STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675441	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renaissance Care Center	1400 Blackshill Dr Gainesville, TX 76240

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49427 Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for one (Resident #9) of four residents reviewed for abuse. The facility failed to protect Resident #9 from verbal abuse by LVN E on 07/26/2024 at 9:15 AM. The noncompliance was identified as Past Noncompliance (PNC). The noncompliance began on 07/26/2024 at 9:15 AM and ended on 08/01/2024. The facility had corrected the noncompliance before the incident investigation began on 02/04/2025. This failure could place residents at risk of serious injury and harm. Findings included: Record review of Resident #9's face sheet, undated, reflected she was an [AGE] year-old female, admitted to the facility on [DATE] with the diagnoses of stroke and dementia (loss of cognition). Record review of Resident #9's Comprehensive MDS, dated [DATE], reflected she had a memory problem and had severely impaired cognition. Record review of Resident #9's care plan, undated, reflected she needed extensive assistance with activities of daily living, was on hospice services, and took an aspirin to prevent blood clots. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of PIR (Form 3613-A of Texas Health and Human Services) dated 07/31/2024 reflected on 07/26/2024 at 9:15 AM the Staffing Coordinator noticed blood on Resident #9's foot and brought her to the nurse (LVN E), when LVN E stated she didn't [expletive] care if [Resident #9] foot fell off because she had requested a new chair for her. The incident was witnessed by the Speech Language Pathologist. LVN E was immediately suspended pending an investigation. The Interim DON performed a head-to-toe assessment and found Resident #9's toenails were long so they were clipped, an x-ray was requested that showed no fracture, and she did not display any distress. LVN E denied saying anything abusive. Review of PIR revealed resident safe surveys were completed for 34 residents with no concerns related to abuse or neglect. Review of employee surveys revealed they reported abuse to the abuse coordinator (Administrator) and had not witnessed any abuse. Review of the Staffing Coordinator's written witness statement dated 07/26/2024 revealed, in front of Resident #4, LVN E told the Staffing Coordinator that she .didn't [expletive] care if her foot fell off because she had requested a new chair . Review of the SLP written witness statement dated 07/26/2024 reflected she witnessed the Staffing Coordinator show LVN E Resident #9 toe and LVN E responded .I don't [expletive] care if her feet fall off I've asked for a different wheelchair . Review of LVN E's written statement, undated, and signed by her reflected, .CNA stated to this nurse that her [Resident #9] toe was currently bleeding this nurse stated that it was not and that I had requested for resident to get a better (wheelchair) and was told by Hospice that Administrator was turning it away so feet would not drag on carpet . Record review of Resident #9's clinical note progress note, dated 07/26/2024, written by the Interim DON, revealed the resident was assessed and showed no signs of distress, pain, or other signs of abuse and neglect; her toenail was bleeding due to propelling herself in her wheelchair. Resident #9's toenail was trimmed and the bleeding stopped upon cleaning; physician and representative were notified of the incident. Observation and attempt to interview on 02/04/2025 at 9:30 AM with Resident #9 revealed she was non-interviewable, appeared pleasant, and was seated in her wheelchair by the nurses' station. In an interview on 02/04/2025 at 12:36 PM with the Staffing Coordinator, she said Resident #9 was nonverbal and ambulated around the facility in her wheelchair by scooting her feet along the floor. She stated on 07/26/2024 she saw Resident #9 had a small spot of blood on the bandage of her toe and took her to see LVN E at the nursing station. She stated LVN E said she had already ordered a new wheelchair and she did not care if Resident #9's '[expletive] toe fell off' because she already ordered a new wheelchair. She stated Resident #9 was present and the Speech Language Pathologist was walking by at the same time. She immediately took Resident #9 to the Administrator and wrote a witness statement and she and the other staff were in-serviced on abuse and neglect. She stated the resident did not show any signs of psychosocial harm or change in her behavior. She stated there are regular in-services on abuse and neglect that included reporting requirements and the abuse coordinator was the Administrator. In an interview on 02/04/2025 at 12:43 PM with the Speech Language Pathologist she said she was walking by the nurses' station when she saw the Staffing Coordinator talking with LVN E about Resident #9's wheelchair and heard LVN E say I don't care if her [expletive] feet fall off, I've already asked for another wheelchair . She stated she and the Staffing Coordinator went to the Administrator and wrote statements . She stated that Resident #9 did not show any signs of being impacted by the incident. She stated that she was in-serviced with staff on abuse and neglect and reporting requirements. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/04/2025 at 2:48 PM with Resident #9's Representative he said he had no concerns regarding the care of Resident #9 and the facility contacted him regarding the incident in July 2024 and that they had terminated the nurse. He stated that he regularly visited with Resident #9 and had not observed any change in behavior or indicators that she was impacted by the event. In an interview on 02/05/2025 at 1:03 PM via phone with the Interim DON he said he did not witness the incident and he assessed the resident for injuries immediately and the resident was wearing a dressing on her toe and had a broken corner of her toenail that had caused a little bleeding; so he clipped her nail and patted the area dry and it stopped bleeding. He stated Resident #9 typically ambulated herself down the hallway and she did not display any psychosocial or mental harm . He stated LVN E was suspended immediately and later terminated due to the incident. He stated it was unacceptable that LVN E used the language she did in front of the resident and other staff and family members were present. He stated that staff were in-serviced the same day on abuse and reporting requirements. Attempts to interview LVN E via phone on 02/04/2025 at 1:06 PM and 02/05/2025 at 9:07 AM were unsuccessful, voicemail message was left requesting a phone call back. In an interview on 02/05/2025 at 11:05 AM with the SSD she said she did not witness the incident and was responsible for a portion of the safe surveys conducted afterward and none of the residents had abuse concerns. She stated she was familiar with Resident #9, who was non-verbal, and did not observe any psychosocial impacts such as change in emotional patterns or behavior. The SSD stated that the facility in-serviced on abuse routinely, was able to name types of abuse and who the abuse coordinator was including reporting requirements . In an interview on 02/05/2025 at 12:34 PM with the Interim Administrator he said he is the abuse coordinator and staff were in-serviced on abuse and neglect monthly and sometimes more often. He stated that LVN E was suspended immediately, did not return to the facility, and was terminated due to the incident. He stated that Resident #9 was non-verbal, had a head-to-toe assessment, and did not show signs of being bothered by the incident. In an interview on 02/05/2025 at 1:46 PM with LVN H she said she was familiar with Resident #9 and did not witness the incident. She stated that she believed Resident #9 understands more than others realize she does and did not see any changes in the resident's emotions or behaviors since the incident in July. She was able to name different types of abuse, the abuse coordinator was the administrator, and reporting requirements. She stated that there were routine in-services on abuse. Interviews on 02/04/2025 and 02/05/2025 across multiple shifts with various staff members (CNA L, CNA M, CNA D, LVN F, LVN G, LVN H, RN J, SPL , SSD, and Interim DON) over various shifts revealed the facility had conducted abuse and neglect in-services on a routine basis and as needed. The above-mentioned staff members were able to verbalize abuse and different forms of abuse and neglect including reporting to the Administrator who was the facility's abuse coordinator. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy titled, Policy and Procedures: Abuse, Neglect and Exploitation dated April 2019 reflected, The Patient has the right to be free from Abuse, neglect, mistreatment of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required in treating the Patient's symptoms verbal abuse is defined as any use of oral, written or gestured language that includes disparaging and derogatory terms to Patient or their families, or within their hearing distance, to describe a Patient, regardless of their age, ability to comprehend, or disability Record review of LVN E's personnel file revealed she was hired on 12/10/2009 with a last worked date of 07/26/2024 and terminated from employment on 08/01/2024. The facility had conducted Texas Department of Public Safety Criminal History verification and Employee Misconduct Registry Employability status check without any concerns. Record Review of abuse and neglect in-services conducted by the facility on 07/26/2024 revealed that the facility staff was trained on abuse and neglect, types of abuse, who was the abuse coordinator and when abuse should be reported. The noncompliance was identified as Past Noncompliance (PNC). The noncompliance began on 07/26/2024 at 9:15 AM and ended on 08/01/24. The facility had corrected the noncompliance before the Incident investigation began. LVN E was terminated from employment and Resident #9 had no other incidents or signs of harm. The facility staff were reeducated regarding Abuse and Neglect on 07/26/2024.

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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** 34918 Based on observation, interview, and record review the facility failed to ensure residents receive adequate supervision and assistance devices to prevent accidents for one of nine residents (Resident #1) reviewed for quality of care. The Facility failed to ensure CNA A used a gait belt when transferring Resident #1 from her wheelchair to the toilet on and off the toilet on 02/04/25. These failures could affect the residents by placing the residents at risk for falls, injuries, and skin tears. Findings included: Record Review of Resident #1's 5-day MDS assessment, dated 01/16/25 reflected a [AGE] year-old female admitted to the facility on [DATE]. Resident #1 was cognitively intact with a BIMs of 15. She had limited range of motion of one side of her lower extremities and was dependent with toileting hygiene and toilet transfers. She was occasionally incontinent of bladder and bowel. She was mobile with a wheelchair and was receiving physical and occupational therapy. Diagnoses included osteomyelitis of the lumbar region (inflammation of the bone caused by infection in the low back), diabetes and morbid obesity. Review of Resident #1's care plan dated 02/04/25 reflected, At risk for falls .Goal-[Resident #1] will demonstrate the ability to ambulate/transfer without fall related injuries over the next 90 days .Interventions . Respond promptly to calls for assist to the toilet .footwear will fit properly and have non-skid soles . In an observation and interview on 02/04/25 at 09:55 a.m. Resident #1 was observed in her wheelchair sitting in her room. She stated she had been at the facility for about 6 weeks and was getting therapy. She stated when she came, she was unable to walk, but stated she was improving each day. An observation on 02/04/25 at 10:45 a.m. revealed CNA A responding to Resident #1's call light. CNA A entered Resident #1's room, put on gloves, and pushed the resident's wheelchair into the bathroom. A gait belt was observed in the CNA's side pants pocket. CNA A faced the resident toward the wall and instructed her to reach for the grab bars and then assisted the resident into a standing position with no gait belt in use. CNA A then moved the wheelchair away and pulled down the resident's brief and guided her toward the toilet. Resident slowly scooted her feet to position herself over the toilet. CNA A asked the resident to pull the call light when she was finished. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow up observation on 02/04/25 at 10:50 a.m. revealed Resident #1's call light on. CNA A returned to Resident #1's room, entered the bathroom and put on gloves. CNA A placed a clean brief around the residents' ankles and asked the resident if she was ready to stand, and resident grabbed the grabs bars and stood without the CNA A placing a gait belt around the resident. CNA A asked the resident if she could stand while she cleaned her buttocks. Resident #1 stated yes. Residents' legs were observed shaking. CNA A wiped the resident's buttocks with a peri-wipe, then removed her gloves. CNA A then put on clean gloves. CNA A then pulled up the brief and fastened it, readjusted the residents' clothes, and assisted her back into her wheelchair. In an interview with CNA A on 02/04/25 at 10:55 a.m. she stated she was not sure of Resident #1 was a fall risk, but stated they were supposed to use a gait belt anytime they assisted with a transfer. She stated a gait belt was used to help steady a resident and help prevent a fall and injury to herself. In an interview with the PTA on 02/05/25 at 9:10 a.m. she stated she and the staffing coordinator had done some new employee training with gait belts, but it was not something they did on a routine basis. She stated the facility's expectation for safe transfers was any resident who needed contact assistance with a transfer would need a gait belt to assist with fall recovery and or prevent falls. She stated Resident #1 was a fall risk and would need the use of gait belt for safety. In an interview with the Interim DON on 02/05/25 at 11:28 a.m. he stated he had covered the facility from June 2024 until a few weeks ago when the new DON had started. He stated he and the ADON had completed skills checks a few weeks ago on all the CNAs and provided gait belts to all the staff. He said it was the expectation for staff to use a gait belt when providing transfers to residents to prevent the risk of injury to the resident and the staff. Record review of CNA A's skills check list titled Transfer skills dated 2/03/24, reflected she had met acceptable performance in the task. Record review of the facility's policy, General Staff Guidelines-Gait Belt Policy dated June 2006, reflected, Purpose-Gait/transfer belts provide a safe method for transfer and ambulation of the Patient .At all times while on duty, all nursing employees are required to have on their person a Gait/Transfer Belt, and to use the Gait/transfer belt for all patient transfers and ambulation .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for three of five residents (Resident #2, Resident #4, and Resident #8) reviewed for catheter and incontinence care. 1. The facility failed to ensure CNA A and CNA B maintained the foley catheter drainage bag below Resident #2's bladder while they transferred the resident with a mechanical lift on 02/04/25 2. The facility failed to ensure CNA C provided Resident #4 timely and appropriate perineal care after an incontinent episode when she failed to check and change the resident from 06:00 a.m. to 10:30 a.m. and failed to clean the resident's penis and scrotum from front to back on 02/05/24. 3. The facility failed to ensure CNA C provided timely incontinence care for Resident #8 on 02/05/25. These failures could place residents at risk for not receiving appropriate care to address their incontinence and could increase the risk of urinary tract infections. Findings included: 1. Record review of Resident #2's quarterly MDS assessment, dated 01/20/25, reflected an [AGE] year-old female with an admitted [DATE]. She had a BIMS of 15, which indicated she was cognitively intact. Resident #2 required substantial/maximum assist with ADLs and was dependent of 2 persons assist with transfers. She had an indwelling catheter and was always incontinent of bowel. Resident #2 had diagnoses which included neurogenic bladder (condition caused by nerve problems affecting the bladder), diabetes and hypertension. Record review of Resident #2's care plan, dated 02/04/25, reflected, At risk of infection related to indwelling catheter .Goal . [Resident #2] will remain free of urinary tract infection during period of catheterization . Interventions .Keep tubing below the level of bladder and free of kinks or twist Record review of Resident #2's February 2025 Physician Order Sheet, dated 02/04/25, reflected .Foley catheter: Check for patency (unobstructed) and placement every shift . with a start date of 06/18/24. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 02/04/25 at 11:30 a.m. CNA A and CNA B entered Resident #2's room to transfer her from her bed to the wheelchair with a mechanical lift. CNA A unhooked the urinary drainage bag from the bed rail and hooked it onto the lower pocket on her pants. Both staff positioned the resident onto the mechanical lift sling and hooked the sling to the mechanical lift. Once the sling was attached, CNA B instructed CNA A to attach the urinary drainage bag to the top bar of the mechanical lift, well above the resident's bladder. CNA A attached the urinary drainage bag to the top bar of the lift while CNA B began to lift the resident from the bed. Once the lift went up the urinary drainage bag was above her head. The resident was positioned over the chair and lowered onto the chair. Urine was observed in the tube flowing up and down. CNA A then unhooked the drainage bag and placed it on the wheelchair. In an interview with CNA B on 02/04/25 at 11:35 a.m. she stated they had been taught the urinary drainage bag was to be kept below the bladder. She stated she knew they were not supposed to hook it to their clothing which is why she instructed CNA B to hook it to the lift. She stated she was not sure how they were supposed to position the drainage bag during a mechanical lift. In an interview with CNA A on 02/04/25 at 11:40 a.m. she stated she had started at the facility about 3 weeks ago. She stated she was assigned with another CNA who had showed her how to do transfers. She stated she knew they were supposed to keep the urinary bag below the bladder and was not sure why CNA B had her hook it to the bar of the mechanical lift. She stated this was her first time working in a facility and she was still learning. In an interview with the ADON on 02/04/25 at 12:45 p.m. she stated staff were taught to keep the urinary drainage bag below the bladder to ensure proper drainage and prevent urine from backing up into the bladder. She stated she and the Interim DON had performed skills checks a few weeks ago and the staff knew they were to keep the drainage bag below the bladder. In an interview with the Interim DON on 02/05/25 at 11:25 a.m., he stated the staff were taught to keep the urinary drainage bag below the bladder to ensure proper drainage and prevent urine from backing up into the bladder. He stated he and the ADON did the competency checks on all the CNA staff a few weeks ago. He stated proper placement of the foley catheter bag during a mechanical lift transfer was not part of their current check off skills, but stated the staff should know how to place it on the sling where it was below the bladder. He stated it was not appropriate to hook it on the top bar of the sling. Record Review of CNA A's Nurse Aide Proficiency skills check off dated 02/03/25 reflected she was competent in the care of indwelling catheters which included keeping the drainage below the bladder. Record Review of CNA B's Nurse Aide Proficiency skills check off dated 02/03/25 reflected she was competent in the care of indwelling catheters which included keeping the drainage below the bladder. Record review of the facility's policy, Catheter Care, dated March 2019, did not reflect the placement of the urinary drainage bag. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #4's quarterly MDS assessment, dated 11/21/24, reflected a [AGE] year-old male with an admitted [DATE]. He had a BIMS of 10, which indicated he was moderately cognitively impaired. Resident #4 required substantial/maximum assist with ADLs and was dependent of 2 persons assist with transfers and toileting hygiene. He was always incontinent of bladder and bowel. Resident #4 had diagnoses which included Parkinson's disease (disorder of the central nervous system that affects movement) and seizure disorder. Record review of Resident #4's care plan dated 02/05/25 reflected, Urinary and Bowel incontinence: [Resident #4] is always incontinent .Goal .Incontinence will be managed by staff without evidence of skin breakdown .Interventions .Patients who are incontinent of bladder and/or bowel will have incontinent care provided every 2 hours as needed In an interview and observation with Resident #4 on 02/05/25 at 09:55 a.m. Resident #4 was observed sitting up in his wheelchair in his room watching TV. Resident #4 stated he needed to be changed and stated he was soaked through his pants. Resident #4 stated no one had changed him this morning. He stated he had been up since the butt crack of dawn. Resident's call light was pushed to obtain assistance. In an observation on 02/05/25 at 10:00 a.m. CNA C entered Resident #4's room in response to his call light. Resident #4 told CNA C he needed to be changed, and stated I am soaked. CNA C stated she would have to get help to transfer the resident to bed. CNA C re-entered Resident #4's room with the mechanical lift at 10:25 a.m. with the ADON. CNA C put on gloves without performing hand hygiene while the ADON washed her hands and put on gloves. Both staff hooked the mechanical sling to the lift and transferred the resident from his wheelchair to the bed. The wheelchair cushions exuded a very strong urine smell when the resident was lifted. The resident's pants were observed to be wet. Staff lowered the resident onto the bed and unhooked the sling. ADON then left the room with the mechanical lift. CNA C assisted the resident to roll from side to side to remove the sling and then removed his wet pants and saturated brief. CNA C rolled the resident onto his left side and wiped his buttocks a few times with a peri-wipe. She then placed a clean brief under the resident with soiled gloves and had him roll onto his back. CNA C then took a peri-wipe and wipe down his groin one time on each side and wiped the top of his penile shaft from his body down toward the head of his penis. She did not clean the resident's scrotum, the underside of his penis, or his inner thighs. CNA C then fastened the brief, removed her gloves, and went to the resident's closet without performing hand hygiene, and retrieved a clean shirt. CNA C removed his dirty shirt and assisted him with putting on the clean shirt. CNA C then gathered the trash and dirty clothes and left the room without performing hand hygiene. In an interview with CNA C on 02/05/25 at 10:50 a.m. she stated they were required to check and change any resident with incontinence every 2 hours, but stated it was just not possible with only 4 of them covering 6 halls. She stated she was not sure how long Resident #4 had been up since the night shift had gotten him up. She stated she was supposed to clean the resident from front to back and stated she did not realize she had not adequately cleaned the resident. She stated failing to clean the resident properly or timely placed him at risk of infections and skin breakdown. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the current DON on 02/05/25 at 12:45 p.m. she stated she had worked the night shift on 02/03/25 and knew the night shift got a few residents up. She stated the residents were gotten up around 4:30 a.m. She stated she was not sure if they had gotten Resident #4 up or not. She stated any resident the night shift got up needed to be checked and changed no later than a few hours after the start of the day shift at 6:00 a.m. She stated any resident who was incontinent of bowel and bladder needed to be checked for incontinence every 2 hours and changed as needed. She stated staff were to clean the peri area including penis and scrotum for male residents then move toward the buttocks. She stated by not providing accurate incontinent care it placed residents at risk for urinary tract infections, skin breakdown and overall poor hygiene. 3. Record review of Resident #8's Comprehensive MDS assessment, dated 12/06/24, reflected a [AGE] year-old female with an admitted [DATE]. Resident #8 was unable to participate in the interview for cognition and was assessed by the staff to be severely impaired. She was dependent for ADL care and was always incontinent of urine and bowel. Her active diagnoses included respiratory failure with hypoxia (not enough oxygen in the blood), and dementia. Record review of Resident #8's care plan, reviewed on 08/12/2019, reflected, .is always incontinent . Interventions: check for incontinence; change if wet/soiled. Clean skin with mild soap and water . Check skin for areas of redness . Observation on 02/05/25 at 08:30 AM, 10:30 AM, and 11:50 a.m. revealed Resident #8 was laying in the Geri-chair (specialized wheelchair) in the activity room. Resident was unable to answer questions. An observation on 02/05/25 at 12:00 p.m. revealed CNA C and CNA I entered Resident #8's room to transfer her back to bed. Both staff washed their hands and put on gloves and transferred the resident via a mechanical lift from her Geri-chair to the bed. Both staff removed their gloves, without performing hand hygiene they re-gloved to provide peri-care. CNA C opened the resident's brief to reveal a strong smell of urine. CNA C provided peri care and with assistance from CNA I turned the resident over on her side to reveal she had saturated through the brief. Resident #8's buttocks was red with creases noted in skin, but no skin breakdown. CNA I provided peri-care and applied barrier cream to the resident's buttocks. In an interview with CNA C on 02/05/25 at 12:30 p.m., she stated she was assigned to Resident #8 today (02/05/25) and did not provide incontinence care to her because she assumed the hospice nurse did because Resident #8 was on hospice. She stated her procedure was to check each resident every two hours or more often depending on the individual. She stated the risk for not changing Resident #8 for a long time would be skin break down and urinary infection. In an interview with CNA I on 02/05/25 at 1:35 p.m., she stated she was not assigned to Resident #8 today (02/05/25), and she would help CNA C when she called for assistance with total care residents. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/05/25 at 01:42 p.m., the DON stated it was her expectation the CNAs provide incontinence care in a timely manner at least every two hours. She stated the risk factor for not performing timely incontinence care was skin rash, infection, and skin breakdown. She stated she felt there was enough staff to care for the current resident census. She stated it was the expectation for the CNAs to come and ask the nurse, medication aide, or herself if they needed assistance with a resident. Record review of the facility's policy titled, Perineal Care Protocol, dated September 2023, reflected, Purpose: to provide care of the external genitalia and anal are which promotes cleanliness and prevents infections .Perform hand hygiene and apply gloves .Assist patient to supine position and remove soiled brief . Remove gloves and perform hand hygiene, and apply new gloves .Perform perineal care (as directed below) . For male patient .Gently hold the shaft of the penis, cleanse the head of the penis from urethral meatus outward in circular motion .Cleanse the shaft of the penis from the head of the penis toward the body .Using the downward one stroke method. Gently cleanse one groin fold and the scrotum, use a new cleansing wipe to cleanse the other groin fold and other side of the scrotum .Cleanse across the lower abdomen and inner thighs using a downward stroke method. Use a separate cleaning wipe for the lower abdomen and inner thighs .Turn the patient to his side to expose the anal area .Cleanse the anal area, wiping in one stroke method from the front toward the rectum .Cleanse the entire buttock and hip area using a separate cleaning wipe for each area .Remove gloves, perform hand hygiene, and apply new gloves .Apply brief .Assist patient to comfortable position .Remove gloves, sanitize hands, and remove sealed plastic bag(s) . Record review of the facility's policy titled, Activities of Daily Living, dated May 2016, reflected, Every effort must be made to assure that assignments of nurses and nurse aides to Patients are as consistent as possible .CNA ADL Tracking Records must be regularly monitored by the DON or designee to ensure that tasks are being performed as scheduled 42971

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 Based on observation, interview and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for three of eight residents (Residents #4, #5, and #6) reviewed for medications and for 1 (nurses cart hall ,d+[DATE]) of 2 medication carts reviewed for pharmacy services in that: 1. The Nurses Cart Hall ,d+[DATE] had 1 insulin pen for Resident #5 with an expired open date of [DATE] and 1 insulin pen for Resident #6 with no open date . Observation of the pen reflected it was not full and it was used. 2. The facility failed to administer Resident #4's Phenobarbital (treats seizures) according to doctor's orders on [DATE] and [DATE]. These failures placed residents at risk of not receiving the therapeutic benefits of the medications. The Findings included: 1. Observation on [DATE] at 09:40 AM of nurses cart hall ,d+[DATE], with LVN F revealed: - The pen of insulin humalog 100 unit /ml for Resident #5 with an expired opened date of [DATE]. - The pen of insulin lantus 100 unit/ml for Resident #6 with no open date . Observation of the pen reflected it was not full and it was used. Interview on [DATE] at 09:35 AM, LVN F stated she did not give insulin to Resident #5 and Resident #6 and she did not check the pen for the open date. LVN F stated the purpose for putting an open date was for expiration purposes because the insulin was only good for 28 days. She stated after 28 days the insulin would be ineffective. Interview on [DATE] at 01:42 PM, the DON stated the insulin flex pens and vial, once opened, needed to be dated because each insulin pen and vial had a specific day's shelf life and if not thrown out before that time the insulin could lose its effectiveness. The DON stated the pharmacy consultant checked the carts monthly and she stated she was supposed to do random checks of the medication carts for monitoring. 2. Record review of Resident #4's face sheet, dated printed [DATE], reflected he was a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of traumatic brain injury and epilepsy. Record review of Resident #4's Comprehensive MDS, dated [DATE], reflected he had a BIMS score of 10, which indicated moderate cognitive impairment. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's care plan, undated, reflected he had a history of seizures and was on levetiracetam divalproex with an intervention of give meds per order . Record review of Resident #4's physician orders revealed an order with a start date of [DATE] for Phenobarbital 30 mg tablet, orally, 3 times daily. Record review of Resident #4's nurses progress notes revealed a note, dated [DATE], written by LVN F at 1:28 PM: Medication Phenobarbital did not arrive last night as pharmacy had said, Called pharmacy again spoke with [Pharmacist K] and said it would be delivered tonight. Record review of Resident #4's electronic Medication Administration Record for [DATE], reflected Phenobarbital 30 mg tablet (2 tablets) orally 3 times a day were not administered on: [DATE] at 2 PM, signed by LVN F and 10 PM signed by LVN G [DATE] at 7 AM and 2 PM signed by LVN F In an interview on [DATE] at 9:06 AM with Resident #4, he was seated in his wheelchair in his room, he was a poor historian and stated he had no concerns with medications. In an interview on [DATE] at 3 PM with LVN F she reviewed [DATE]'s medication administration record for Resident #4 and stated she remembered that she was unable to give the medication (2 tablets of Phenobarbital 30 mg) to Resident #4 on [DATE], and [DATE]. She said the seizure medication had not been refilled and it was not in the emergency kit. She stated that Resident #4 had no negative effects, and no break through seizures. She stated she could not remember when she contacted the pharmacy and when she did, they said it would be sent to the facility, and they usually delivered in the middle of the night. She stated that the following day she saw the medication had not been filled and called the pharmacy again and spoke with Pharmacist K who said they would be delivered that evening. She stated she most likely would have mentioned it to the physician but could not remember and did not remember if she told the Interim Director of Nursing. She stated that there was not a local company to get the medications from in these situations. She stated that the cut off time for medications to come in at midnight was 3 PM. In an interview on [DATE] at 4:08 PM with LVN G she reviewed Resident #4's [DATE] Medication Administration Record (MAR) and stated she remembered that the resident was out of the medication Phenobarbital and she was unable to administer the medication. She stated it was not a medication that they kept in the emergency kit. She stated she was unable to recall if she contacted the pharmacy but knew they had been notified and there was not a local pharmacy they could contact. She stated that usually medication refills are ordered a week in advance through fax and they received deliveries at midnight on Tuesdays or Thursdays. She stated refill requests needed to be completed by noon on Tuesdays to receive them Tuesday at midnight or they would not receive the medication until Thursday. In an interview on [DATE] at 12:34 PM with Interim Administrator he said if a resident missed a dose of medication, because it was not available then he expected nurses to check the emergency kit and if it was not available then they would notify the physician and follow whatever orders the physician gave and document in the progress notes. He stated he was unaware any residents missed a seizure medication in [DATE] and the risk to a resident could be break through seizures. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a phone interview on [DATE] at 1:03 PM with Interim DON he said he was unaware that Resident #4 had missed any doses of a seizure medication in November of 2024 and did not remember if nurses informed him that the facility had run out of a seizure medication. He stated he would have expected the nurse to check the emergency kit and if there was not any medication there then inform the DON and he would have called the pharmacy directly and the physician. He stated that the medication should have been ordered ahead of time. He stated the risk to the resident could be break through seizures. In an interview on [DATE] at 1:46 PM with LVN H she said she was the charge nurse and was not aware of any resident missing seizure medications in [DATE]. She stated that they send refill requests on Tuesdays and Thursday by noon to the pharmacy by printing the labels and faxing them to the pharmacy. She stated that if a resident is out of a medication they should notify the physician and follow any new orders. She stated a resident missing 4 doses of a seizure medication like Phenobarbital placed them at risk for breakthrough seizures. In an interview on [DATE] at 2:50 PM with the DON she said medications refill requests are sent via fax to the pharmacy and they receive fax confirmations. She stated it would be concerning if a resident did not receive 4 doses of Keppra because it would put them at risk for break through seizures. She stated she expected nurses to notify the pharmacy of refill requests timely and notify the physician and the DON if the medication was not available and document it in the progress notes. On [DATE] at 3:38 PM, an attempt to interview Pharmacist K via phone revealed he was not available and in interview with Pharmacist L she stated the Phenobarbital was dispensed on [DATE] with a quantity of 120 pills. She stated that it was important to not miss doses because a resident who took Phenobarbital to control seizures could experience break through seizures if they missed several doses. She stated the facility faxes the prescription labels with a refill request and had the ability to call them. Record review of the facility's medication reordering policy, titled Medication Ordering Procedures, dated revised [DATE], reflected Purpose: To ensure that medications are ordered appropriately and to assist both the Facility and Pharmacy in maintain a timely medication re-ordering schedule . Procedure 3) .Check each medication card/container/package and ensure there is enough medication on hand to meet the needs of the Patient. Reorder as needed . 4) Medications should not be reordered until there is a ,d+[DATE] day supply remaining. Compare the directions and quantity carefully to determine the appropriate time to reorder. 5) If a medication refill is needed, remove the small re-order sticker from the prescription label and affix to an appropriate re-order form. Scan or fax this form to [Pharmacy]. Keep all fax confirmation sheets. Note: Do not attempt to fax the original reorder sheet as the prescription labels may jam the fax machine. Instead, make a copy of this form and fax the copy to [Pharmacy] . 7) If a medication refill was overlooked during the twice weekly review process and is needed prior to the Facility's next assigned refill day, please call [Pharmacy] and make arrangements for the processing of a refill outside your normal schedule . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled Medication Labeling and Storage, revised February 2023, revealed in part .5. Multi-dose vials that have been opened or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. 49427

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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. 34399 Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for one of one kitchen reviewed for Food and Nutrition Services. 1. The facility failed to ensure the walk-in freezer was free of ice accumulation. 2. The facility failed to ensure Dietary [NAME] O used proper hand hygiene while handling and serving food during the lunch meal preparation and service on 02/04/25. These failures could place residents at risk for food-borne illness if consumed and food contamination. Findings included: 1. Observation on 02/04/25 at 9:13 AM of the walk-in freezer revealed ice accumulation of about 4 ft length x 3 ft wide including icicles up to 2 inches covering the ceiling. There was an ice thickened patch of about 2 ft length x 1 foot length in the back right corner of the walk-in freezer. There were ice particles and patches of ice covering the floor of the walk-in freezer. There were ice patches near the door of the walk-in freezer. The freezer door was difficult to open from inside due to ice accumulation. Interview on 02/04/25 at 9:16 AM with Dietary Consultant stated she had reached out to the service company to come look at it but could not remember when and if they were coming to look at the freezer. She could not recall the last time the freezer had been serviced. She stated she was aware of the ice accumulation in the freezer. Interview on 02/04/25 at 10:48 AM with Maintenance Supervisor revealed he was not aware of the walk-in freezer having ice accumulation or any issues at this time. He was unable to recall the last time he had seen the walk-in freezer. He stated the walk-in freezer in the past had to be serviced but could not remember when and what was repaired in the walk-in freezer. Interview on 02/04/25 at 10:57 AM with Dietary [NAME] O revealed the walk-in freezer was serviced in the past for the rubber seal around the door coming out. She stated the walk-in freezer did have ongoing ice issues and the freezer door could get stuck due to the ice accumulation. She could not recall how long the walk-in freezer had ice accumulation and was not sure what the facility was doing to address it. Interview on 02/04/25 at 12:17 PM with Dietary Aide P revealed the walk-in freezer did have ice accumulation for some time but did not specify how long. She stated the ice particles on the floor of the walk-in freezer were concerning and were a fall hazard for staff. She could not recall when the walk-in freezer was last serviced or looked at. (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 02/04/25 at 12:18 pm revealed Dietary [NAME] O did not wash her hands, put gloves on, touched plates with gloved hands while scooping food onto plates for lunch. There were no observations of hand washing by Dietary [NAME] O. She continued to plate food for residents in the dining room until 12:33 PM. Interview on 02/04/25 at 1:25 PM with Dietary [NAME] O revealed she normally washed her hands prior to putting on gloves. She stated she should have washed her hands to prevent germs and viruses. Interview on 02/04/25 at 3:40 PM with Administrator revealed he expected dietary staff to use appropriate hand hygiene to prevent infection. He stated today was his second day as the new Administrator. He was not aware of the walk-in freezer needing to be serviced until today and he would need to look into it. He expected the facility staff including dietary staff to communicate to the Maintenance Supervisor of any maintenance concerns and to write it down in the maintenance log. The Administrator stated he could not find any other service documentation for the walk-in freezer since December 2024. Interview on 02/04/25 at 3:55 PM with the Dietitian revealed the dietary staff should wash hands prior to putting on gloves to prevent cross contamination. Review of email from the Service Vendor to the Maintenance Supervisor dated 12/20/24 reflected on 12/19/24 technician notes reflected vendor found a piece of ice between blade and fan guard. The service company serviced the fan guard removing the ice ball and installed a trap on the drain line to create air lock. Review of facility's policy Use of plastic gloves dated September 2006 reflected Plastic gloves will be worn when handling food directly with hands to ensure that bacteria is not transferred from the food handlers' hands to the food product being served .1. Hands are to be washed .before putting on the gloves .Staff are educated on the importance of hand washing and retrained and reminded as necessary on .policy and procedure. Review of facility's policy Handwashing dated September 2006 reflected Dietary Staff will wash hands .after removing gloves and at other times hands have been soiled. The facility did not have a policy on kitchen maintenance or general maintenance policy per the Administrator on 02/05/25. Record review of the Food and Drug Administration Food Code, dated 2022, reflected .2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLESP and (E) After handling soiled EQUIPMENT or UTENSILS; (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks . (H) Before donning gloves to initiate a task that involves working with FOOD; P and (I) After engaging in other activities that contaminate the hands

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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. 34918 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 and to help prevent the development and transmission of communicable diseases and infections for four of eight Residents (Resident #1, Resident #2, Resident #4, and Resident #8) observed for infection control. 1. The facility failed to ensure CNA A used the required PPE for Resident #1, who was on enhanced barrier precautions due to her venous access device, while assisting resident with toileting on 02/04/25 and failed to perform hand hygiene before and after assistance. 2. The facility failed to ensure CNA A and CNA B used the required PPE for Resident #2, who was on enhanced barrier precautions due to her foley catheter, while performing a mechanical lift transfer on 02/04/25. 3. The facility failed to ensure that CNA C changed her gloves and performed hand hygiene before moving to the clean supplies after completion of incontinence care to Resident #4 and before leaving the resident's room on 02/05/25. 4. The facility failed to ensure CNA C and CNA I changed her gloves and performed hand hygiene while providing incontinence care to Resident #8 on 02/05/25. These failures could place the residents at risk of cross-contamination and development of infection. Findings included: 1. In an observation and interview on 02/04/25 at 09:55 a.m. Resident #1's room was noted with a sign outside of her door which indicated she was in Enhanced Barrier Precautions. Resident #1 was observed in her wheelchair sitting in her room. She stated she had been at the facility for about 6 weeks and was getting therapy and IV antibiotics. Resident #1 was noted to have a PICC line in her upper right arm. An observation on 02/04/25 at 10:45 a.m. revealed CNA A responding to Resident #1's call light. CNA A entered Resident #1's room, put on gloves, but did not put on a gown, and pushed the resident's wheelchair into the bathroom. CNA A faced the resident toward the wall and instructed her to reach for the grab bars and then assisted the resident into a standing position. CNA A then moved the wheelchair away and pulled down the resident's brief and guided her toward the toilet. The resident slowly scooted her feet to position herself over the toilet. CNA A asked the resident to pull the call light when she was finished. CNA A placed the dirty brief in a trash bag, removed her gloves and left the room without performing hand hygiene, and went down the hall to dispose of the trash. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A follow up observation on 02/04/25 at 10:50 a.m. revealed Resident #1's call light on. CNA A returned to Resident #1's room, entered the room, without performing hand hygiene she put on gloves, but no gown. CNA A placed a clean brief around the residents' ankles and asked the resident if she was ready to stand. CNA A asked the resident if she could stand while she cleaned her buttocks. Resident #1 stated yes. Residents' legs were observed shaking. CNA A wiped the resident's buttocks with a peri-wipe, then removed her gloves. CNA A then put on clean gloves without performing hand hygiene. CNA A then pulled up the brief and fastened it, readjusted the residents' clothes, and assisted her back into her wheelchair. CNA A removed her gloves and left the room without performing hand hygiene. 2. In an interview and observation on 02/04/25 at 9:45 a.m., Resident #2's room was noted with a sign outside of her door which indicated she was on Enhanced Barrier Precautions. Interview with Resident #2 stated she had a foley catheter. In an observation on 02/04/25 at 11:30 a.m. CNA A and CNA B entered Resident #2's room to transfer her from her bed to the wheelchair with a mechanical lift. CNA B washed her hands and put on gloves, but no gown. CNA A put on gloves without performing hand hygiene, and not a gown. CNA A unhooked the urinary drainage bag from the bed rail and hooked it onto the lower pocket on her pants. Both staff positioned the resident onto the mechanical lift sling and hooked the sling to the mechanical lift. Once the sling was attached, CNA B instructed CNA A to attach the urinary drainage bag to the top bar of the mechanical lift, well above the resident's bladder. CNA A attached the urinary drainage bag to the top bar of the lift while CNA B began to lift the resident from the bed. Once the lift went up the resident was in a supine position with her urinary drainage bag above her head. The resident was positioned over the chair and lowered onto the chair. Urine was observed in the tube flowing up and down. CNA A then unhooked the drainage bag and placed it on the wheelchair. In an interview with CNA B on 02/04/25 at 11:35 a.m. she stated she saw the sign indicating the resident was on Enhanced Barrier precautions, but stated they only had to put on the gown if they were emptying the urinary drainage bag and providing incontinent care. She stated that was her understanding. In an interview with CNA A on 02/04/25 at 11:40 a.m. she stated she had started at the facility about 3 weeks ago. She stated she was assigned with another CNA who had showed her how to do things. She stated she did not know why Resident #1 was on enhanced barrier precautions. She stated it was her understanding they only had to wear the gown when providing incontinent care to Resident #2 and it was not required for transfers. She stated she was supposed to perform hand hygiene before and after care, and stated she thought she had done that. She stated this was her first time working in a facility and she was still learning. In an interview with the ADON on 02/04/25 at 12:45 p.m. she stated staff were taught that any resident who was in Enhanced Barrier Precautions required gloves and gown when providing any contact with the resident. She stated it is written on the notice posted on the door what care required gown and gloves. She stated she and the Interim DON had performed skills checks a few weeks ago which included infection control and hand hygiene. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Interim DON on 02/05/25 at 11:25 a.m., he stated they had trained the staff on the difference between Enhanced Barrier precautions and Isolation. He stated the signage they used clearly stated what care required the use of PPE. He stated he and the ADON did the competency checks on all the CNA staff a few weeks ago. He stated failing to follow protocol placed staff and other residents at risk of the spread of germs and infections. 3. In an observation on 02/05/25 at 10:00 a.m. CNA C entered Resident #4's room in response to his call light. Resident #4 told CNA C he needed to be changed and stated, I am soaked. CNA C put on gloves and proceeded to strip the resident's bed and gathered up the soiled linen and placed them in a plastic bag. CNA C then removed her gloves and left the room without performing hand hygiene. CNA C went down the hallway and deposited the dirty linen in the soiled linen room. CNA C returned to the clean linen cart and re-entered Resident #4's room. CNA C then put on gloves without performing hand hygiene and made the resident's bed. CNA C stated she would have to get help to transfer the resident to bed to change him. CNA C removed her gloves and left the room without performing hand hygiene. CNA C re-entered Resident #4's room with the mechanical lift at 10:25 a.m. with the ADON. CNA C put on gloves without performing hand hygiene while the ADON washed her hands and put on gloves. Both staff hooked the mechanical sling to the lift and transferred the resident from his wheelchair to the bed. The wheelchair cushions exuded a very strong urine smell when the resident was lifted. The resident's pants were observed to be wet. Staff lowered the resident onto the bed and unhooked the sling. The ADON then left the room with the mechanical lift. CNA C assisted the resident to roll from side to side to remove the sling and then removed his wet pants and saturated brief. CNA C rolled the resident onto his left side and wiped his buttocks a few times with a peri-wipe. She then placed a clean brief under the resident with soiled gloves and had him roll onto his back. CNA C then took a peri-wipe and wipe down his groin one time on each side and wiped the top of his penile shaft from his body down toward the head of his penis. She did not clean the resident's scrotum, the underside of his penis, or his inner thighs. CNA C then fastened the brief, removed her gloves, and went to the resident's closet without performing hand hygiene, and retrieved a clean shirt. CNA C removed his dirty shirt and assisted him with putting on the clean shirt. CNA C then gathered the trash and dirty clothes and left the room without performing hand hygiene. In an interview with CNA C on 02/05/25 at 10:50 a.m. she stated they were required to perform hand hygiene before and after they provided care. She stated she realized she had not done this. She stated she did not realize she had to change gloves during care. She stated the risk of not performing hand hygiene was the spread of germs and infections. 4. An observation on 02/05/25 at 12:00 p.m. revealed CNA C and CNA I entered Resident #8's room to transfer her back to bed. Both staff washed their hands and put on gloves and transferred the resident via a mechanical lift from her Geri-chair to the bed. Both staff removed their gloves, without performing hand hygiene they re-gloved to provide peri-care. CNA C opened the resident's brief to reveal a strong smell of urine. CNA C provided peri care and with the same gloves on and with assistance from CNA I turned the resident over on her side to reveal she had saturated through the brief. CNA I provided peri-care and without changing her gloves, she applied barrier cream to the resident's buttocks. CNA I changed her gloves without performing hand hygiene, she placed a clean brief under the resident. Both staff then rolled the resident. Both staff closed the resident brief, assisted her with dressing, and transferred her via a mechanical lift from her bed to Geri-chair. Both staff then removed their gloves and washed their hands. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675441	A. Building B. Wing	02/05/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/05/25 at 12:30 p.m. CNA C stated she should change her gloves and perform hand hygiene when she went from dirty to clean. CNA C stated failing to provide proper care exposed the resident to infections. CNA C stated she did not realize she had soiled gloves on when she assisted Resident #8 to turn on her side. In an interview on 02/05/25 at 01:35 p.m. CNA I stated she should change her gloves and perform hand hygiene when she went from dirty to clean. CNA I stated failing to provide proper care exposed the resident to infections. In an interview on 02/05/25 at 01:42 p.m., the DON stated they had trained on when staff were to change their gloves and sanitize their hands. She stated staff needed to change their gloves when they go from dirty to clean. She stated the risk was increased risk of infections. She stated she would be re-training and observing care to ensure staff compliance. Record review of the facility's undated signage from the CDC for Enhanced Barrier precautions reflected, Enhanced Barrier Precautions Everyone must: Clean hands, including before entering and when leaving the room. Providers and Staff Must Also: Wear gloves and gown for the following High-Contact Resident Care Activities. dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting. Device Care or use: Central line, urinary catheter, feeding tube, tracheostomy, Wound Care: any skin opening requiring a dressing. Record review of the facility's policy titled, Hand Hygiene, dated August 2024, reflected, Hand washing is the single most important means of preventing the spread of infection . Record review of the facility's policy titled, Perineal Care Protocol, dated September 2023, reflected, Purpose: to provide care of the external genitalia and anal are which promotes cleanliness and prevents infections .Perform hand hygiene and apply gloves .Assist patient to supine position and remove soiled brief . Remove gloves and perform hand hygiene, and apply new gloves .Perform perineal care(as directed below) . Remove gloves, perform hand hygiene, and apply new gloves .Apply brief .Assist patient to comfortable position .Remove gloves, sanitize hands, and remove sealed plastic bag(s) . 42971

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 34399 Based on observations, interviews, and record review the facility failed to maintain equipment in safe operating condition in facility's kitchen reviewed for physical environment. 1. The facility failed to ensure the walk-in freezer was in good repair and free of ice accumulation on 02/04/25. 2. The facility failed to ensure 3-compartment sink was not leaking underneath from the pipe. 3. The facility failed to ensure the steam table did not have 3 missing knobs while in use for lunch on 02/04/25. This failure could place a potential for fire hazard risk in the facility kitchen with equipment not in safe operating condition. Findings included: 1. Observation on 02/04/25 at 9:13 AM of the walk-in freezer revealed ice accumulation of about 4 ft length x 3 ft wide including icicles up to 2 inches covering the ceiling. There was an ice thickened patch of about 2 ft length x 1 foot length in the back right corner of the walk-in freezer. There were ice particles and patches of ice covering the floor of the walk-in freezer. There were ice patches near the door of the walk-in freezer. The freezer door was difficult to open from inside due to ice accumulation. Interview on 02/04/25 at 9:16 AM with Dietary Consultant stated she had reached out to the service company to come look at it but could not remember when and if they were coming to look at the freezer. She could not recall the last time the freezer had been serviced. She stated she was aware of the ice accumulation in the freezer. Interview on 02/04/25 at 10:48 AM with Maintenance Supervisor revealed he was not aware of walk-in freezer having ice accumulation or any issues at this time. He was unable to recall the last time he had seen the walk-in freezer. He stated the walk-in freezer in the past had to be serviced but could not remember when and what was repaired in the walk-in freezer. Interview on 02/04/25 at 10:57 AM with Dietary [NAME] O revealed the walk-in freezer was serviced in the past for the rubber seal around the door coming out. She stated the walk-in freezer did have ongoing ice issues and the freezer door could get stuck due to the ice accumulation. She could not recall how long the walk-in freezer had ice accumulation and was not sure what the facility was doing to address it. Interview on 02/04/25 at 12:17 PM with Dietary Aide P revealed the walk-in freezer did have ice accumulation for some time but did not specify how long. She stated the ice particles on the floor of the walk-in freezer were concerning and were a fall hazard for staff. She could not recall when walk-in freezer was last serviced or looked at. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation on 02/04/25 at 11:48 AM on 02/04/25 revealed water dropping into a container from under the 3 compartment sink with the container being full to the top. Interview on 02/04/25 at 11:49 AM with Dietary Consultant revealed the 3-compartment sink had been leaking for about a week and Maintenance Supervisor was aware of it. 3. Observation on 02/04/25 at 11:50 AM revealed the steam table was in use with red light indicated with 3 of 5 knobs missing on the steam table. Interview on 02/04/25 at 11:51 AM with Dietary [NAME] O revealed she showed the knob to the surveyor. She stated the knob will not stay on and she had to use one knob each time to turn the steam table to the proper setting. She stated it had been like this for some time but could not recall how long. Interview on 02/04/25 at 3:40 PM with Administrator revealed today was his second day as the new Administrator. He was not aware of the walk-in freezer in the kitchen needing to be serviced until today and would need to look into it. He expected facility staff including Dietary staff to communicate to Maintenance Supervisor of any maintenance concerns and to write it down in the maintenance log. The Administrator stated he could not find any other service documentation for the walk-in freezer since December 2024. He expected the Maintenance Supervisor to repair if possible and replace. He stated if unable to fix the equipment then the facility should reach out to a vendor to have the equipment looked at. He was not aware of the steam table having missing knobs and was unaware of the 3-compartment sink leaking. Interview on 02/05/25 at 10:34 AM with Maintenance Supervisor revealed he was not aware of the 3-compartment sink leaking. He stated he did a walk through of the kitchen yesterday and did not observe it. He stated the leaking could cause damage to the walls. He stated Dietary communicated to him about maintenance concerns by calling him or tells him when Dietary sees him in the building. Review of Email from Service Vendor to the Maintenance Supervisor dated 12/20/24 reflected on 12/19/24 technician notes reflected vendor found a piece of ice between blade and fan guard. Service company serviced the fan guard removing the ice ball and installed trap on drain line to create air lock. Review of facility's Maintenance Log for December 2024 to February 2025 revealed no kitchen maintenance repairs. The facility did not have a policy on kitchen maintenance or general maintenance policy per the Administrator on 02/05/25. The facility did not submit a policy on kitchen maintenance or general maintenance policy by the date and time of exit.