STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675443	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Acres	201 E 15th Friona, TX 79035

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 48491 Based on interviews and record review, the facility failed to implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents for 1 (CNA I) of 12 staff reviewed for abuse policies. The facility did not implement the training /orientation of CNA I related to abuse, neglect, and exploitation per facility policy. This failure could place residents in the facility at risk of Abuse, Neglect, or Exploitation. Findings included: Record Review of CNA I's employee file revealed she was hired on 03/01/24 and her Abuse, Neglect, or Exploitation Training took place on 03/28/24. During an interview on 05/30/24 at 3:11 PM, ADM stated he hired this CNA after she had worked for the facility as agency staff. ADM stated he needed CNAs so badly that he allowed her to work and do trainings after she was hired. During an interview on 05/30/24 at 3:37 PM, ADM stated that a possible negative outcome for not having staff trained about Abuse and Neglect would be that they would not be prepared for issues that could arise. He stated he made a judgment call to hire this CNA without proper training, and it was his mistake. Record review of the facility provided New Hire Instructions page included the following: .New Hire MUST complete the following BEFORE floor work: - [Brand name of electronic program] Training And after all training is complete - then they are added to the schedule for orientation. Record Review of the facility provided policy titled Abuse, Neglect and Exploitation Prevention Program not dated, revealed the following: (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Require staff training/orientation programs that include such topics as abuse prevention, identification, and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534 Based on observations, interviews, and record reviews the facility failed to develop and implement a comprehensive person-centered care plan for 1 (Resident #35) of 12 residents reviewed for care plans. The facility failed to implement Resident #35's care plan for a chair alarm in his w/c and 1:1 monitoring, and he had an unwitnessed fall which resulted in a broken left hip. This failure could place residents at risk of injury due to falls. Findings Included: Record review of Resident #35's admission record dated 05/30/24 revealed an [AGE] year-old male originally admitted to the facility 03/29/23 with a most recent admitted [DATE]. He had diagnoses that included, but were not limited to, infection following a procedure, fracture of neck of right femur (right hip), dementia (a group of thinking and social symptoms that interferes with daily functioning), impulse disorder (lack of ability to control self), wandering, and Alzheimer's (a progressive disease that destroys memory and other important mental functions). Record review of Resident #35's Quarterly MDS completed on 05/17/24 revealed the following: Section C of the MDS revealed a BIMS of 3 which indicated severely impaired cognition. Section GG of the MDS revealed Resident #35 was dependent on staff for walking and needed partial to substantial assistance with other mobility ADLs. Section J of the MDS indicated Resident #35 had had major surgery to repair a fracture as well as another major surgery. Section P of the MDS revealed bed and chair alarms were used daily. Record review of Resident #35's care plan completed on 05/29/24 revealed a focus area of fall risk due to impaired mobility, cognitive deficits and weakness. Interventions were as follows: 03/18/24 used a mobility monitor on his w/c for safety. 03/14/24 have increased assistance, surveillance, activities involvement, a mobility alarm, and be placed near the nurses' station. 03/14/24 1:1 monitoring, and or activities to maintain (his) safety and to divert (his) attention away from attempting to stand/ambulate without supervision/assistance. Record review of Resident #35's active orders dated 05/30/24 revealed the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An order for admission to skilled service related to hip fracture dated 03/13/24. An order to monitor left hip for s/s of infection twice a day dated 05/29/24. Record review of Resident #35's Fall Risk Assessments front sheet in the EHR revealed he was assessed as a moderate risk for falls prior to his falls on 03/08/24 and 05/20/24 which resulted in a broken right hip and a broken left hip. Record review of Resident #35's Progress Notes revealed the following: 03/08/24 written by DON revealed Resident #35 had fallen in his room and was found on the floor on his left side next to his bed. He was sent to the ER via ambulance. 03/13/24 written by LVN H revealed Resident #35 was returning to facility following surgery on 03/09/24 for a right hip fracture. 03/15/24 written by RN L revealed Resident #35 attempted to turn himself in his bed without staff assistance. 03/17/24 written by RN M revealed Resident #35 attempted to get up without staff assistance. 03/18/24 written by RN M revealed Resident #35 attempted to get up without staff assistance. 03/19/24 written by RN L revealed Resident #35 attempted to get up without staff assistance. 03/20/24 written by RN L revealed Resident #35 attempted to get up without staff assistance. 03/25/24 01:11 PM written by RN L revealed Resident #35 got up from his bed without assistance. 03/25/24 10:50 PM written by RN M revealed Resident #35 attempted to get out of bed by himself. 04/30/24 written by LVN H revealed Resident #35 had a mobility alarm on his w/c. 05/03/24 written by RN L revealed Resident #35 attempted to get out of bed by himself. 05/12/24 written by RN M revealed Resident #35 got out of bed by himself. 05/20/24 02:54 PM written by LVN C revealed Resident #35 fell from his w/c and was sent via ambulance to the ER. 05/20/24 05:51 PM written by DON revealed Resident #35 was being sent from the local hospital to a higher level of care for a broken left hip. Record review of Resident #35's Daily Skilled Nurses Note2 dated 05/20/24 at 10:50 AM and filled out by LVN C revealed services provided for Resident # included Management/Evaluation of Resident Care Plan, Observation/Assessment of Resident's Condition and Therapy (PT, OT, ST). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility investigation into Resident #35's fall on 05/20/24 revealed Resident #35 had just received a haircut and was wheeling himself in his w/c down the hall from the salon and fell near the chapel door. AD heard him saying help and found him lying on the floor. She asked her assistant to notify nursing staff and LVN C assessed Resident #35 and called an ambulance, his family member, the DON, and his doctor. During an interview on 05/29/24 at 07:19 AM ADM stated Resident #35 had just been transitioned from a geri chair to a w/c before the fall on 05/20/24 when he broke his left hip. During an observation and interview on 05/29/24 at 09:12 AM, AD stated she found Resident #35 wheeling himself in his w/c in the lobby on 05/20/24. She said she asked him if he wanted a haircut, and he said yes. At that point she wheeled him back to the salon and cut his hair. She stated he was strolling out (here she made motions with both hands as if she was spinning the wheels of a wheelchair). AD stated Resident #35 was moving along just fine so she started sweeping up in the salon. She said she heard him say help, help and she peeked around the corner of the salon doorway and could not see him, so she walked around the corner into the hallway and saw him on the floor. AD stated she did not see how he fell or what happened just that he was on the floor. She asked her activity aide to get a nurse. During an interview on 05/29/24 at 09:41 AM, LVN C stated on 05/20/24 she saw therapy working with Resident #35 on walking and later when he was in his w/c she saw him paddling his feet as if he was walking. LVN C stated when she was sitting at the nurses' station facing the lobby, she heard someone make a moaning sound twice. She said she turned to someone sitting next to her and they discussed the sound but did not know where it came from. LVN C stated staff said, [First name of Resident #35]'s on the floor, [First name of Resident #35]'s on the floor! She then got up from the nurses' station and assessed Resident #35. She stated he was lying on his right side on the incision from his prior hip surgery when she found him, and his w/c was next to him. LVN C said Resident #35 complained of pain in his back at the time she was assessing him. She stated when the ambulance arrived and the EMTs were assessing him, he told them his left arm hurt and they removed his shirt and found a skin tear on his left elbow. During an interview on 05/30/24 at 09:58 AM, Resident #35's family member stated she had some concern that he had fallen twice in three months and broken both of his hips. She stated the first fall she could understand as he walked all the time without the aid of a cane or walker, and he had trouble seeing out of his left eye. She stated she could see how his constant walking and trouble seeing combined with his Alzheimer's diagnosis might have contributed to a fall. She stated when the second fall happened the chair alarm that was to be in use to help prevent another fall was not in use. She stated two staff members, LVN C and DON, told her during two different phone conversations that the chair alarm was not in use because they were too busy to put it in (his w/c). Resident #35's family member stated neither staff member elaborated on what they were busy doing. She said LVN C told her Resident #35 had just been working with therapy and staff did not have time to put the alarm in his w/c before he fell . During an interview on 05/30/24 at 10:34 AM, DON stated Resident #35 was supposed to have a mobility alarm in his w/c when he fell but therapy had just taken him out of the geri chair to work with him in the w/c and then staff got him for a haircut and were with him. The alarm was in his geri chair and we had not moved it over to the w/c because he was with somebody the whole time. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/30/24 at 10:40 AM, AD stated she did not remember if any staff person was with Resident #35 when she found him in the lobby and asked him if he wanted a haircut. She stated she did not know Resident #35 needed to have an alarm in his w/c. During an interview and observation on 05/30/24, AD pointed out the door of the salon, the 20 to 30-foot hallway to the corner, and the spot around the corner where she found Resident #35 on the floor after hearing him moaning. During an interview on 05/30/24 at 02:02 PM, ADM and DON stated 1:1 meant a resident would receive individual attention during a specific time from a staff member. DON stated no residents in the facility required 1:1 monitoring all the time and the facility did not have enough staff to provide that type of monitoring. During an interview on 05/30/24 at 03:31 PM, ADM and DON stated the 1:1 monitoring mentioned in Resident #35's care plan meant if he was attempting to ambulate or stand we will give the resident assistance and when he was stable and settled, they would stop the 1:1 monitoring. During an interview on 05/30/24 at 03:28 PM, MDS RN stated she was responsible for writing care plans. She said a care plan was instructions on how to care for a resident and if they are not followed that is not gonna be good. MDS RN stated the 1:1 monitoring mentioned in Resident #35's care meant, If he is trying to get up staff will intervene and keep him from getting up and stay with him until he is settled. During an interview on 05/30/24 at 03:37 PM, DON stated if a resident's care plan was not followed it would be detrimental for the resident. During an interview on 05/30/24 at 03:39 PM, LVN H stated if a resident is care planned for a mobility alarm in their w/c it should be put on immediately. She stated if the alarm was not used the resident could get hurt. During an interview on 05/30/24 at 03:50 PM, ADM stated there could be a negative outcome if a resident's care plan is not followed. He stated in the case of Resident #35's chair alarm, I don't think the alarm would have helped him from falling, it would have alerted us to the fall. Record review of undated facility policy titled Care Plans, Comprehensive Person-Centered revealed the following: . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Record review of undated facility policy titled Fall and Fall Risk, Managing revealed the following: . Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. 8. Position change alarms will not be used as the primary or sole intervention to prevent falls, but rather will be used to assist the staff in identifying patterns and routines of the resident The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner.

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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 0689 Level of Harm - 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** 46534 Based on observations, interviews, and record reviews the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for 1 (Resident 35) of 12 residents reviewed for accidents. On 05/20/24 the facility failed to provide adequate supervision and assistance devices for Resident #35 and he had an unwitnessed fall which resulted in a broken left hip. This failure could place residents at risk of injury or harm. Findings Included: Record review of Resident #35's admission record dated 05/30/24 revealed an [AGE] year-old male originally admitted to the facility 03/29/23 with a most recent admitted [DATE]. He had diagnoses that included, but were not limited to, infection following a procedure, fracture of neck of right femur (right hip), dementia (a group of thinking and social symptoms that interferes with daily functioning), impulse disorder (lack of ability to control self), wandering, and Alzheimer's (a progressive disease that destroys memory and other important mental functions). Record review of Resident #35's Quarterly MDS completed on 05/17/24 revealed the following: Section C of the MDS revealed a BIMS of 3 which indicated severely impaired cognition. Section GG of the MDS revealed Resident #35 was dependent on staff for walking and needed partial to substantial assistance with other mobility ADLs. Section J of the MDS indicated Resident #35 had had major surgery to repair a fracture as well as another major surgery. Section P of the MDS revealed bed and chair alarms were used daily. Record review of Resident #35's care plan completed on 05/29/24 revealed a focus area of fall risk due to impaired mobility, cognitive deficits and weakness. Interventions were as follows: 03/18/24 used a mobility monitor on his w/c for safety. 03/14/24 have increased assistance, surveillance, activities involvement, a mobility alarm, and be placed near the nurses' station. 03/14/24 1:1 monitoring, and or activities to maintain (his) safety and to divert (his) attention away from attempting to stand/ambulate without supervision/assistance. Record review of Resident #35's active orders dated 05/30/24 revealed the following: (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 0689 Level of Harm - Actual harm Residents Affected - Few	An order for admission to skilled service related to (right) hip fracture dated 03/13/24. An order to monitor left hip for s/s of infection twice a day dated 05/29/24. Record review of Resident #35's Fall Risk Assessments front sheet in the EHR revealed he was assessed as a moderate risk for falls prior to his falls on 03/08/24 and 05/20/24. The falls resulted in a broken right hip and a broken left hip respectively. Record review of Resident #35's Progress Notes revealed the following: 03/08/24 written by DON revealed Resident #35 had fallen in his room and was found on the floor on his left side next to his bed. He was sent to the ER via ambulance. 03/13/24 written by LVN H revealed Resident #35 was returning to facility following surgery on 03/09/24 for a right hip fracture. 03/15/24 written by RN L revealed Resident #35 attempted to turn himself in his bed without staff assistance. 03/17/24 written by RN M revealed Resident #35 attempted to get up without staff assistance. 03/18/24 written by RN M revealed Resident #35 attempted to get up without staff assistance. 03/19/24 written by RN L revealed Resident #35 attempted to get up without staff assistance. 03/20/24 written by RN L revealed Resident #35 attempted to get up without staff assistance. 03/25/24 01:11 PM written by RN L revealed Resident #35 got up from his bed without assistance. 03/25/24 10:50 PM written by RN M revealed Resident #35 attempted to get out of bed by himself. 04/30/24 written by LVN H revealed Resident #35 had a mobility alarm on his w/c. 05/03/24 written by RN L revealed Resident #35 attempted to get out of bed by himself. 05/12/24 written by RN M revealed Resident #35 got out of bed by himself. 05/20/24 02:54 PM written by LVN C revealed Resident #35 fell from his w/c and was sent via ambulance to the ER. 05/20/24 05:51 PM written by DON revealed Resident #35 was being sent from the local hospital to a higher level of care due to a broken left hip. Record review of Resident #35's Daily Skilled Nurses Note2 dated 05/20/24 at 10:50 AM and filled out by LVN C revealed services provided for Resident # included Management/Evaluation of Resident Care Plan, Observation/Assessment of Resident's Condition and Therapy (PT, OT, ST). (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 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of facility investigation into Resident #35's fall on 05/20/24 revealed Resident #35 had just received a haircut and was wheeling himself in his w/c down the hall from the salon and fell near the chapel door. AD heard him saying help and found him lying on the floor. She asked her assistant to notify nursing staff and LVN C assessed Resident #35 and called an ambulance, his family member, the DON, and his doctor. During an interview on 05/29/24 at 07:19 AM ADM stated Resident #35 had just been transitioned from a geri chair to a w/c before the fall on 05/20/24 when he broke his left hip. During an observation and interview on 05/29/24 at 09:12 AM AD stated she found Resident #35 wheeling himself in his w/c in the lobby on 05/20/24. She said she asked him if he wanted a haircut, and he said yes. At that point she wheeled him back to the salon and cut his hair. She stated he was strolling out (here she made motions with both hands as if she was spinning the wheels of a wheelchair). AD stated Resident #35 was moving along just fine so she started sweeping up in the salon. She said she heard him say help, help and she peeked around the corner of the salon doorway and could not see him, so she walked around the corner into the hallway and saw him on the floor. AD stated she did not see how he fell or what happened just that he was on the floor. She asked her activity aide to get a nurse. During an interview on 05/29/24 at 09:41 AM LVN C stated on 05/20/24 she saw therapy working with Resident #35 on walking and later when he was in his w/c she saw him paddling his feet as if he was walking. LVN C stated when she was sitting at the nurses' station facing the lobby, [Resident #35's fall happened at the end of the hall behind LVN C, if she was facing the lobby] she heard someone make a moaning sound twice. She said she turned to a staff member sitting next to her and they discussed the sound but did not know where it came from. LVN C stated a different staff said, [First name of Resident #35]'s on the floor, [First name of Resident #35]'s on the floor! She then got up from the nurses' station and assessed Resident #35. She stated he was lying on his right side on the incision from his prior hip surgery when she found him, and his w/c was next to him. LVN C said Resident #35 complained of pain in his back at the time she was assessing him. She stated when the ambulance arrived and the EMTs were assessing him, he told them his left arm hurt and they removed his shirt and found a skin tear on his left elbow. During an interview on 05/30/24 at 09:58 AM Resident #35's family member stated she had some concern that he had fallen twice in three months and broken both of his hips. She stated the first fall she could understand as he walked all the time without the aid of a cane or walker, and he had trouble seeing out of his left eye. She stated she could see how his constant walking and trouble seeing combined with his Alzheimer's diagnosis might have contributed to a fall. She stated when the second fall happened the chair alarm that was to be in use to help prevent another fall was not in use. She stated two staff members, LVN C and DON, told her during two different phone conversations that the chair alarm was not in use because they were too busy to put it in (his w/c). Resident #35's family member stated neither staff member elaborated on what they were busy doing. She said LVN C told her Resident #35 had just been working with therapy and staff did not have time to put the alarm in his w/c before he fell . During an interview on 05/30/24 at 10:34 AM DON stated Resident #35 was supposed to have a mobility alarm in his w/c when he fell but therapy had just taken him out of the geri chair to work with him in the w/c and then staff got him for a haircut and were with him. The alarm was in his geri chair and we had not moved it over to the w/c because he was with somebody the whole time. (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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/30/24 at 10:40 AM AD stated she did not remember if any staff person was with Resident #35 when she found him in the lobby and asked him if he wanted a haircut. She stated she did not know Resident #35 needed to have an alarm in his w/c. During an interview and observation on 05/30/24 AD pointed out the door of the salon, the 20 to 30-foot hallway to the corner, and the spot around the corner where she found Resident #35 on the floor after hearing him moaning. During an interview on 05/30/24 at 02:02 PM ADM and DON stated 1:1 meant a resident would receive individual attention during a specific time from a staff member. DON stated no residents in the facility required 1:1 monitoring all the time and the facility did not have enough staff to provide that type of monitoring. During an interview on 05/30/24 at 03:28 PM MDS RN stated a care plan was instructions on how to care for a resident and if they are not followed that is not gonna be good. MDS RN stated the 1:1 monitoring mentioned in Resident #35's care meant, If he is trying to get up staff will intervene and keep him from getting up and stay with him until he is settled. During an interview on 05/30/24 at 03:31 PM ADM and DON stated the 1:1 monitoring mentioned in Resident #35's care plan meant if he was attempting to ambulate or stand we will give the resident assistance and when he was stable and settled, they would stop the 1:1 monitoring. During an interview on 05/30/24 at 03:37 PM DON stated if a resident's care plan was not followed it would be detrimental for the resident. During an interview on 05/30/24 at 03:39 PM LVN H stated if a resident is care planned for a mobility alarm in their w/c it should be put on immediately. She stated if the alarm was not used the resident could get hurt. During an interview on 05/30/24 at 03:50 PM ADM stated there could be a negative outcome if a resident's care plan is not followed. He stated in the case of Resident #35's chair alarm, I don't think the alarm would have helped him from falling, it would have alerted us to the fall. Record review of undated facility policy titled Care Plans, Comprehensive Person-Centered revealed the following: . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Record review of undated facility policy titled Fall and Fall Risk, Managing revealed the following: . Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. 8. Position change alarms will not be used as the primary or sole intervention to prevent falls, but rather will be used to assist the staff in identifying patterns and routines of the resident The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534 Based on observation, interview, and record review the facility failed to ensure a resident who is fed by enteral means receives the appropriate treatment and services to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers for 1 (Resident #91) of 1 residents reviewed for tube feeding. The facility failed to check for PEG tube placement before administering medication (Cephalexin) via the tube for Resident #91. This failure could place resident at risk of aspiration, bleeding, or perforation, pneumonia, and even death. Findings Included: Record review of Resident #91's admission record dated 05/30/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included but were not limited to cerebral infarction due to embolism (stroke due to blood clot), dysphagia following cerebral infarction (difficulty in swallowing following stroke), epilepsy (disorder that causes seizures or unusual sensations and behaviors), pneumonitis due to inhalation of food and vomit (inflammation of lung tissue), aspiration of fluid (breathing fluid into the lungs), and acquired absence of part of stomach. Record review of Resident #91's quarterly MDS completed on 03/26/24 revealed the following: Section C revealed a BIMS of 3 which indicated severely impaired cognition. Section GG noted eating was not attempted due to medical condition or safety concerns. Section K revealed Resident #91 was on a feeding tube while a resident and received 51% or more of his total calories and 500 cc/day or less of fluid through the tube. Record review of Resident #91's care plan completed 05/02/24 revealed a focus area of risk for aspiration r/t feeding tube initiated on 02/27/24. One intervention for this focus area was to ensure proper tube placement prior to beginning feeding. A second focus area initiated on 08/10/24 addressed the requirement for tube feeding r/t dysphagia. One intervention for this focus area was to ensure placement of the tube by marking the length of the tube. A second intervention for this focus area addressed Resident #91's medications being crushed and administered through his PEG tube. A third intervention for this focus area referred the reader to the previous risk for aspiration focus area. Record review of Resident #91's active order summary dated 05/29/24 revealed the following: An order for Cephalexin to be given via PEG tube four times a day related to aspiration of fluid with a start date of 05/24/24. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 05/28/24 at 11:57 AM LVN C administered Cephalexin to Resident #91 via his PEG tube without first checking the tube for placement. During an interview on 05/29/24 at 12:18 PM DON stated administering medication through a PEG tube without first checking the tube for placement could create issues in the abdomen of the resident and medications/food could go in the wrong place. She stated nurses were responsible to provide proper care to Resident #91's PEG tube. During and interview on 05/29/24 at 12:42 PM LVN C stated she has worked for the facility for several years part time. She stated she did not check the placement of Resident #91's tube before administering his medication on 05/28/24. She said, I know, I know I didn't. I went back and looked at it. I did it wrong and I understand. She explained the proper procedure that she should have done was to fill a syringe with a little air, attach it to the tube and listen with her stethoscope at the base of the tube for a whoosh sound as she pushed the air into the tube. LVN C said not checking for placement of the tube could result in an infection for the resident. Record review of undated facility policy titled Enteral Feedings-Safety Precautions revealed the following: . Preventing aspiration 1. Check enteral tube placement every 4 hours and prior to feeding or administration of medication. Record review of undated facility policy titled Enteral Nutrition revealed the following: . 16. Risk of aspiration is assessed by the nurse and provider and addressed in the individual care plan. [NAME] of aspiration may be affected by: . d. failure to confirm placement of the feeding tube prior to initiating the feeding.

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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 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** 46534 Based on observation, interview, and record review the facility failed to ensure a resident who needs respiratory care, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 (Resident #34) of 12 residents reviewed for respiratory care. Resident #34 had physician's orders for oxygen via nasal cannula at 2-3 lpm and was receiving oxygen at 5 lpm. This failure could place residents at risk for hypercapnia (too much carbon dioxide in the blood), pulmonary oxygen toxicity (damage to the lung lining tissues and air sacs), hypoxemia (low levels of oxygen in the blood, decreasing the oxygen supply to vital organs), and shortness of breath. Findings Included: Record review of Resident #34's admission record dated 05/28/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning), lack of coordination, anxiety disorder (mental disorder characterized by significant and uncontrollable feelings of anxiety and fear), muscle weakness, and tremor (Unintentional trembling or shaking movements in one or more parts of the body). Record review of Resident #34's significant change MDS completed on 03/21/24 revealed the following: Section C revealed a BIMS of 2 which indicated severely impaired cognition. Section O of the MDS revealed Resident #34 was receiving O2 therapy while a resident. Record review of Resident #34's care plan completed 05/02/24 revealed I have Oxygen Therapy r/t Ineffective gas exchange. This focus area was initiated on 03/07/2024. One of the interventions listed was Maintain my oxygen settings per physician's orders. Check on liter flow when entering my room. Record review of Resident #34's active orders dated 05/28/24 revealed the following order with a start date of 03/20/24: Oxygen 2-3 L to maintain oxygen levels at or above 90%. Two times a day related to MUSCLE WEAKNESS .CHRONIC PAIN. Record review of Resident #34's O2 saturations for the last 4 months revealed 4 entries for February of 2024 all of which were above 90% and were on room air. Resident #32's O2 saturation was checked 27 times in March of 2024 4 of those times she was on room air, the other 23 times she was receiving O2 via NC. Resident #34's O2 saturation did not drop below 90% during the month of March. Her O2 saturation was checked 62 times in April of 2024, it never dropped below 90% during the month. Resident #34 was on room air for 11 of those times and receiving O2 via nasal cannula the other 51 times. Her O2 saturation was checked 60 times from May 1-28, 2024. It did not fall below 90% for the month and she was on room air 2 of the times and receiving O2 via NC the other 58 times. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 05/28/24 at 10:38 AM Resident #34 was seated in her w/c near the nurses' station receiving O2 via NC at 5 lpm. During an observation on 05/28/24 at 12:09 PM Resident #34 was seated in her w/c at a table in the dining room receiving O2 via NC at 5 lpm. During an observation on 05/28/24 at 03:23 PM Resident #34 was seated in her w/c near the nurses' station receiving O2 via NC at 5 lpm. During an observation on 05/29/24 at 07:35 AM Resident #34 was seated in her w/c at a table in the dining room receiving O2 via NC at 5 lpm. During an observation on 05/29/24 at 08:50 AM Resident #34 was seated in her w/c near the nurses' station receiving O2 via NC at 5 lpm. During an interview on 05/29/24 at 08:57 AM CNA D stated CNAs do not have anything to do with setting lpm on O2 concentrators. He said he will check the lpm to be sure it was what the nurses tell him it should be. He stated Resident #34's O2 was normally set at 2 lpm unless she gets anxious and then we will turn it up to 3 (lpm). During an interview on 05/29/24 at 11:53 DON stated it was the nurses who were responsible for setting O2 levels for residents. She said they know what lpm to set the O2 by referring to physician orders. She stated she did not know why Resident #34's O2 was set at 5 lpm. She stated a resident receiving O2 at higher levels than ordered could result in the O2 not being effective or could create respiratory issues for the resident. During an interview on 05/29/24 at 12:43 PM LVN C stated she checked lpm for each resident receiving O2 each morning when she documented O2 saturation. She stated receiving O2 at higher concentrations than ordered could be bad for the resident. LVN C said she looked at physician orders to find out what lpm to set the O2. During an interview on 05/30/24 at 03:54 PM LVN H stated a resident could develop issues breathing if they were to receive O2 at a higher lpm than ordered by the physician. She stated she knew what lpm to set O2 concentrators for residents by referring to the physician's orders. Record review of undated facility policy titled Administering Medications revealed the following: . Medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescriber orders . Record review of undated facility policy titled Oxygen Administration revealed the following: . 2. Check physician's orders for liter flow and method of administration. 11. Set the flow meter to the rate ordered by the physician. 15. At regular intervals, check liter flow .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47854 Based on observation, the interview and record review, the facility failed to ensure residents were free of any significant medication errors for one of 1 (Resident #20) 12 residents reviewed for medication administration. -LVN C was attempting to administer Resident #20's expired insulin. Resident #20's insulin did not have an open date on the vial; therefore it could not be determined if insulin was expired. This failure could place residents who receive insulin medications at an increased risk for complications such as increased blood glucose levels, change in cognition, and an exacerbation of symptoms and disease process. Findings include: Record review of Resident #20's face sheet, dated [DATE], revealed Resident #20 as a [AGE] year-old female who was admitted into the facility on [DATE]. Resident #20 had the following diagnosis: Cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery. Type 2 diabetes mellitus without complication, Essential (Primary)Hypertension, cognitive communication deficit, muscle weakness (Generalized), major depressive disorder, recurrent, unspecified. Record review of Resident #20's current MDS, dated [DATE], revealed Resident #20 had a BIMS of 07, which indicates that Resident 20 is severely impaired when it comes to cognitive function. Resident #20's functional ability revealed that Resident #20 is dependent upon staff for most ADLs except for eating. Record review of Resident #20's care plan dated [DATE] revealed Resident #20 was care planned for her Diabetes mellitus. Interventions read that Diabetes medication as ordered by doctor. Monitor/document side effects and effectiveness. Record review of Resident #20's physician orders, dated [DATE] revealed that Resident #20 has an order for the following insulins: HumaLOG Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 0 - 149 = 0; 150 - 200 = 2; 201 - 250 = 3; 251 - 300 = 4; 301 - 350 = 5; 351 - 400 = 6 If over 400 call MD, subcutaneously before meals and at bedtime related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS (E11.9) Lantus Solution 100 UNIT/ML (Insulin Glargine) Inject (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	30 unit subcutaneously one time a day related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS (E11.9) Record review of Resident #20's MARs, dated for the month of [DATE] revealed that Resident #20 received Humalog sliding scale every day for the last 30 days of May except on [DATE], [DATE], and [DATE]. These 3 days Resident #20 did not need her Humalog sliding scale. Record review of Resident #20's blood glucose logs, dated [DATE] revealed that resident did not have any dangerously high blood sugars for the month of May. The highest Resident #20's blood glucose got was 300mg/dL (milligrams/deciliter) on [DATE] and that was covered by 4 units of her Humalog sliding scale. Observation/Interview on [DATE] at 09:46 AM revealed LVN C getting insulin from the facility's treatment cart. Insulin for Resident #20 was drawn up in an insulin syringe by LVN C. LVN C went into the room of Resident #20 proceeded to give 2 units of medication to resident in her right arm. LVN C was stopped by surveyor before medication was administered. LVN C was asked to review the expiration and open date on the insulin. LVN C stated that she could not find the open date on the insulin. LVN C was asked if the medication should be given since the open date is nowhere to be found. LVN C stated she would go and take it to the DON. LVN C was asked if the insulin had been given today, LVN C stated that it had been given. Interview on [DATE] at 11:49 AM with LVN C stated that giving a medication that is expired would not be effective for the resident. Interview on [DATE] at 10:05 AM with DON stated that the negative outcome of giving an expired insulin would be that the medication is not as effective. Record review of facility provided policy titled, Adverse Consequences and Medication Errors, undated, revealed the following: .4. The staff and practitioner shall strive to minimize adverse consequences by: a. Following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication; . .5. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 6. Examples of medication errors include: . .h. Failure to follow manufacturer instructions and/or accepted professional standards . .9. Facility staff monitor the resident for possible medication -related adverse consequences, including mental status and level of consciousness, when the following conditions occur: . (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.f. Medication error, e.g., wrong or expired medication. Record review of facility provided policy titled, Labeling of Medication Containers, undated, revealed the following: .3. Labels for individual resident medications include all necessary information, such as: . .h. The expiration date when applicable; . Record review of facility provided policy titled, Administering Medications, undated, revealed the following: .12. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. Record review of https://humalog.lilly.com, manufacture website for Humalog, website revised ,d+[DATE] revealed the following: After vials have been opened: Store opened vials in the refrigerator or at room temperature up to 86 F (30 C) for up to 28 days. Keep vials away from heat and out of direct light. Throw away all opened vials after 28 days of use, even if there is insulin left in the vial.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47854 Based on observation, interview, and record review, it was determined the facility failed to ensure drugs and biologicals were stored in locked compartments and labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 2 of 2 (Halls Emerald and [NAME], and Halls Topaz and Sapphire) medication carts and 1 of 1 medication room, and 1 of 1 treatment cart reviewed for medication storage. -1 insulin medications were found in Hall Emerald and [NAME] medication cart with no date of when medication vial was opened. -Medication refrigerator in medication room was logged at 30 degrees 4 out of the last 28 days. -LVN C left treatment cart unlocked and unattended. The facility's failure to ensure drugs and biologicals were stored at appropriate temperatures, in locked compartments, and labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable could place residents at risk. Findings include: Observation on [DATE] at 09:44 AM revealed medication room for facility and the medication refrigerator was out of temperature range 4 ([DATE]th, [DATE]th, [DATE]th, and [DATE]th) out of the last 28 days with a temp of 30 degrees. E-kit in fridge was full of insulins and narcotic box had Lorazepam oral concentrate for Resident #11, Resident #23, and Resident #16. Observation of the treatment cart with LVN C [DATE] at 09:46 AM revealed Resident #20's Humalog insulin did not have an open date on the vial. Observation on [DATE] at 11:07 AM revealed LVN C left treatment cart unattended while letting DON that insulin for Resident #20 did not have an open date on it. The treatment cart was left unattended until 11:11am. An agitated resident was in hallway next to treatment cart being redirected by other staff away from the unlocked cart. Interview on [DATE] at 11:49 AM LVN C stated if she had administered the expired insulin to Resident #20 a negative outcome would be that the medication would not be effective for the resident. Interview on [DATE] at 10:05 AM with DON stated the negative outcome of giving an expired insulin would be that the medication was not as effective. DON stated the negative outcome for leaving an unlocked medication cart unattended would be that another resident could get into it. DON stated the negative outcome for frozen medications would be the effectiveness of the medication could be compromised. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility provided policy titled, Refrigerators and Freezers, undated, revealed the following: Policy Interpretation and Implementation 1. Acceptable temperature ranges are 35 degrees F to 40 degrees F for refrigerators and less then 0 degrees F for freezers. .3. Monthly tracking sheets will include date, temperature, and initials. If temperatures are not within range, staff must notify supervisor immediately. Record review of facility provided policy titled, Labeling of Medication Containers, undated, revealed the following: .3. Labels for individual resident medications include all necessary information, such as: . .h. The expiration date when applicable; . Record review of facility provided policy titled, Administering Medications, undated, revealed the following: .12. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. Record review of https://humalog.lilly.com, manufacture website for Humalog, website revised ,d+[DATE] revealed the following: After vials have been opened: Store opened vials in the refrigerator or at room temperature up to 86 F (30 C) for up to 28 days. Keep vials away from heat and out of direct light. Throw away all opened vials after 28 days of use, even if there is insulin left in the vial. Record review of Drug label information for Lorazepam concentrate on DailyMed - LORAZEPAM concentrate (nih.gov), updated [DATE] revealed the following: Store at Cold Temperature-Refrigerate 2 -8 C (36 -46 F) Dispense only in the bottle and only with the calibrated dropper provided. Discard opened bottle after 90 days. Record review of facility provided policy titled, Security of Medication Cart, undated revealed the following: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. The nurse must secure the medication cart during the medication pass to prevent unauthorized entry. .4. Medication carts must be securely locked at all times when out of the nurse's view. 5. When the medication cart is not being used, it must be locked and parked at the nurses' station or inside of the medication room.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48491 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with the professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. 1. The facility failed to ensure freezer items were properly stored, labeled, and dated. 2. The facility failed to ensure walk-in refrigerator items were stored, labeled, and dated. 3. The facility failed to ensure pantry foods were properly stored, labeled, and dated. These failures could place residents who ate food served by the kitchen at risk of food-borne illness. Findings include: Observation of the walk-in pantry on 05/28/24 at 9:12 AM revealed the following: 1. (1) Package of opened bread, with no label or date. 2. (1) Tray of brownies, labeled and dated, with plastic wrap covering most of it except sides which were open to air. 3. (1) Box of corn starch, labeled and dated, box top open and inner bag open to air. 4. (1) container of garlic salt with no date or label. 5. (1) container of parsley flakes with no date or label. 6. (1) container of chives with no date or label. 7. (1) container of ground sage with no date or label. 8. (1) container of Italian seasoning with no date or label. 9. (1) container of ground nutmeg with no date or label. 10.(7) boxes of peanut butter crackers with individualized packages inside, with no dates or labels. Observation of the walk-in refrigerator on 05/28/24 at 9:18 AM revealed the following: 1. (2) bags of what appeared to be lettuce with no dates or labels. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. (1) whole watermelon with no date or label. 3. (2) trays of cups with what appeared to be juice and tea in them, covered in saran wrap, with no dates or labels. 4. (6) individualized yogurts, with no dates or labels. 5. (6) individualized puddings, with no dates or labels. Observation of the freezer on 05/28/24 at 9:23 AM revealed the following: 1. (1) open box of what appeared to be frozen bread sticks, with bag inside open to air, with no date or label. 2. (1) large package of what appeared to be ground beef, with no date or label. 3. (1) tray of brownies, with no date or label. In an interview on 05/28/24 at 10:56 AM, Cook A stated it was everyone's responsibility to make sure that all food in the kitchen was labeled and dated. Cook A stated a possible negative outcome for not having labeled and dated food in walk in refrigerator, pantry, and freezers would be that the food would be that they could be giving outdated food to residents and that it would be bad. In an interview on 05/29/24 at 8:37 AM, DM stated that it was everyone's responsibility to make sure that food in the kitchen was labeled and dated. DM stated that a possible negative outcome for not having everything in the kitchen labeled and dated would be that they would not know what the open date was if it was not dated/labeled and then they would not know when to throw out the food and bacteria could grow and then that could be bad if it was served. In an interview on 05/29/24 at 8:38 AM, Cook B stated it was everyone's responsibility to label and date food in the kitchen. Cook B stated a possible negative outcome would be that residents could get sick. Record review of the facility-provided policy dated January 2024 titled Food Storage - Dry Storage. .Food must be stored in a properly covered container with a date and label identifying what is in the container. Record review of the facility-provided policy dated January 2024 titled Food Storage - Refrigerated and Frozen Foods. .Food must be stored in a properly covered container with a date and label identifying what is in the container. Foods may remain in the [NAME] box as long as content and date are easily visible on the box. Any foods removed from the [NAME] box must be dated and labeled. Record review of the facility-provided policy undated titled Refrigerators and Freezers (continued on next page)

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	675443	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Acres	201 E 15th Friona, TX 79035

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	.All food shall be appropriately dated to ensure proper rotations by expiration dates. Received dates (dates of delivery) will be marked on cases and on individual items removed from cases for storage. Use by dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and use by dates indicated once food is opened.

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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. 47854 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 4 (LVN C, CNA E, NA G, and CNA F) of 5 staff members in that: -LVN C did not don PPE to administer medication via PEG tube to Resident #91 -LVN C did not perform hand hygiene or change gloves in between dirty and clean portions of wound care for Resident #5. -CNA E did not perform hand hygiene before, during, or after incontinent care of Resident #24. -NA G did not perform hand hygiene before, during, or after incontinent care of Resident #24. -CNA F did not perform hand hygiene in between assisting Resident #17 and Resident #21 with eating at lunch time meal. -LVN C did not perform hand hygiene between assisting Resident #24 and Resident #5 with eating at lunch time meal. These deficient practices have the potential to affect all residents in the facility by exposing them to care that could lead to the spread of viral infections, secondary infections, communicable diseases. Findings include: Observation on 05/28/24 at 11:57 AM revealed LVN C did not don PPE for the administration of antibiotic to Resident #91 via his PEG tube. PPE was in the Residents room next to the sink. Observation on 05/28/24 at 12:25 PM revealed LVN C going from table to table touching residents' silverware and then moving on to other residents with no hand hygiene being performed in between residents. Observation on 05/28/24 at 12:28 PM revealed LVN C touched her clothing and then assisted an unidentified resident with the cutting up of her food. No hand hygiene was performed before LVN C assisted resident. Observation on 05/28/24 at 12:29 PM LVN C touched her clothing and then helped Resident # 24. Resident #24 was handed a spoon to better assist with getting food to his mouth. LVN C then went over to assist Resident # 5 with eating. No hand Hygiene was performed in between the 2 different residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation 05/28/24 at 12:32 PM CNA F was assisting Resident # 17 with eating and then turned around to give Resident # 21 a drink from her cup. No hand hygiene was performed in between these two residents. Observation on 05/28/24 at 12:35 PM LVN C assisted Resident #24 with eating, then went to assist Resident #5, no hand hygiene was performed in between these two residents. Observation on 05/28/24 at 02:47 PM revealed CNA E and NA G who performed incontinent care for Resident #24. No HH was performed before the task was started. No HH or glove change was performed in between cleaning BM from Resident #24 and placing a clean brief on Resident #24. CNA E then proceeded to touch resident, residents' blankets, pillow, bed control, and call light with no HH performed and soiled gloves still on that she cleaned BM with. No HH was performed after incontinent care was concluded or before leaving Resident #24's room. Interview on 05/28/24 at 02:59 PM with CNA E revealed that a negative outcome for not performing HH during incontinent care would be there would be a chance of increased risk of cross contamination. Interview on 05/28/24 at AM with CNA F revealed that a negative outcome for not performing HH between assisting residents to eat would be the spread of germs from one resident to another. Observation on 05/29/24 at 9:52 AM revealed LVN C who performed wound care on Resident #5. There was no dressing on the wound when Resident #5 was turned to her right side. LVN C cleaned the wound and the surrounding areas. Once the area was cleaned LVN C proceeded to take the clean foam dressing and placed it on Resident #5's coccyx. LVN C did not perform a glove change or hand hygiene in between the dirty and clean portion of the wound care. Interview on 05/29/24 at 10:02 PM with LVN C revealed that a negative outcome for not performing HH or a glove change during wound care could lead to an increased risk of infection for the resident. Interview on 05/30/24 at 10:03 AM with DON revealed that a negative outcome for not performing HH and glove changes during incontinent care, HH during mealtime assistance, and HH and glove changes during wound care for residents could all lead to the increased risk for the spread of infection. DON revealed that not donning PPE during a PEG tubed medication administration could also lead to the spread of infection. Interview on 05/31/24 at 10:02 AM with LVN C revealed that LVN C was not aware that she needed to don PPE during a PEG tube medication administration. LVN C stated when she was asked what a negative outcome would be for not donning PPE, her response was I was not informed I needed to put PPE on. Record review of facility provided policy titled Handwashing/Hand Hygiene, revised August 2019, revealed the following: .2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection to other personnel, resident, and visitors. .7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations; . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.b. Before and after direct contact with residents; . .D. Before performing any non-surgical invasive procedures; . . H. Before moving from a contaminated body site to a clean body site during resident care; I. After contact with a resident intact skin; J. After contact with blood or bodily fluids . . M. After removing gloves; . .P. Before and after assisting a resident with meals; . . 8. Hand hygiene is the final step after removing and disposing of personal protective equipment Record review of facility provided policy titled, Incontinent Care Procedure, undated, revealed the following: . Wash hands Put on gloves, . .Reposition resident for safety Dispose of all soiled wipes, linens protector and gloves, tie off bag for final disposal, Wash hands and put on clean gloves, Place a clean brief on resident, secure catheter if needed (ensure tubing has no kinks, obstructions, or loops. Ensure that the privacy cover is in place for the catheter bag) Remove gloves and wash hands Reposition resident for comfort Place signaling device within reach . .Sanitize immediately after leaving the resident's room. Record review of facility provided policy titled, Wound Care Procedure, undated, revealed the following: .9. Perform hand hygiene and apply nonsterile gloves. .13. Assess the wound: . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.16. Cleanse the wound based on orders, using moistened gauze, commercial cleanser, or sterile irrigant. When using moistened gauze, use one moistened 2X2 sterile gauze per stroke. Work in straight lines, moving away from the wound with each stroke. Strokes should move from a clean area to a dirty area and from top to bottom. .18. Remove gloves, perform hand hygiene, and apply new gloves. .20. Apply outer dressing if required, Secure the dressing tape as needed. 21. Remove gloves and perform hand hygiene. .24. Perform hand hygiene. Record review of CMS policy titled, Enhanced Barrier Precautions in Nursing Homes, dated 03/20/2024, revealed the following: .Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply: or Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Wounds generally include chronic wounds, not shorter-lasting wound, such as skin breaks or skin tears covered with an adhesive bandage (e.g., Band-Aid) or similar dressing. Examples of chronic wounds include, but are not limited to pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. Indwelling medical devices examples include central lines, urinary catheters, feeding tubes, and tracheostomies. A peripheral intravenous line (not a peripherally inserted central catheter) is not considered an indwelling medical device for the purpose of EBP.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 48491 Based on interview and record review the facility failed to provide training to their staff that at a minimum educates staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property and procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property and dementia management for 2 (CNA I and CNA J) of 12 employees reviewed for staff training. The facility failed to train CNA I on what constitutes abuse, neglect, exploitation, misappropriation of resident property and how to report the above. The facility failed to train CNA I on dementia management. The faciltiy failed to train CNA J on dementia management. These failures could place residents at risk of injury or harm due to being cared for by untrained staff. Findings included: Record review of CNA I's employee file revealed a hire date of 03/01/24. The file did not contain any record of training on abuse, neglect, exploitation, misappropriation of resident property or dementia. Record review of CNA J's employee file revealed a hire date of 08/07/23. The file did not contain any record of dementia training During an interview on 05/30/24 at 3:11 PM, ADM stated a couple of the CNAs were agency staff before they came over to officially work for the facility and he needed CNA's so badly, that he let them work and do trainings after hire. During an interview on 05/30/24 at 3:37 PM, ADM stated a possible negative outcome for not having staff trained about HIV would be that they would not be prepared for issues that arise and that it was a judgment call that he made to hire those 2 employees without proper training, and it was his mistake. Record review of facility provided New Hire Instructions page revealed the following: .New Hire MUST complete the following BEFORE floor work: - [Name of Electronic Program] Training And after all training is complete - then they are added to the schedule for orientation. Record Review of the facility provided policy titled Abuse, Neglect and Exploitation Prevention Program not dated, revealed the following: (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. 4. Require staff training/orientation programs that include such topics as abuse prevention, identification, and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior.