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	06/05/2025

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for one (Resident #193) of three residents reviewed for baseline care plans. The facility failed to complete a baseline care plan within 48 hours of admission for Resident #193. This failure could place residents at risk for not receiving care and services to meet their needs. Findings included: Review of Resident #193's Face Sheet, dated 06/04/2025, reflected a [AGE] year-old male admitted to the facility on [DATE] with a diagnoses of chronic diastolic heart failure (left heart ventricle is stiff and has difficulty relaxing and filling with blood between heart beats), atherosclerotic heart disease of native coronary artery with unspecified angina pectoris (when arteries that carry blood to your heart become narrowed and blocked), paroxysmal atrial fibrillation (irregular heart beat), and difficulty in walking (any changes in the normal walking pattern that makes it difficult or unusual). Review of Resident#193's MDS Assessment, dated 05/30/2025, reflected Resident #193 had a BIMS score of 14 which indicated his cognition was intact. Resident #193 required partial/moderate assistance- (helper did less than half the effort) with toileting hygiene, showers, lower body dressing, transfers, and personal hygiene. He required supervision with upper body dressing, and oral hygiene. Resident #193 had shortness of breath when lying flat. He was at risk of developing pressure ulcers and required pressure reducing device for his bed. Review of Resident #193's Baseline Care Plan, on 06/04/2025, reflected it was not completed in the electronic medical record. Review of the facility's nurse's admission checklist, not dated, reflected baseline care was to be completed by the nurse. (continued on next page)

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

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/05/2025 at 9:55 AM the Director of Nurses stated baseline care plans were to be completed within 48 hours of the resident's admission date. She stated it was the nurse in charge of the resident responsibility to complete baseline care plan. The Director of Nurses stated the nurses had a checklist to follow when admitting a resident to the facility and complete a baseline care plan was on this check list. She stated when the nurse completed the baseline care plan it was her responsibility to review the care plan and ensure it was correct. The Director of Nurses stated, I would sign and date the baseline care plan to ensure it was correct. She stated there was no explanation of why Resident #193's care plan was missed. The Director of Nurses stated it was her responsibility to monitor the baseline care plans. She stated if a resident did not have a baseline care plan there was a potential a resident may not receive the appropriate care such as transfers, bathing, hygiene, toileting, etc. She stated a resident required a Hoyer lift for transfer and the staff did not use the Hoyer lift, there was a possibility the resident may fall. The Director of Nurses stated the resident sustain an injury from the fall such as broken bone. Interview on 06/05/2025 at 10:30 AM LVN C stated it was the nurse's responsibility to complete baseline care plan upon admission. He stated the nurse admitting a resident was to complete the baseline care plan. LVN C stated there was an admission checklist to follow and completing baseline care plan was on the checklist. He stated the information on the baseline care plan would transfer to the Kardex. He stated the Kardex was the electronic medical record the CNAs used to know what type of ADL care a resident needed at the time of admission. LVN C stated there was a possibility a resident may not receive the appropriate resulting in an injury. LVN C did not specify what type of injury or how a resident may sustain an injury. Record review of the facility's policy on Baseline Care Plan, dated 10/5/2023, reflected the facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. Policy Explanation and Compliance Guidelines: 1. The baseline care plan will: a. Be developed within 48 hours of a resident's admission. b. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: i. Initial goals based on admission orders. ii. Physician orders. iii. Dietary orders. iv. Therapy services. v. social services. vi. PASARR recommendation, if applicable. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative, if applicable. a. Once gathered, initial goals shall be established that reflect the resident's stated goals and objectives. b. Interventions shall be initiated that address the resident's current needs including: i. Any health and safety concerns to prevent decline or injury, such as elopement, fall, or pressure injury risk. ii. Any identified needs for supervision, behavioral interventions, and assistance with activities of daily living. iii. Any special needs such as for IV therapy, dialysis, or wound care. c. Once established, goals and interventions shall be documented in the designated format. 3. A supervising nurse shall verify within 48 hours that a baseline care plan has been developed.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed, to provide an ongoing activities program to support residents in their choice of activities, both facility sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident , encouraging both independence and interaction in the community for two of five residents (Resident #7 and Resident #10 reviewed for activities. The facility failed to provide Resident #7 and Resident #10 in room activities on the dates of 05/01/2025 thru 05/13/2025. This failure could place residents at risk for boredom, depression, and diminished quality of life. Findings included: Review of Resident #7's Face sheet, dated 06/04/2025, reflected a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with a diagnosis: vascular dementia, moderate, with psychotic disturbance (problems with blood flow to the brain with psychotic symptoms such as delusions and hallucinations), generalized anxiety disorder (a mental health condition characterized by persistent and excessive worry about everyday things, which can be difficult to control), and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (hemiplegia is paralysis, hemiplegia causes muscle weakness- they are similar conditions in that they both can affect one side of the body. Cerebral infarction- a condition where the brain tissue is damaged due to lack of blood flow). Review of Resident #7's Annual MDS, dated [DATE], reflected Resident #7 had a BIMS score of 2 which indicated her cognition was severely impaired. Resident #7's activity preference was listening to music, being around pets, participating in religious activities or practices. Review of Resident #7's Comprehensive Care Plan, dated 5/08/2025, reflected Resident #7 was dependent on staff with meeting emotional, intellectual, physical, and social needs related to cognitive deficits, and physical limitations. Intervention: Resident #7 required 1:1 beside/in-room visits and activities. Review of Resident #7's Activity Initial Review Form, dated 03/25/2024, reflected she required assistance in attending group activities such as singing hymns, crafts, bible study, coffee social, bean bag games, balloon tennis, community outings and trivia. Resident #7 's activities was required to be modified to address communication deficit (provide time for resident to respond to questions). Review of Resident #7's Activity Progress Note Assessments after, 03/25/2024, reflected the Activity Director did not complete annual or quarterly activity progress notes. Review of Resident #7's Activity Participation Records for the month of May 2025, reflected Resident #7 did not receive in room activities from 05/01/2025 thru 05/13/2025. Observation on 06/06/2025 at 8:46 AM revealed Resident #7 was in her bed. She would open and close her eyes. She was not interviewable. Resident #7's television was on in her room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/07/2025 at 8:30 AM Resident #7 was in her bed. She was not interviewable. Resident #7's eyes were opened, and she looked toward wall in front of her. There was no stimulation in her room such as: television or music. Review of Resident # 10's Face Sheet, dated 06/04/2025, reflected a [AGE] year-old male was admitted on [DATE] and readmitted on [DATE] with a diagnoses of multiple sclerosis (a condition where the body's immune system mistakenly attacks the protective covering of the nerve cells in the brain and spinal cord), anxiety disorder (a mental health condition characterized by persistent and excessive worry about everyday things, which can be difficult to control), schizoaffective disorder, unspecified (a mental health condition, this is a mix of schizophrenia symptoms, such as hallucinations and delusions- perception of something that is not actually there such as hearing voices or seeing things). Review of Resident #10's Annual MDS, dated [DATE], reflected Resident #10 had a BIMS score of 8 which indicated his cognition was moderately impaired. Resident #10's activity preference was listening to music, watching news, and participate in religious services or practices. Attending group activities was not important to him. Review of Resident #10's Comprehensive Care Plan, dated 05/15/2025, reflected Resident #10 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to physical limitations and schizophrenia. Interventions: Resident #10 needed 1:1 bedside/in-room activities. Provide a program of activities of Resident #10's interest. Review of Resident #10's Initial Activity Assessment, dated 08/30/2024, reflected Resident #10 enjoyed listening to music and watch movies. He did not want to attend group activities and preferred 1:1 activities with staff. Review of Resident #10's progress notes reflected the Activity Director did not complete a progress note after the date of 08/30/2024. Resident #10's last progress note was completed on 07/14/2022. Review of Resident #10's Activity Participation Record reflected Resident #10 did not receive in room /1:1 activities during the time frame of 05/01/2025 - 05/13/2025. Observation and interview on 06/03/2025 at 8:56 AM Resident #10 was in his room lying in bed listening to music. He stated he wanted more visits from the activity staff. Resident #10 stated he did become lonely sometimes and would prefer for activity staff to visit him three or four times a week. He stated the Activity Director would come in sometimes, however, in May she did not visit very much. Resident #10 did not respond to question if he requested more visits from the Activity Director. He stated he listens to music and watches TV. Resident #10 stated he wanted someone to visit and talk to him. Interview on 06/04/2025 at 1:15 PM The Activity Director stated Resident #10 and Resident #7 was on the in-room activity program. She stated Resident #10 very seldom was out of room. She stated Resident #7 had increased being in bed over the past 6 months. The Activity Director stated Resident#7 or Resident #10 did not receive in room activities during the dates of 05/01/2025 to 05/13/2025. She stated she was responsible for ensuring all the residents received activities. The Activity Director stated Resident #10 and Resident #7 was expected to receive visits from the activity staff in her room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/05/2025 at 8:45 AM The Activity Director stated she was expected to ensure all residents received activities based on their preferences and their physical abilities. She stated if a resident was not receiving any type of activities there was a possibility a resident may become bored, depressed or have a decline in their quality of life. She stated not receiving activities would affect their overall quality of life. The Activity Director stated if she was not in the facility, she instructed the Activity Assistant to visit in room residents. She stated she was off few days during the time Resident #10 and Resident #7 did not receive in room activities. The Activity Director stated she did not know why the Activity Assistant did not visit Resident #10 or Resident #7. She stated she was responsible to monitor Activity Assistant. Interview on 06/05/2025 at 10:15 AM the Activity Assistant stated she was trained on in room activities by the Activity Director. She stated she did not recall the date of the training. The Activity Assistant stated when the Activity Director was on vacation during first week of May she was instructed to visit residents on the in-room activity program. She stated she did not visit Resident #7 or Resident #10. She did not respond to the question of the reason why she did not visit Resident #7 or Resident #10. She stated if a resident was not receiving in room activities there was a possibility a resident may become depressed, isolated, or decline in mental status. Interview on 06/05/2025 at 11:00 AM the Administrator stated she expected in room activities be provided to the residents needing these type of activities. She stated if the Activity Director was not in the facility, she expected the Activity Assistant to provide in room activities. The Administrator stated if a resident was not receiving in room activities there was a possibility a resident may become depressed, bored, and isolated. She stated the Activity Director was responsible for monitoring the activity programs and the Activity Assistant. Requested via email the Facility Policy on Activity Programming and Documentation on 06/04/2025 at 2:50 PM. The Administrator responded via email on 06/04/2025 at 2:51 PM the facility did not have a policy on activity programming or documentation.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care, consistent with professional standards of practice, for 3 of 4 residents (Resident #27, Resident #74 and Resident #45) reviewed for quality of care. The facility failed to ensure Resident #27, Resident #74 and Resident #45's nebulizing mask and tubing, that were observed on 06/03/25, were bagged for sanitation when not in use. This failure could affect residents who received nebulizing treatment and place them at risk for respiratory infections. The findings included: Record review of Resident #27's face sheet dated 06/03/25 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses were dementia, behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, hypotension, history of transient ischemic attack and cerebral infarction(stroke), shortness of breath, unsteadiness on feet and cognitive communication deficit. Record review of Resident #27's quarterly MDS assessment, dated 05/06/25 revealed a BIMS score of 02 indicating his cognition was severely impaired. Record review of Resident #27's care plan dated 05/25/25 reflected he had asthma. The relevant intervention was giving medications as ordered and educating resident/family/caregivers regarding side effects and overuse of inhalers and nebulizers. Record review of Resident #27's physician's order reflected : NEB: Clean mask weekly and PRN. Change mask, tubing, and bag monthly. and PRN, every night shift starting on the 1st and ending on the 1st every month change. -Start Date-12/01/2023. Record review of Resident #74's face sheet on 06/03/25 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses were hypertension, behavioral disturbance, chronic obstructive pulmonary disease(difficulty to breath), obstructive acute respiratory failure with hypoxia(low oxygen level), dementia, depression, shortness of breath and unsteadiness on feet. Record review of Resident #74's quarterly MDS assessment, dated 10/13/24 revealed a BIMS score of 06 indicating his cognition was severely impaired. He was coded for oxygen therapy while he was at the facility. Record review on 06/03/25 of Resident #74's care plan dated 05/27/25 revealed the resident had COPD and at risk for ineffective airway clearance. The intervention was giving aerosol or bronchodilators as ordered and monitoring any side effects and effectiveness. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #74's physician's order reflected : 1.Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3ML) 0.083% (Albuterol Sulfate):1vial inhale orally via nebulizer two times a day related to chronic obstructive pulmonary disease. -Start date-2/21/2023. 2. Clean mask weekly and PRN. Change mask, tubing, and bag monthly and PRN, every night shifts every Sun for resident care. -Start Date-11/12/2023. Review of Resident #45's face sheet dated 06/04/25 reflected an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, chronic pain syndrome, dependence on supplemental oxygen, muscle wasting, basal cell carcinoma of skin(skin cancer) and altered mental status. Review of Resident #45's quarterly MDS assessment, dated 05/13/25, reflected a BIMS score of 15, indicating his cognition was intact. He was ordered for oxygen therapy while he was at the facility. Review of Resident #45's care plan, dated 01/14/25, reflected Resident #45 had COPD and at risk for ineffective airway clearance. The relevant intervention was giving aerosol or bronchodilators as ordered. Review of Resident #45's physician's order reflected: NEB: Clean mask weekly and PRN. Change mask, tubing, and bag monthly and PRN. every night shifts every Sun for resident care. -Start Date-11/12/2023 Observation and interview on 06/03/25 at 10:45am of Resident #27, Resident #74, and Resident #45's room revealed there were nebulizers on the side tables. The masks and tubing of the nebulizers were exposed to the environment as they were not stored in a protective bag. LVN D who witnessed the nebulizer masks stated they were supposed to be sanitized before and after use and should have been stored in a protective bag whenever not in use. He stated this was necessary to avoid infections especially respiratory. During an interview on 06/05/25 at 11:30am the DON stated all staff were supposed to be compliant with the facility policy for using the oxygen cannula and nebulizers. She stated the nebulizer masks were to be cleaned and DON safely stored in the protective bags provided. She stated there was a potential for respiratory infectious diseases due to this deficiency. DON stated she or ADON did routine inspection to ensure if the mask and tubing were appropriately sanitized and stored in protective bags. Record review of the facility's policy, titled Oxygen Safety dated 01/26/24 had not reflected the necessity for storing oxygen/nebulizer tubing, cannulas, and facemasks in protective bags when not in use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of web site https://www.nhlbi.nih.gov/sites/default/files/publications/How-to-Use-a-Nebulizer-21-HL-8163.pdf reviewed on 06/10/25 reflected: . Between uses: o Store nebulizer parts in a dry, clean plastic storage bag. If the nebulizer is used by more than one person, keep each person's medicine cup, mouthpiece or mask, and tubing in a separate, labeled bag to prevent the spread of germs. o Wipe surface with a clean, damp cloth as needed. Cover nebulizer machine with a clean, dry cloth and store as stated in the instructions. o Replace medicine cup, mouthpiece, mask, tubing, filter, and other parts as stated in the instructions or when they appear worn or damaged

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 4 medication carts (200 Hall Med Aide Cart) reviewed for medication storage . The facility failed to ensure that the 200 Hall Med Aide Cart did not contain personal belongings of MA E, along with the medications for residents. This failure could place residents at risk for contamination and medication errors through confusion and distraction among the medication administration staff . Findings include: During an observation and interview on 06/04/25 at 9:35am it was revealed that the 200-hall med cart was operated by MA E. It was observed there was an orange-colored handbag at the bottom drawer of the cart that belonged to MA E. MA E immediately removed it from the drawer and placed it elsewhere. She stated she should not have placed her bag in the med cart drawer as it was against the facility policy. MA E stated the Med cart supposed to have only resident's medications that were in use to avoid confusion and not introducing germs into the cart. During an observation and interview on 06/04/25 at 10:20am LVN C stated he was the nurse in charge for the shift. He was present when the investigator going through the 200 hall Med Aide Cart, as part of the survey process. After witnessing the hand bag of MA E in the drawer of the Med cart, LVN C stated personal items needed to be kept away in designated staff rooms or any other places safely. He said personal items might not be clean and could potentially introduce germs into the med cart. LVN C added, Med carts were used to handle medications only and should be kept clean and sterile all the time. In an interview on 06/05/25 at 11:30am, the DON said nursing staff were expected to check their med carts daily for inappropriately placed medications and any other items other than residents' medications. She stated personal belongings should not be in a med cart in a nursing facility to prevent medication errors, maintain safety, and ensure proper medication administration practices. She stated med cart procedures should prioritize medication organization and safety and introducing personal items was a deviation from these established procedures . Med carts were specifically designed to hold medications and treatment related supplies. She said introducing non-essential items caused confusion and distraction that potentially lead to mistakes, also contaminate the medications and treatment supplies stored in the cart. Record review of the facility policy titled Medication Carts and Supplies for Administering Meds revised on 10/01/2019 reflected: Policy: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility maintains equipment and supplies necessary for the preparation and administrations of medications to residents. The mobile medication cart will be used to facilitate administration of medications to residents. The purpose of the mobile medication system is to ensure appropriate control and surveillance of resident assigned medications The licensed nurse or medication aide should maintain a clean top surface on the medication cart. while passing medications and clean and replenish the medication cart after each use. Equipment and supplies relating to medication administration are clean and orderly

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, 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. The facility failed to ensure Dietary [NAME] changed her gloves during food preparation after touching a bread bag and a piece of paper. This failure could place residents who ate food from the kitchen at risk for foodborne illness. Findings include: Observation on 06/04/2025 at 3:55 PM, revealed the Dietary [NAME] was wearing gloves. She touched a piece of paper with her forefinger and middle finger on her right hand. She touched outside of the bread bag with all fingers on both hands. She reached inside the bread bag and obtained 4 pieces of bread. She placed the bread in the puree processor. The Dietary [NAME] touched outside the bread bag when she obtained 8 pieces of bread. She placed the 8 pieces of bread into the puree processor. The Dietary [NAME] did not change her gloves in between tasks and continued to puree the bread. Her middle finger and fore finger on her right hand touched inside the puree processor and touched the pureed bread. During the entire process of pureeing the bread, Dietary [NAME] did not change her gloves. Interview on 06/04/2025 at 4:05 PM, the Dietary [NAME] stated she did not change her gloves after she touched the piece of paper and touched outside of the bread bag. She stated the paper, and the bread bag was considered contaminated. She stated the bread came from a manufacturer plant and there was a possibility a lot of people had touched the bread bag before being delivered to the facility. She stated the paper was also considered contaminated. The Dietary [NAME] stated she was expected to change her gloves and wash her hands after touching anything contaminated. She stated there was a possibility germs on her gloves may spread to the bread. The Dietary [NAME] stated if the bread was contaminated and a resident ate the bread, there was a potential a resident may become physically ill such as vomiting and diarrhea. She stated she had been in-service on hand hygiene. The Dietary [NAME] did not recall the date of the in-service. Interview on 06/05/2025 at 10:35 AM, the Dietary Manager stated all staff were required to change their gloves and wash hands between tasks and whenever they touched anything contaminated. She stated the bread bag, and a piece of paper was considered contaminated. She stated if a resident ingested contaminated food, there was a potential a resident may become ill with some type of food borne illness. The Dietary Manager stated the staff were in-serviced on hand hygiene. She stated she did not recall the date of the in-service. (continued on next page)

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	675434	A. Building B. Wing	06/05/2025

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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/05/2025 at 11:00 AM, the Administrator stated she expected the dietary staff to change their gloves and wash their hands in between tasks or when they touched any contaminated item. She stated if dietary staff did not wash their hands after touching anything considered contaminated, there was a potential a resident may become ill with an upset stomach such as nausea or vomiting if a resident ingested any type of bacteria in their food. The Administrator stated the Dietary Manager was responsible to monitor the kitchen and it was her responsibility to monitor the Dietary Manager. Review of the Facility's Handwashing Policy, dated 10/01/2018, reflected The facility recognizes that food-borne illness has the potential to harm elderly and frail residents. All Nutrition and Foodservice employees will practice good hand washing practices in order to minimize the risk of infection and food borne illness.

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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** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program, designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for 3 (Resident #56,Resident #22, and Resident #293) of 5 residents reviewed for infection control practices, in that: The facility failed to: 1. Ensure CNA B changed dirty gloves when handling clean items while providing peri care to Resident #56 2. Ensure MA E sanitized blood pressure monitor in between Resident #22 and Resident #293 while obtaining blood pressure. These failures could place residents at risk for healthcare associated cross-contamination and infections. Findings included: Review of Resident #56's face sheet dated 06/04/25 reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, type 2 diabetes, hypertension, psychotic disturbance, mood disturbance, anxiety, need for assistance with personal care and unsteadiness on feet. Review of Resident #56's quarterly MDS assessment, dated 03/07/25 reflected a BIMS score of 0, indicating he had severely impaired cognition. MDS indicated Resident #56 was always incontinent with bowel and bladder. Review of Resident #56's care plan, dated 02/21/25, reflected Resident #56 had ADL self-care performance deficit r/t Alzheimer's, dementia. The relevant intervention was providing extensive one staff assistance with personal hygiene and oral care. During an observation on 06/03/25 at 8:34am CNA B was providing peri care for Resident #56 while CNA A assisted her. CNA B put on gloves after washing her hands. After that she opened the brief and cleaned Resident #56's front and back with wet wipes dispensed directly from the wipe's packet. In that process she handled the whole wipe packet with the soiled gloves. After the completion of peri care she saved the contaminated wipe packet containing wet wipes in Resident #56's room at his bedside. (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 06/03/25 at 10:20am CNA B stated she worked at the facility for two years, mostly in the night shift and recently started working in the day shifts. CNA B stated she received training on peri care and had attended in- service recently. CNA B said, from the trainings and in-services she learned all the aspects of peri care procedure and infection control protocols. When the investigator walked through the peri care that she had done on Resident #56, CNA B stated she understood she should not have contaminated the wet wipe packet by handling it with soiled gloves, due to the danger of spreading germs. Review of Resident #22's face sheet dated 06/04/25 reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including seizures, hypertension, acquired absence of right leg above knee, adult failure to thrive, altered mental status, depressive disorders, need for assistance with personal care, and dementia. Review of Resident #22's quarterly MDS assessment, dated 05/07/25 reflected a BIMS score of 8, indicating he had moderately impaired cognition. Review of Resident #22's care plan, dated 05/07/25, reflected Resident #22 was at risk for hypertensive crisis . The relevant intervention was obtaining blood pressure readings and administering anti-hypertensive medications as ordered by MD. Review of Resident #22' s medication order reflected : Lisinopril Tablet 5 MG: Give 1tablet by mouth one time a day for HTN .Hold for SBP less than 110. -Start date : 02/06/25. Review of Resident #293's face sheet dated 06/04/25 reflected a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of type 2 diabetes, hypertension, chronic congestive heart failure, alcoholic cirrhosis, atrial fibrillation (irregular fluttering of heart) , cough and adjustment disorder with mixed anxiety and depressed mood. Review of Resident #293's quarterly MDS assessment, dated 04/30/25, reflected a BIMS score of 12, indicating he had moderately impaired cognition. Review of Resident #293's care plan, dated 05/27/25 reflected Resident #293 was at risk for hypertensive crisis. The relevant intervention was obtaining blood pressure readings and administer antihypertensive medications as ordered by MD. Review of Resident #293's physician's order reflected: Prazosin HCl Oral Capsule 5 MG (Prazosin HCl): Give 1 capsule by mouth at bedtime related to essential (primary) hypertension . Give with 5mg to=7 mg. Hold for SBP<110, Pulse <60. -Start Date- 10/28/2024. (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 06/04/25 at 9:35am MA E took the blood pressure of Resident #22 with a blood pressure monitor without sanitizing it. After administering the medications to Resident #22 she moved on to Resident #293 and used the same blood pressure monitor on him without sanitizing it. MA E did not sanitize the monitor after the use on Resident #293 until the investigator pointed it out. During an interview on 06/04/25 at 10:15 a.m., MA E stated sanitizing blood pressure cuffs in between the residents was important and, in a rush, she forgot to do it so. She continued, mistakes could happen with anyone and the best way to resolve it was learning from their mistakes. MA E stated, following infection control protocol was important to minimize spreading diseases from one resident to another. MA E stated she received trainings on infection control previous month and there were no in-services specifically on sanitizing medical equipment. During an interview on 06/05/25 at 11:35am the DON stated CNA B should not have handled the wet wipe packet with soiled gloves. She stated CNA B was supposed to throw away the contaminated wet wipe packet instead of saving for future. The DON stated she already completed a one-to-one in service with CNA B and would be doing an in service for all the staff members for peri care. The DON stated , the IP is on long leave, and she was responsible for the duties of IP until she returns. She said, as per facility's infection control protocol all the medical equipment in use including blood pressure cuffs should be sanitized immediately after they use it on residents. This was one of the ways minimizing contagious diseases and staff were trained for this. The DON stated she could not remember exactly when the staff received in services on infection control however she could find out the days by reviewing the in-service folder at the facility. Review of the in-service records from 03/01/25 to 06/01/25 revealed there were separate in services on 04/10/25 on hand hygiene and using gloves during nursing care. Record review of facility's policy Perineal care dated 10/24/22 reflected : Policy: It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown. 6. Perform hand hygiene and put on gloves. Apply other personal protective equipment as appropriate. 7. Set up supplies. 9. If perineum is grossly soiled, turn resident on side, remove any fecal material with toilet paper, then remove and discard. a. Cleanse buttocks and anus, front to back; vagina to anus in females, scrotum to anus in males, using a separate washcloth or wipes. b. Thoroughly dry. 10. Re-position resident in supine position. Change gloves if soiled and continue with perineal care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility's policy Infection Prevention and Control Program revised in November 2024 reflected: . Equipment Protocol: a. All reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment. b. Single-use disposable equipment is an alternative to sterilizing reusable medical instruments. Single-use devices must be discarded after use and are never used for more than one resident. c. Reusable items potentially contaminated with infectious materials shall be placed in an impervious clear plastic bag. Label bag as CONTAMINATED and place in the soiled utility room for pickup and processing