to receive the care the physician had ordered every day. The Director of Nurses also stated if Resident #54 was not wearing her compression socks there was a possibility Resident #54's edema on her legs and feet might become worse and she may develop a wound. She stated it was her responsibility to monitor the nurses. The Director of Nurses also stated if Resident #54 refused to wear the compression socks the nurse would document the refusal on the skilled administration record. She stated the nurses would document it in the nurses notes if Resident #54 wanted the compression socks off her feet during the day. She stated it was her expectations for all refusals to be documented in the electronic medical record on the appropriate form and in the nurses' notes. She stated she was not aware of Resident #54 refusing to wear compression socks. She stated she would look to find a policy for not following physician orders. (Policy not provided at time of exit). Record review of Resident #54's Nurses Notes on 05/23/2024 at 8:15 AM reflected Resident #54 did not refuse compression socks for the month of May 2024, and she did not ask anyone to remove the compression socks. In an interview on 05/23/2024 at 9:16 AM the Administrator stated all nurses were expected to follow the physician orders. She stated if there was an issue with the resident not complying with the physician order, the nurse was expected to call the physician and document accordingly. The Administrator stated LVN A was expected to visibly see Resident #54 to ensure Resident #54 was wearing compression socks prior to documenting the compression socks had been applied to Resident #54. She also stated if Resident #54 was not wearing compression socks there was a potential for her legs to increase with swelling and Resident #54 may develop discomfort to her legs. She stated it was the Director of Nurses responsibility to monitor the nurses and it was her responsibility to monitor all staff. In an interview on 05/23/2024 at 10:30 AM CNA E stated she had not observed Resident #54 refusing compression socks. She stated she did not notice if Resident #54 had compression socks on today. She stated the nurse usually placed the compression socks on Resident #54. In an interview on 05/23/2024 at 10:44 AM LVN B stated he had not witnessed Resident #54 refusing compression socks. He stated he was not assigned to Resident #54's hall today and did not know if she was wearing compression socks.

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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** 30633 Based on observations, interviews, and record review the facility failed to ensure the environment remains as free of hazards as is possible and each resident received adequate supervision and assistance devices to prevent accidents for one (Resident #71) out of eight residents reviewed. The facility failed to safely and securely store mouthwash and hand sanitizer in Resident #71's room. The deficient practice could affect residents by delaying treatment, care, and services that could result in residents not attaining or maintaining their highest practicable physical, mental, and psychosocial well-being. Findings included: Review of the face sheet for Resident #71 reflected he was admitted to the facility on [DATE] with diagnoses of: Unspecified Dementia, High Blood Pressure, Chronic Atrial fibrillation, and Bilateral Osteoarthritis of hips. Review of the quarterly MDS assessment for Resident #71 dated 3/04/24 reflected a BIMS score of 5 indicating severe cognitive impairment. His physical assessment reflected he needed one person assistance or supervision for all ADLs and two-person assistance for transfers. He was ambulating with a wheelchair and unable to walk. He was assessed as occasionally incontinent of bowel and bladder. Review of the Care Plan for Resident #71 reflected interventions were in place for: DNR status, assistance getting up and out of bed, Dementia, poor vision, refuses showers at times, and high fall risk. Resident #71 had risks associated with ADL deficits and cognitive impairment. No interventions related to supervision or safety were noted. In an interview on 5/21/24 at 10:19 am Resident #71 stated some staff were better than others at their job. Observation of the room revealed a large bottle of mouthwash on his nightstand and a bottle of hand sanitizer nearby. Observation of Resident #71's room on 5/22/24 at 10:45 am revealed he had a 1.5-liter bottle of Mouthwash (generic) with a warning sticker which stated keep out of reach of children. His room also contained a 295 ml bottle of hand sanitizer, with the warning label keep out of reach of children. In an interview of 5/22/24 at 11:30 am a Hospitality Aide (HA) stated she had not observed anything in resident's rooms that might be a hazard to residents. When asked if she had seen any mouthwash, hand sanitizer, or over the counter medications in any room, she stated no. HA stated if any sharps or hazardous materials were seen the aides were to remove them to a safe storage area. She stated she worked on halls 100 and 200 but had only been in the facility two weeks. (continued on next page)

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	675434	A. Building B. Wing	05/23/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/22/24 at 1:07 pm LVN A stated Resident #71 may have received the hand sanitizer and mouth wash from his family. She stated some residents were allowed to have mouthwash with supervision. She stated Resident #71 was pretty well oriented. LVN A stated in general the residents should not have mouthwash and hand sanitizer in their rooms. In an interview on 5/22/24 at 2:21 pm LVN B stated his understanding was no resident should have mouthwash, hand sanitizer, or potentially hazardous substances in their room. He stated no confused residents would be allowed to have hand sanitizer or mouthwash in their room. He stated any resident who ingested such things would be taken to hospital immediately for treatment of poisoning. In an interview on 5/22/24 at 3:35 pm Resident #71 stated he had no idea where the mouthwash and hand sanitizer in his room had come from. He stated he could not remember when they arrived or who had brought them to him. The observation revealed the mouthwash and hand sanitizer had been removed from his room. In an interview on 5/22/24 at 3:40 pm the DON stated Resident #71 and all other residents were banned from having mouthwash with alcohol in their rooms. She stated hand sanitizer was considered a hazardous substance and not allowed in rooms. In an interview on 5/23/24 at 10:03 am CNA F stated Resident #71 was usually well oriented and responded correctly to questions. She stated he was hard of hearing but not confused. She stated Resident #71 usually stayed in his room. She stated his wife and son visited a few times a week, but she had not seen them bring in any mouthwash or hand sanitizer. In an interview on 5/23/24 at 11:50 am the Administrator stated the staff had responded to the state surveyor inquiries about mouthwash and hand Sanitizer in Resident #71's room. She stated potentially hazardous or poisonous materials should not be left with residents. She stated visitors sometimes bring them in. The Administrator stated after the state surveyor pointed out the hazards, the facility performed a sweep, removed care items from resident rooms, notified RP's, and provided education on items which may be safely brought to the facility.

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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** 40884 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute food in accordance with professional standards for food service safety for one of one kitchen reviewed for kitchen sanitation. 1. The facility failed to properly label food and store food by not sealing/covering food items. in one of one walk in refrigerators and dry storage shelves located in the kitchen. 2. The facility failed to ensure a visitor wore a hair net and a beard guard when he entered the kitchen from the exit side door leading to the outside near parking area. These failures placed residents at risk for health complications and foodborne illnesses. Findings included: 1. Observation on [DATE] at 9:02 AM reflected the following food and drinks were not covered and/or not labeled in the walk-in refrigerator: - Leftover chicken in a white container dated ,d+[DATE] was not covered. - Two bowls of pureed fruit and two bowls of pureed bread pudding not covered or labeled and dated. The pureed fruit had a brownish color crust around the edges of the fruit. - Three trays with approximately 15 bowls of fruit on each tray not labeled or dated - Leftover boiled eggs in a container not labeled or dated. Observation on [DATE] at 9:15 AM on the dry storage shelf next to the oven reflected a large container of brown sugar not labeled or dated. A large clear plastic bag opened dated [DATE] had the following items in the clear bag: - An opened chicken gravy packet - the date was smeared and was unable to read the date. - An opened biscuit gravy mix packet dated [DATE]. - An opened chili seasoning mix packet dated [DATE]. - An opened brown gravy mix dated [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation on [DATE] at 9:25 AM a male Visitor J entered the kitchen from the kitchen side door from the outside of the facility near the parking area. He had long hair passed his shoulders and a long beard below his neck. The male visitor did walk by the food prep table near the stove and walked by clean dishes on another food prep table in the main kitchen area. There were hair nets and did not observe any beard guards near the door. In an interview on [DATE] at 9:27 AM Visitor J stated he never wore a hair net or beard guard when he entered the kitchen. He stated he came to the facility a few times per week. He also stated he was a contractor but did not respond to what he was working on in the kitchen . Visitor J never donned a beard net or hair net when in the kitchen. In an interview on [DATE] at 9:33 AM the Dietary Aide K stated all food was expected to be labeled and dated. She stated if there was any leftover food such as boiled eggs and they did not know when the boiled eggs were placed in the refrigerator, it was a possibility the boiled eggs may be spoiled. She also stated if the boiled eggs were served to a resident there was a potential the resident might become sick with food poisoning. She stated she had been in-serviced on labeling and dating foods and not to leave any containers opened. She stated the visitor came into the kitchen several times. She did not answer what repairs he was doing in the kitchen. In an interview on [DATE] at 9:00 AM the Dietary Manager stated the chicken was expected to be covered. She stated all left over foods were to be dated, covered, or sealed. She stated all foods were required to be labeled and dated. The Dietary Manager stated if a date was smeared the item was to be discarded. She stated she discarded all the packets with the different dates in the clear plastic bag. She stated the dates on the packets did not match the dates on the clear plastic bag. She also stated the gravy mix, seasoning, and biscuit mix needed to be discarded and not used in the food due to being expired. She also stated the boiled eggs was expected to be labeled, dated, and covered. The dietary manager stated the visitor in the kitchen on [DATE] was not a contractor. She stated he previously worked at another facility owned by the same company on the same road as this facility. She stated he came in the kitchen several times per week and would bring a bucket to get food scraps for his chickens. She also stated he was informed by her to wear a hair net and beard guard when he entered the kitchen. The Dietary Manager stated he would wear a baseball cap sometimes, but it did not cover all his hair. She stated the hair net and beard policy applied to anyone entered the kitchen. The Dietary Manager stated hair could fall onto plates or food if someone was not wearing a hair net or beard guard. She stated if hair was on the food or plate and a resident ingested the hair, there was a potential a resident may become ill with some type of stomach illness. She stated there was bacteria on people's hair and hair was considered contaminated. She also stated if the left-over food had been in the refrigerator for over a week and the staff served the food to the residents, there was a possibility the resident may become physically ill with food poisoning. She stated she did an in-service for the dietary staff on labeling, dating, and covering leftover foods. She stated any foods that have been in the refrigerator or anywhere over 72 hours was expected to discard the food. She stated if there was not a date on when the leftover food was placed in the refrigerator, the staff were expected to discard the food immediately. The dietary manager stated there were beard guards and hair nets beside the door. (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 on [DATE] at 9:16 AM the Administrator stated she expected all foods to be covered, sealed, and with the correct label. She stated there was potential a resident may become physically ill such as food poisoning. She stated it was possible for a resident to have symptom of vomiting. The Administrator also stated anyone that enters the kitchen, including visitors, were expected to wear a hair net. She stated if the visitor was a male and had a beard, he was expected to wear a beard net. She stated hair was considered contaminated. The Administrator also stated if a resident ingested the hair the resident may become sick with some type of stomach issue. She stated a person that did not work at the facility or was in the facility to do any type of contract work was not allowed in the kitchen for any reason. She stated the visitor was not a contractor. The Administrator stated he was not to be allowed to walk into the kitchen to get food scraps. She stated the Dietary Manager was responsible to monitor the kitchen and she was over the Dietary Manager. Record review of the Facility's Policy on Food Storage, revised on [DATE], reflected refrigerators: date, label, and tightly seal all refrigerated foods. To ensure freshness, store opened, and bulk items in tightly covered containers. All containers must be labeled and dated. Record review of the Facility's Policy on Employee Sanitation, dated [DATE], reflected hairnets, head bands, caps, beard coverings, or other effective hair restraints must be worn to keep hair from food and food-contact surfaces. 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

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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. 49099 Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communication diseases and infections. AD and CNA I failed to use proper hand hygiene techniques when assisting 2 unidentified residents each (4 residents total) to eat during lunch meal service. These failures had the potential to affect residents in the facility by placing them at risk of contracting, spreading, and/or exposing them to bacterial or viral infections that could lead to the spread of communicable diseases. Findings included: During an observation on 05/21/24 at 12:14 PM revealed AD and CNA I feeding 2 different unidentified residents each at lunch service in the dining room. Both AD and CNA I did not perform hand hygiene between feeding the 2 separate unidentified residents at each of their tables. During an interview on 05/21/24 at 01:46 PM AD stated it was normal for the facility to have staff sit between two residents to assist with feedings. AD stated she knew she should have sanitized in between feeding the two residents and that by not doing so there was potential for cross contamination. AD stated she remembered to sanitize while passing trays but forgot when it came to sitting and assisting the 2 separate unidentified residents with their meals. During an interview on 05/21/24 at 02:20 PM CNA I stated that the facility encourages staff to assist two residents at once when possible, during meal services. CNA I stated that staff are supposed to sanitize in between helping residents and she said she was not paying attention and just forgot to sanitize. CNA I said that a potential negative outcome to not sanitizing while feeding the 2 separate unidentified residents was cross contamination and an infection control issue. During an interview on 05/23/24 at 02:00 PM the DON stated that by the staff not performing HH while feeding the residents any type of acute illness can be passed back and forth. During an interview on 05/23/24 at 02:15 PM with the Administrator she stated it was her expectation that staff assisting residents with feedings should be sanitizing and using separate utensils in order to prevent cross contamination. Record Review of facility provided policy Infection Prevention and Control Program, dated 05/13/23, revealed, Policy: This facility has established and maintains 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 as per accepted national standards and guidelines. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	All staff are responsible for following all policies and procedures related to the program. Standard Precautions: - All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. - Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 49099 Based on observations, interviews, and record review the facility failed to maintain an effective pest control program so that the facility was free of pests for 1 of 1 dining room reviewed for environment. The facility failed to ensure the dining room was free of flies during the resident meal services. These failures could place residents at risk for infection and not receiving a home free of pest or comfortable environment to live. Findings Included: In an observation on 05/21/24 at 12:14 PM multiple flies were seen in and around residents' food throughout the dining room during meal service. A staff member was heard saying to an unidentified resident eat your food the flies are eating it all. AD and CNA I were observed swatting flies as they assisted in feeding 2 unidentified residents each. In an observation on 05/22/24 at 12:20 PM in the dining room multiple flies were observed again during meal services. The DON and SNA were observed swatting flies that were landing on food and flying around as they assisted in feeding two unidentified residents . In an interview on 05/21/24 at 01:46 PM with AD she stated she had not noticed flies being an issue until today. The AD said that flies in and around residents' food was an infection control issue and can lead to contamination. In an interview on 05/21/24 at 02:20 PM with CNA I, she stated it was very common seeing flies in and around residents' food during meal services. NA said she has verbalized the issue with some of the other staff members but has never made an official report of the pest problem. She stated that she remembered there was a section to report flies in the pest control book located at the nurses' station, but she never thought to go write it down. CNA I said flies have the potential to spread bacteria and larva to residents' food. In an interview on 05/23/24 at 02:00 PM with the DON she stated she has recently noticed more flies around during meal services but she had not in the past and had not had to report them previously. She stated a negative outcome to flies in residents' food would be the potential for illness. In an interview on 05/23/24 at 02:15 PM with the Administrator she stated that due to the heavy rain recently she has noticed more flies in the building. She stated flies in residents' food was a disruption but could potentially also cause contamination. The Administrator stated there was no policy for pest control. Record review of the facility pest control log reflected that prior to the report made on 05/21/24 by the AD after being notified of the fly concern there were no prior reports on flies made to notify pest control in the last 12 months.