STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675490	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Villa	1104 S William St Atlanta, TX 75551

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45643 Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for 1 of 19 residents reviewed for environment. (Resident #4) The facility failed to replace missing slats from Resident #4's window blinds. These failures could place residents at risk of an unsafe or uncomfortable environment and a decrease in quality of life and self-worth. Findings included: Record review of a face sheet revealed Resident #4 was [AGE] years old and was admitted on [DATE] with diagnoses including Transient Cerebral Ischemic Attack (A brief stroke-like attack that, despite resolving within minutes to hours, still requires immediate medical attention to distinguish from an actual stroke), Hyperlipidemia (An elevated level of lipids - like cholesterol and triglycerides - in your blood), Overactive bladder (A problem with bladder function that causes the sudden need to urinate.) Record review of a quarterly MDS assessment dated [DATE] indicated Resident #4 was understood and understood others. The MDS indicated a BIMS of 6 indicating severe cognitive impairment for Resident #4. Record review of a care plan revised on 02/16/24 indicated Resident #4 had an ADL self-care performance deficit and required partial or moderate assistance with ADLs. During an interview on 4/29/24 at 9:54 a.m. with Resident #4 she said that the missing vertical slats on her room window bother her. She said her bed faces the window and with the missing slats the sunshine comes right through. She said this makes it more difficult for her to nap and it makes it bright in her room. She said she had asked for it to be fixed several times. She said she did not remember who she told that she wanted her blinds fixed. She said the slats have been missing for months. During an observation on 4/29/24 at 10:02 a.m. Resident #4's window slats were not replaced. Sunlight was entering the room without the filter of window blinds. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/1/24 at 9:02 a.m. with the Maintenance Supervisor he said that he does rounds in the building to see what needed maintenance. He said that CNAs can write on the Maintenance Report to report things in the building that need to be worked on. He said that he will provide the Maintenance Report that showed what has been reported by the CNAs. Record Review of the Maintenance Log dated from 2/5/2024 to 5/1/2024 revealed that Resident # 4's room, was not listed as having blind slats needing to be replaced. Maintenance log shows that the Maintenance Supervisor fixed blinds in various rooms except Resident #4's room. During an interview on 5/1/24 at 12:14 p.m. with the DON they said they expect facility staff to follow company policy and that also means maintaining a homelike environment for the residents of the facility. He stated that residents have the right to a comfortable environment which includes blinds on the windows. During an interview on 5/1/24 at 12:24 p.m. with the ADM they said they expect facility policies such as a homelike environment to be followed. He stated that it was the responsibility of the maintenance man to ensure that residents' rooms were properly maintained. Review of a facility policy titled Quality of Life - Homelike Environment revised May of 2017 indicated, . Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible .The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: Clean, Sanitary and orderly environment, Comfortable (minimum glare) yet adequate (suitable to the task) lighting, Inviting colors and decor, Personalized furniture and room arrangements, Clean bed and bath linens that are in good condition, Pleasant, neutral scents, Plants and flowers, where appropriate, Comfortable and safe temperatures (71 F - 81 F), and Comfortable noise levels.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on observation, interview and record review, the facility failed to ensure an accurate MDS assessment was completed for 4 of 19 residents reviewed for MDS accuracy. (#61, #51, #12, and #13) 1.The facility failed to code the MDS with an accurate weight for Resident #61. 2.The facility failed to code the wound and wound treatment for Resident #61. 3.The facility failed to code the diagnoses of anxiety and depression for Resident #51. 4. The facility failed to ensure Resident #12 use of an antidepressant (are prescription medicines to treat depression), Duloxetine, was reflected on her MDS. 5. The facility failed to ensure Resident #13 diagnoses of anxiety (is a feeling of fear, dread, and uneasiness) and major depressive disorder (is a mood disorder that causes a persistent feeling of sadness and loss of interest) were listed on the primary active diagnoses of Psychiatric/Mood Disorder on the MDS. These failures could place residents at risk for not receiving needed care and services. Findings included: 1. Record review of an undated face sheet revealed Resident# 61 was a 62- year-old- male, admitted on [DATE] with diagnoses of wound infection (occurs when bacteria or other microorganisms invade a cut or wound, leading to complications in healing), diabetes mellitus(metabolic disorder in which the body has high sugar levels for prolonged periods of time), and atrial fibrillation (irregular and often very rapid heart rhythm). Record review of an admission MDS dated [DATE]for Resident #61 revealed a BIMS of 11, which indicated a moderate cognitive impairment. The MDS also revealed Resident #61 required supervision only for bed mobility, transfer, and toileting. Resident #61 was independent with eating. The MDS had 262 pounds coded for the weight of Resident #61. No wounds, treatments, or interventions were coded for Resident #61's skin conditions on the MDS. Record review of the care plans dated 03/22/2024 for Resident #61 revealed no care plan for the wound to his left lower extremity and no care plan for Resident #61's weight loss. Record review of consolidated physician orders dated 04/29/2024 revealed Resident #61 had the following orders: 03/21/2024- Cleanse area to LLE with wound cleanser/normal saline, pat dry and apply betadine daily until healed. Record review of a TAR dated 03/21/2024 indicated a treatment for a wound care to Resident #61's LLE was completed on 03/21/2024 and 03/22/2024 prior to the MDS completion. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of wound care on 04/29/2024 at 2:00 p.m., Resident #61 had wound care to his left lower extremity and the wound on his left shin area was measured at 4.8 cm by 5.2 cm with a tunnel at 10 o'clock measuring 1.2 cm. Record review of the weight variance report dated 10/01/2023 to 04/29/2024 revealed the following weights for Resident #61 Admit weight- 262- on 03/16/2024 Weekly weight-255.4 on 03/20/2024 2.Record review of an undated face sheet revealed Resident #51 was a 68- year-old- female, admitted on [DATE] with diagnoses of depression (a common and serious medical illness that negatively affects how you feel, the way you think and how you act), diabetes mellitus(metabolic disorder in which the body has high sugar levels for prolonged periods of time), and anxiety (Intense, excessive, and persistent worry and fear about everyday situations). Record review of an admission MDS dated [DATE] for Resident #51 revealed a BIMS of 09, which indicated a moderate cognitive impairment. The MDS also revealed Resident #51 required supervision only for bed mobility, transfer, and toileting. Resident #51 was independent with eating. Diagnoses of anxiety and depression were not coded. Record review of MD signed consolidated orders for April 2024 for Resident #51 included the diagnoses of anxiety and depression. Record review of the care plans dated 12/14/2023 indicated Resident # 51 received antidepressant and anxiety medication related to depression and anxiety. 3.Record review of a face sheet printed 04/29/24 indicated Resident #12 was an [AGE] year-old, female and was admitted on [DATE] with diagnoses including anxiety disorder (persistent and excessive worry that interferes with daily activities), depression (is a common and serious medical illness that negatively affects how you feel, the way you think and how you act), and dementia (a group of thinking and social symptoms that interferes with daily functioning). Record review of the quarterly MDS assessment dated [DATE] indicated Resident #12 was understood and understood others. The MDS indicated Resident #12 had a BIMS score of 07 which indicated severe cognitive impairment. The MDS indicated Resident #12 required moderate assistance for oral, toilet, and personal hygiene, shower/bathe self and dressing. The MDS did not indicated Resident #12 use of an antidepressant. Record review of a care plan dated 01/12/24 indicated Resident #12 received antianxiety medication related to depression and anxiety. Intervention included monitor mood and response to medication. The care plan did not indicate Resident #12's use of an antidepressant. Record review of Resident #12's consolidated physician order dated 04/01/24-04/30/24 indicated Duloxetine 30 mg, 1 tablet, oral, DX: Depression, once a day, 6:00 am-11:00 am. Start date 01/10/24, no end date. Record review of Resident #12's MAR dated 04/01/24-04/30/24 indicated Duloxetine 30 mg, 1 tablet, oral, DX: Depression, once a day, 6:00 am-11:00 am. Start date 01/10/24, no end date. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4.Record review of a face sheet printed 04/29/24 indicated Resident #13 was a [AGE] year-old, female and was admitted on [DATE] and 04/08/24 with diagnoses including bipolar (is a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), major depressive disorder (is a mood disorder that causes a persistent feeling of sadness and loss of interest), delusional disorder (is a type of mental health condition in which a person can't tell what's real from what's imagined), and anxiety disorder (persistent and excessive worry that interferes with daily activities). Record review of Resident #13's consolidated physician orders indicated: *Venlafaxine 150mg, 2 capsule=300mg, oral, DX: major depressive disorder, once a day, 4:00 pm-10:00 pm. Start date 06/15/23, no end date. *Xanax 2mg, 1 tablet, oral, DX: Anxiety disorder, twice a day, 7:00 am and 7:00 pm. Start date 11/15/23, no end date. Record review of a Medicare 5-day Part A Stay MDS dated [DATE] indicated Resident #13 was understood and understood others. The MDS indicated Resident #13 had a BIMS score of 07 which indicated severe cognitive impairment. The MDS indicated Resident #13 had a Mood score of 15 out of 27 which indicated moderately severe depression. The MDS indicated Resident #13's admission performance indicated maximal assistance for toilet hygiene, shower/bathe self, dressing, and supervision for oral hygiene and eating. The MDS indicated Resident #13 had an active diagnosis of bipolar disorder but not major depressive disorder and anxiety disorder. Record review of a care plan dated 12/07/21, reviewed/revised 03/30/24, indicated Resident #13 was at risk for adverse consequence related to antidepressant, antianxiety and antipsychotic medication for treatment of depression, anxiety, and bipolar disorder. Intervention included assess/record effectiveness of drug treatment. During an interview on 05/01/2024 at 12:32 p.m., the MDS Coordinator stated it was important the MDS was coded correctly because the care plan would be developed from the information coded on the MDS. The MDS also required accuracy to reflect the level of care each individual required and was used for staffing purposes. Not coding the MDS correctly could affect what was care planned for each resident and could cause the facility to staff more or less people depending on what was miscoded. Not coding a diagnosis or medication can affect the quality measures CMS calculates and it could affect the facilities funding. During an interview on 05/01/2024 at 1:15 p.m., the DON stated accurate coding of the MDS was the responsibility of the MDS nurse. He stated she did all sections of the MDS by gathering the information from other members of the team. He reviewed the MDS for completion and depended on the MDS nurse to ensure accuracy. He also stated accuracy of the MDS was important to build an individualized care plan and keep the residents with the most accurate care for their needs. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/01/2024 at 1:45 p.m., the ADM stated the MDS must be accurate not only for reimbursement, but also to ensure the resident was receiving appropriate care. He stated it was the responsibility of the MDS nurse to ensure they were accurate. He stated by not having the MDS coded correctly reflected the facility had not provided the care and services they individual needed for a good quality of life. He stated it will always be the facilities goal to provide the best possible care to each resident to promote the best quality of life possible. Review of the facility policy titled MDS accuracy dated 07/2021 indicated, the facility will ensure each resident receives an accurate assessment by qualified staff to address the needs of the resident .According to CMS's RAI Version 3.0 manual; the MDS is a core set of screening, clinical, and functional status elements .which forms the foundation of a comprehensive assessment for all residents of nursing homes .the items of the MDS standardize communication about resident problems and conditions with nursing homes, between nursing homes, and outside agencies .Federal regulations .require that .the assessment accurately reflects the resident's status . 44933

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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 - Some	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** 44596 Based on observations, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment for 4 of 19 residents (Resident #61, Resident #77, Resident #30 and Resident #12) reviewed for comprehensive person-centered care plans. 1.The facility failed to implement a nutritional care plan with interventions for Resident #61's weight loss and implement a wound care plan with interventions for Resident #61's open lesion to his left lower extremity. 2.The facility failed to implement a nutritional care plan with interventions for Resident #77's weight loss. 3.The facility failed to ensure Resident #12 use of an antidepressant (are prescription medicines to treat depression) and diuretic (water pills, help your kidneys put extra salt and water into your urine or pee) were care planned. 4.The facility failed to ensure Resident #30 diagnosis of hypothyroidism (the thyroid gland (is a vital endocrine (hormone-producing) gland) doesn't make enough thyroid hormone) and use of a diuretic were care planned. These failures could place residents at risk of not having their individualized needs met, falls, weight loss and a decline in their quality of care and life. Findings included: 1.Record review of an undated face sheet revealed Resident# 61 was a 62- year-old- male, admitted on [DATE] with diagnoses of wound infection (occurs when bacteria or other microorganisms invade a cut or wound, leading to complications in healing), diabetes mellitus(metabolic disorder in which the body has high sugar levels for prolonged periods of time), and atrial fibrillation (irregular and often very rapid heart rhythm). Record review of an admission MDS dated [DATE] for Resident #61 revealed a BIMS of 11, which indicated a moderate cognitive impairment. The MDS also revealed Resident #61 required supervision only for bed mobility, transfer, and toileting. Resident #61 was independent with eating. Record review of the care plans dated 03/22/2024 for Resident #61 revealed no care plan for the wound to his left lower extremity and no care plan for Resident #61's weight loss. Record review of consolidated physician orders dated 04/29/2024 revealed Resident #61 had the following orders: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	04/17/2024 ACE wrap to left lower extremity after dressing change daily. 04/24/2024 Cleanse left inferior medial calf with wound cleanser or normal saline, pat dry, apply xeroform and a gauze island border dressing daily. 04/24/2024 Cleanse left shin with wound cleanser or normal saline, pat dry and apply antiseptic collagen powder and fill the void at 10 o'clock position with alginate and cover with gauze island border dressing. Change daily. 04/24/2024 Cleanse left superior shin with wound cleanser, pat dry, apply alginate and cover with gauze island dressing with border. 03/21/2024- Weekly weights 03/18/2024- Regular diet, low concentrated sweets, no salt on try. Record review of the weight variance report dated 10/01/2023 to 04/29/2024 revealed the following weights for Resident #61 Admit weight- 262- on 03/16/2024 Weekly weight-255.4 on 03/20/2024 Weekly weight-250.60 on 04/01/2024 Weekly weight-244 on 04/08/2024 Weekly weight- 240.2 on 04/15/2024 Weekly weight-240.04 on 04/22/2024 During an observation of wound care on 04/29/2024 at 2:00 p.m., Resident #61 had wound care to his left lower extremity and the wound on his left shin area was measured at 4.8 cm by 5.2 cm with a tunnel at 10 o'clock measuring 1.2 cm. 2.Record review of an undated face sheet revealed Resident #77 was a [AGE] year-old-male, admitted on [DATE] with diagnoses of bladder cancer, diabetes mellitus (metabolic disorder in which the body has high sugar levels for prolonged periods of time), and obstructive uropathy (a disorder of the urinary tract occurs due to obstructed urinary flow). Record review of the quarterly MDS dated [DATE] for Resident #77 revealed a BIMS of 11, which indicated a moderate cognitive impairment. The MDS also revealed Resident #77 required supervision for eating and maximum assistance for dressing and personal hygiene. The MDS revealed Resident #77 had a weight of 105 pounds and had a weight loss. The MDS revealed Resident #77 was not on a physician prescribed weight loss regime. Record review of the care plan dated 03/30/2024 for Resident #77 revealed no care plan for the weight loss or potential weight loss as indicated on the MDS. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.Record review of a face sheet printed on 04/29/24 indicated Resident #12 was an [AGE] year-old, female and was admitted on [DATE] with diagnoses including depression (is a common and serious medical illness that negatively affects how you feel, the way you think and how you act) and acute or chronic diastolic (congestive) heart failure (is a long-term condition in which your heart can't pump blood well enough to meet your body's needs). Record review of the quarterly MDS assessment dated [DATE] indicated Resident #12 was understood and understood others. The MDS indicated Resident #12 had a BIMS score of 07 which indicated severe cognitive impairment. The MDS indicated Resident #12 required moderate assistance for oral, toilet, and personal hygiene, shower/bathe self and dressing. The MDS indicated Resident #12 use of a diuretic but not an antidepressant. Record review of a care plan dated 01/12/24 indicated Resident #12 received antianxiety medication related to depression and anxiety. Intervention included monitor mood and response to medication. The care plan did not indicate Resident #12 use of an antidepressant or diuretic. Record review of Resident #12's consolidated physician order dated 04/01/24-04/30/24 indicated: *Duloxetine 30 mg, 1 tablet, oral, DX: Depression, once a day, 6:00 am-11:00 am. Start date 01/10/24, no end date. *Furosemide 20mg, 3 tablets=60mg, oral, DX: acute or chronic diastolic (congestive) heart failure, once a day, 6:00 am. Start date 02/16/24, no end date. Record review of Resident #12's MAR dated 04/01/24-04/30/24 indicated: *Duloxetine 30 mg, 1 tablet, oral, DX: Depression, once a day, 6:00 am-11:00 am. Start date 01/10/24, no end date. *Furosemide 20mg, 3 tablets=60mg, oral, DX: acute or chronic diastolic (congestive) heart failure, once a day, 6:00 am. Start date 02/16/24, no end date. 4. Record review of a face sheet printed on 04/29/24 indicated Resident #30 was a [AGE] year-old, female and was admitted on [DATE] and 10/24/2020 with diagnoses including hypothyroidism (the thyroid gland can't make enough thyroid hormone to keep the body running normally) and combined systolic (congestive) and diastolic (congestive) heart failure (occurs when either disease or defect causes the heart muscle to lose the ability to pump blood efficiently). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #30 was understood and understood others. The MDS indicated Resident #30 had a BIMS score of 07 which indicated severe cognitive impairment. The MDS indicated Resident #30 required maximal assistance for oral, toilet, and personal hygiene, shower/bathe self, and dressing. The MDS indicated Resident #30 received a diuretic during the last 7 days of the assessment period. Record review of a care plan dated 03/13/17, reviewed/revised 04/25/24, indicated Resident #30 required substantial/maximal assistance, staff does more than half the effort for ADLs. Intervention included assist with ADLs as needed. The care plan did not indicate a care plan Resident #30's diagnoses of hypothyroidism or use of a diuretic. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #30's consolidated physician orders dated 04/01/24-04/30/24 indicated: *Cytomel 50 mcg, 1 tablet, by mouth, oral, DX: Hypothyroidism, once a day, 6:00 am. Start date 01/23/20, no end date. *Levothyroxine 100mcg, 1 tablet, oral, DX: Hypothyroidism, once a morning, 6:00 am. Start 09/08/21, no end date. *Furosemide 20mg, 1 tablet, oral, DX: combined systolic (congestive) and diastolic (congestive) heart failure, once a morning, 8:00 am. Start date 11/16/18, no end date. Record review of Resident #30's MAR dated 04/01/24-04/30/24 indicated: *Cytomel 50 mcg, 1 tablet, by mouth, oral, DX: Hypothyroidism, once a day, 6:00 am. Start date 01/23/20, no end date. *Levothyroxine 100mcg, 1 tablet, oral, DX: Hypothyroidism, once a morning, 6:00 am. Start 09/08/21, no end date. *Furosemide 20mg, 1 tablet, oral, DX: combined systolic (congestive) and diastolic (congestive) heart failure, once a morning, 8:00 am. Start date 11/16/18, no end date. During an interview on 05/01/2024 at 12:32 p.m., the MDS Coordinator stated it was her responsibility to ensure care plans were completed for each resident in the facility. She stated the care plans were the blueprint to individual resident care. She stated she care planned using the information coded on the MDS, active diagnoses and major medications. Major medications would include all psychotropic medications, blood thinners, diabetic medications, any injections. She stated she tried very hard to get most of the medications but she knew she lacked a few here and there. She stated since the high-risk medications were added to the MDS she felt it was important to care plan any of the medications that fell into those categories. If it was marked on the MDS it should be care planned. Not care planning the information can lead to the resident not receiving appropriate care because the care plans are the instructions to individualized resident care. This could in turn lead to a decreased quality of life. During an interview on 05/01/2024 at 1:15 p.m., the DON stated care plans were important to keep the residents care individualized and they were created from the information the MDS nurse coded in the MDS. He stated himself and other nursing staff did acute care plans. Acute care plans included falls, weight changes, skin issues, and changes in behavior. He stated new orders, weights, and falls were discussed in morning stand up and care planned then. He stated he was ultimately responsible for ensuring care plans were completed, revised, and accurate. He stated inaccurate care plans could hinder the resident by not allowing the facility to care for the resident as an individual and not just a patient here. During an interview on 05/01/2024 at 1:35 p.m., the ADM stated the care plans were nursing's responsibility to ensure they were accurate, complete, revised and individualized. He stated care plans were important because they were supposed to be followed to ensure the care for the residents are individualized. He stated not having accurate and revised care plans could lead to all the residents being treated the same and they are not the same. (continued on next page)

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	675490	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Villa	1104 S William St Atlanta, TX 75551

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy requested on 05/01/2024 at 1:30 p.m. ADM informed surveyor the facility followed CMS' policy on care planning. 44933

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview and record review, the facility failed to ensure each resident's person-centered comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 2 of 19 residents (Residents #12 and Resident #13), reviewed for care plans. The facility failed to revise and update Resident #12's comprehensive care plan for the type of blood thinner she was prescribed. Resident #12's care plan indicated she was prescribed Eliquis (is an anticoagulant drug (blood thinner) that helps prevent blood clots) instead of Aspirin (help prevent another heart attack or clot-related stroke). The facility failed to revise and update Resident #13's comprehensive care plan to reflect she was no longer prescribed Eliquis, discontinued on 04/08/24. These deficient practices could affect residents by placing them at risk of not receiving appropriate interventions to meet their current needs. Findings included: 1. Record review of a face sheet printed on 04/29/24 indicated Resident #12 was an [AGE] year-old, female and was admitted on [DATE] with diagnosis paroxysmal atrial fibrillation (is a type of irregular heartbeat). Record review of the quarterly MDS assessment dated [DATE] indicated Resident #12 was understood and understood others. The MDS indicated Resident #12 had a BIMS score of 07 which indicated severe cognitive impairment. The MDS indicated Resident #12 required moderate assistance for oral, toilet, and personal hygiene, shower/bathe self and dressing. The MDS indicated Resident #12's use of an antiplatelet (a group of medicines that stop blood cells (called platelets) from sticking together and forming a blood clot). Record review of a care plan dated 01/12/24, reviewed/revised 03/28/24, indicated Resident #12 was at high risk for increased bleeding related to blood thinning agent. Resident #12 was currently taking Eliquis. Intervention included Resident #12 currently took Eliquis. Resident #12's care plan did not reveal she was on Aspirin. Record review of Resident #12's consolidated physician order dated 04/01/24-04/30/24 indicated Aspirin 81mg, 1 tablet, oral, DX: paroxysmal atrial fibrillation, once a day, 6:00am-11:00am. Start date 01/10/24, no end date. The consolidated physician order did not reveal an order for Eliquis. Record review of Resident #12's MAR dated 04/01/24-04/30/24 indicated Aspirin 81mg, 1 tablet, oral, DX: paroxysmal atrial fibrillation, once a day, 6:00am-11:00am. Start date 01/10/24, no end date. The MAR did not reveal an order for Eliquis. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of a face sheet printed 04/29/24 indicated Resident #13 was a [AGE] year-old, female and was admitted on [DATE] and 04/08/24 with diagnoses including gastrointestinal hemorrhage (is all forms of bleeding in the gastrointestinal tract, from the mouth to the rectum) and other specified diseases of the digestive system-upper gastrointestinal bleed (refers to bleeding that occurs anywhere in the esophagus, the stomach, or the upper part of the small intestine). Record review of a Medicare 5-day Part A Stay MDS assessment dated [DATE] indicated Resident #13 was understood and understood others. The MDS indicated Resident #13 had a BIMS score of 07 which indicated severe cognitive impairment. The MDS indicated Resident #13 had a Mood score of 15 out of 27 which indicated moderately severe depression. The MDS indicated Resident #13's admission performance indicated maximal assistance for toilet hygiene, shower/bathe self, dressing, and supervision for oral hygiene and eating. The MDS indicated Resident #13 was not prescribed an anticoagulant or antiplatelet during the last 7 days of the assessment period. Record review of a care plan dated 12/07/21, reviewed/revised 03/30/24, indicated Resident #13 was at high risk for increase bleeding related to blood thinning agent. Intervention included Resident #13 was currently taking Eliquis. Record review of Resident #13's order history dated 03/29/24-04/29/24 indicated Eliquis 5mg, 1 tablet, oral, twice a day. Start date 06/15/23, end date 04/08/24. Record review of Resident #13's consolidated physician order dated 04/01/24-04/30/24 did not reveal an order for Eliquis. During an interview on 05/01/24 at 12:32 p.m., the MDS Coordinator stated she was responsible for revision of the resident's care plan. She stated care plans were the blueprint to individualized resident care. She said revision of the care plans were also important because they signified a change in the care plan. She said not care planning and revising the information could lead to the resident not receiving appropriate care because the care plans were the instructions to individualized resident care. She said this could in turn lead to a decreased quality of life. During an interview on 05/01/24 at 1:15 p.m., the DON stated care plans were important to keep the residents' care individualized and they were created from the information the MDS nurse coded in the MDS. He stated he was ultimately responsible for ensuring care plans were completed, revised, and accurate. He stated an accurate care plan could hinder the resident by not allowing the facility to care for the resident as an individual and not just a patient there. During an interview on 05/01/24 at 1:35 p.m., the ADM Stated the care plans were nursing's responsibility to ensure they were accurate, complete, revised and individualized. He stated care plans were important because they were supposed to be followed to ensure the care for the residents were individualized. He stated not having accurate and revised care plans could lead to all the residents being treated the same and they are not the same. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility's Care Plans, Comprehensive Person-Centered revised 12/2016 indicated . assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change .the interdisciplinary team must review and update the care plan .when the resident has been readmitted to the facility from a hospital stay .when there has been a significant change in the resident's condition .at least quarterly, in conjunction with the required quarterly MDS assessment .

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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** 44933 Based on observation, interview, and record review, the facility failed to ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 3 residents (Resident #43) and 2 of 4 staff (CNA F and LVN H) reviewed for transfer. The facility failed to ensure CNA F and LVN H performed a safe 2 person transfer for Resident #43. This failure could place residents at risk of injury from accidents. Findings included: Record review of a face sheet printed 05/01/24 indicated Resident #43 was an [AGE] year-old, female and was admitted on [DATE] and 01/04/23 with diagnoses including dementia (a group of thinking and social symptoms that interferes with daily functioning) and age-related osteoporosis (is a bone disease that develops when bone mineral density and bone mass decreases, or when the structure and strength of bone changes). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #43 was understood and understood others. The MDS indicated Resident #43 had a BIMS score of 07 which indicated severe cognitive impairment. The MDS indicated Resident #43 had limited range of motion on one side of her upper extremities but on both sides of her lower extremities. The MDS indicated Resident #43 used a wheelchair for her mobility device. The MDS indicated Resident #43 required maximal assistance (helper does more than half the effort) for oral, toilet, and personal hygiene, dressing, bathe/shower self. The MDS indicated Resident #43 was dependent (Helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.) for sit to stand and chair/bed-to-chair transfer. Record review of a care plan dated 12/07/21, reviewed/revised on 03/12/24, indicated: *Resident #43 required substantial/maximal assistance. Resident #43 required assist of 1 staff member with gait belt, is mobile in facility via wheelchair with staff assist. Intervention included assist with transfer as needed. *Resident #43 was at risk for falling related to fall history, weakness, incontinent episode, history of syncope (a loss of consciousness for a short period of time), osteoporosis, and chronic pain. Intervention included provide resident with safety devices/appliance. Record review of Resident #43's PT Therapy Progress Report dated 04/23/24-05/01/24 indicated . impairments .balance deficits, strength impairments, limitation in ROM, fine motor control deficit and gross motor coordination deficits .objective progress/long term goals .patient will safely perform functional transfers with maximal .current: total dependence with attempts to initiate . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/20/24 at 9:31 a.m., Resident #43 was lying in bed. CNA F and LVN H assisted Resident #43 to the side of the bed. CNA F and LVN H got on each side of Resident #43 and wrapped an arm underneath Resident #43's arms. CNA F and LVN H lifted Resident #43 from under her arms and instructed her to pivot. Resident #43 was placed in the shower chair. Resident #43 did not have a gait belt on during the transfer. During an interview on 05/01/24 at 1:10 p.m., CNA F said she did a transfer on Resident #43 with LVN H. She said Resident #43 was a 2-person transfer. She said she transferred Resident #43 under her arms and held on to the back of her pants. She said she did not use a gait belt. She said Resident #43 did not stand at all on her feet and she should be a mechanical lift, but she refused. She said she did not think using the gait belt with Resident #43 was safer. She said there was not enough leverage from the front. She said Resident #43 would fall with a gait belt on because she did not bend her legs, and they were stiff. She said it was the facility's policy to use a gait belt for 1 or 2 person transfers but Resident #43 was a mechanical lift transfer and refused that. She said even though it was the facility's policy to use a gait belt during transfers, it was harder to assist Resident #43 with a gait belt. She said there was more danger of her falling with the gait belt than without one. She said LVN J told her it was the resident's choice whether they used a gait belt during transfers. During a phone interview on 05/01/24 at 1:24 p.m., LVN J said she did not tell CNA F she did not need to use a gait belt during transfer or that it was the resident's choice. She said Resident #43 was a mechanical lift transfer but refused the lift. She said the safest thing for Resident #43 was to use a gait belt during transfers. She said not using a gait belt during 1 or 2 person transfers could cause a fall with injury. During an interview on 05/01/24 at 1:30 p.m., the DON said when transferring a resident, it is never ok to chicken wing (lifting residents underneath their arms) a resident to put them in bed. He said this technique could cause damage to the arms and shoulders of the residents. He said if the resident was not a mechanical lift transfer, then a gait belt must be used for all transfers unless care planned otherwise. He said he was unaware the CNAs were transferring Resident #43 without a gait belt and chicken wing her arms. He said therapy could screen Resident #43 for the most appropriate way to transfer to keep her and the staff safe. During an interview on 05/01/24 at 1:35 p.m., the ADM said it was never ok to not use a gait belt when transferring, unless therapy had signed off on a special transfer technique that was checked off on and care planned for the individual resident. He said he was unaware the staff was transferring Resident #43 in that manner until it was brought to his attention after surveyor observation. He said improper transfer could lead to falls with injury for the resident. Record review of CNA F's competencies provided by the facility on 05/01/24 at 2:15 p.m., indicated CNA F had completed nurse aide training program on 09/22/23. The competencies provided by the facility did not reveal 2-person transfer check off. Record review of LVN H's competencies provided by the facility on 05/01/24 at 2:15 p.m., indicated skills check off for the mechanical lift but did not reveal one for 2-person transfer. Record review of an undated facility's Transfer to Resident- Safe Patient Handling policy and procedure indicated .purpose: to safely move resident from one place to another .equipment: gait belt . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an undated facility's Transfer, Two Person Pivot policy and procedure indicated .staff will use gait belt to assist in getting resident to stand and guiding resident to pivot .equipment: gait belt .apply gait belt snugly around waist .stand in front of the resident .each staff member places one hand under the front of the belt and one hand under the back of the belt, using an underhand grip .instruct the resident on the count of three to lean forward and push up from the bed with his/her hands while you assist bring the resident's weight forward with the belt .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45643 Based on interview and record review, the facility failed to ensure each residents' drug regimen was free from unnecessary psychotropic drugs (without adequate behavior monitoring) for 1 (Resident # 12) of 5 residents whose medications were reviewed in that: 1.The facility failed to ensure Resident #12 had behavior monitoring (monitor activities and mood) for her prescribed Duloxetine (antidepressant; is used to treat depression and anxiety). 2. The facility failed to ensure Resident #12 had behavior monitoring for her prescribed Lorazepam (antianxiety; is a prescription medication that's used for anxiety, insomnia, and seizures) 3. The facility failed to ensure Resident #12 had side effects monitoring (are defined as unintended responses to approved pharmaceuticals (is any kind of drug used for medicinal purposes) given in appropriate dosages) for her prescribed Duloxetine. 4. The facility failed to ensure Resident #12 had side effects monitoring for her prescribed Lorazepam. These deficient practices could place residents at risk of not receiving the intended therapeutic benefits of their psychotropic medications. Findings included: Record review of a face sheet printed 04/29/24 indicated Resident #12 was an [AGE] year-old, female and was admitted on [DATE] with diagnoses including anxiety disorder (persistent and excessive worry that interferes with daily activities), depression (is a common and serious medical illness that negatively affects how you feel, the way you think and how you act), and dementia (a group of thinking and social symptoms that interferes with daily functioning). Record review of the quarterly MDS assessment dated [DATE] indicated Resident #12 was understood and understood others. The MDS indicated Resident #12 had a BIMS score of 07 which indicated severe cognitive impairment. The MDS indicated Resident #12 required moderate assistance for oral, toilet, and personal hygiene, shower/bathe self and dressing. The MDS indicated Resident #12 had been prescribed an antianxiety during the last 7 days of the assessment period but not an antidepressant. Record review of a care plan dated 01/12/24 indicated Resident #12 received antianxiety medication related to depression and anxiety. Intervention included monitor mood and response to medication. The care plan did not indicate Resident #12's use of an antidepressant. Record review of Resident #12's consolidated physician order dated 04/01/24-04/30/24 indicated: *Duloxetine 30 mg, 1 tablet, oral, DX: Depression, once a day, 6:00 am-11:00 am. Start date 01/10/24, no end date. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Lorazepam 0.5mg, 1 tablet, oral, DX: Anxiety disorder, twice a day, 7:00 am and 7:00 pm. Start date 02/19/24, no end date. No order for behavior or side effect monitoring noted. Record review of Resident #12's MAR dated 04/01/24-04/30/24 indicated: *Duloxetine 30 mg, 1 tablet, oral, DX: Depression, once a day, 6:00 am-11:00 am. Start date 01/10/24, no end date. *Lorazepam 0.5mg, 1 tablet, oral, DX: Anxiety disorder, twice a day, 7:00 am and 7:00 pm. Start date 02/19/24, no end date. No order for behavior or side effect monitoring noted. During an interview on 05/01/24 at 1:15 p.m., the DON stated all psychotropic medications must have behavior and side effect monitoring. He said these were important because psychotropic medications had several different major side effects that affected the elderly in different ways than the younger population and the staff needed to be documenting if any of these effects were occurring for the residents and any behaviors. He stated Resident #12 was on hospice and he felt it was an oversite related to hospice prescribing the medication, but he would complete an audit to ensure everyone had behavior and side effect monitoring. During an interview on 05/01/24 at 1:35 p.m., the ADM stated all medication and medication monitoring was the duty of the nursing staff to ensure it was happening. He stated not monitoring the side effects of a psychotropic medication could lead to an oversite of side effects associated with psychotropic medications. He stated behavior monitoring needed to be done to know if the medication was working or not. He stated the side effects should be reported to the MD to ensure no harm was occurring to the resident. Record review of a facility's Psychotic Medication policy dated 2017 indicated .ongoing documentation must include a root cause analysis of behavioral indicators or symptoms, monitoring for efficacy and adverse consequence .identified target behaviors will be monitored each shift along with individualized interventions as well as supporting documentation in the clinical record .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48958 Based on observation, interview, and record review the facility failed to provide food that is palatable, attractive, and at a safe and appetizing temperature for 7 (Residents #30, #33, #36, #44, #45, #63, and #82) of 89 residents reviewed for palatable food. 1.The facility did not provide meals services in a manner to ensure palatable food served was appetizing to residents. 2.The facility failed to provide palatable food served at an appetizing temperature or taste to Residents #30, #33, #36, #44, #45, #63 and #82, who complained the food served did not taste good. This failure could place residents who ate food from the kitchen at risk of weight loss, altered nutritional status, and diminished quality of life. Findings included: During an interview on 04/29/2024 at 10:54 AM, Resident #45 said she does not eat the food at the facility, because it tasted horrible. She said she had to buy her own food and made sandwiches. She said on one occasion she tried to eat chicken from the facility, and it was raw and bleeding, when she bit into the chicken. During an interview on 04/29/2024 at 11:10 AM, Resident #30 said the facility's food was not good. She said the facility got a new cook about a month ago and the food had been horrible since then. She said her eggs were cooked so hard; she could fan herself with them. During an interview on 04/29/2024 at 11:25 AM, Resident #63 said the food at the facility was not good. She said the facility had alternate meals on request, but that food was not good. During an interview on 04/29/2024 at 2:21 PM, Resident #33 said the food the facility serves is not good. He said sometimes it is good and sometimes it was not so good, but it keeps him going. During an interview on 04/29/2024 at 3:21 PM, Resident #44 said the food is terrible. He said he ordered food from outside of the facility. He said the facility had lunch and dinner mixed up. He said he thinks the facility should provide light meals for lunch and heavier meals for dinner, because breakfast was not until the next day. On 4/30/2024 at 12:39 PM- A test tray with a regular diet was provided. The survey team members and dietary manager sampled the test tray. The sample plate was covered with an insulated plate cover. The noodles were sticky and had no flavor. The green beans did not have any seasoning and tasted bland. The chicken fried steak was soggy and had no flavor. The white gravy on the chicken fried steak had good seasoning. During an interview on 4/30/2024 at 12:47 PM, the Dietary Manager tasted the food after the surveyors. She stated, the noodles and green beans needed salt, but the gravy on the chicken fried steak tasted good. She said she had been telling the cook the food needs more flavoring. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/30/2024 at 2:00PM during resident council meeting, Resident #36 said the food was ok, but the cook that came tomorrow was better. She said the food does not have much flavor. Resident #82 said she agreed with Resident #36, the food had very little flavor. During an observation and interview on 05/01/2024 at 12:50 PM, Resident #44 was not in his room, but his lunch tray was on the bedside table. The tray consisted of carrots, cornbread, macaroni and cheese; with one chicken leg bone. Resident only ate the chicken leg and the other food was untouched. Resident #44 said I am not used to processed foods. He said they do not season the food and the residents had asked the facility several times to buy the residents different salt and seasoning mix. He said the facility had not bought the seasoning yet. He said the residents had discussed it in the resident council meeting several times. During an interview on 05/01/2024 at 1:00 PM Resident #44 said he does not hardly eat the facility food. He said for lunch he only ate the one chicken leg and the other food was untouched. He said he does not eat the facility food and that was why he did not have much money, because he had to buy the food he liked to eat. He said the facility cooked the food for older people only, because it was too soft and not enough flavor. During an interview on 05/01/2024 at 1:21 PM, the DON said residents had not complained about the food to him. He said he heard in the morning meetings that residents had complaints about the food. He said the Administrator had been working on the dietary staff. He said the Administrator was attentive to any complaints. He said himself and the Administrator ate food from the facility. He said they sample the food. He said what he ate was very satisfactory to him. He said the facility gave supplements and always had an alternate. He said the outcomes of a resident not eating can lead to malnutrition, weight loss and bad health. He said he does not get food complaints from residents. He said he had not noticed any of the residents that had not eaten their meals. During an interview on 05/01/2024 at 1:37 PM, the administrator said he was aware of the food complaints, but the food was much better now. He said the facility had a staff member going around the facility every morning to enquire what residents would like to eat; and the menu was available from 9:30 AM to 6:30 PM to decide what residents wanted to eat. He said not one single resident had come to him lately about the food in the facility. He said he did a survey on the dining room and he had good results over a 4-week period. The Administrator said he does eat at the facility and he does not like all the food served, but some of it tasted good. He said he loved the fish and beef tips and rice the facility prepares. He said the facility has a new cook on Mondays and Tuesdays; she prepares breakfast and lunch. He said the facility put out salt and seasoning packages on resident request, because they are expensive. He said regular salt and pepper was offered if they can have it. He said if the residents do not like the food and they do not have an alternate meal they like available; they will get whatever they want to eat. He said most of the food served at the facility was prepared. He said the facility watched and monitored residents' weights for weight loss prevention. He said the facility tried different interventions when they notice residents are losing weight. He said residents need nutrition for wound recovery and for mental health. Record review of a facility Food And Nutrition Services policy Revised dated 10/01/2017 indicated, each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. (continued on next page)

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	675490	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a facility Dining and Food Service policy and procedure dated 2005 indicated, residents will be provided with nourishing, palatable, attractive meals that meet the resident's daily nutritional and special dietary needs. Each resident will be provided with services to maintain or improve eating skills. The dining experience will enhance the resident's quality of life and be supportive of the resident's needs during dining. Record review of a facility Dietary Supervision policy dated 2005 indicated, the dietary manager is responsible for the safe, sanitary, economical and nutritional operation of the dietary department. 44596 44933

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35295 Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for 2 of 4 residents reviewed for foley catheter care (Resident #31 and #47) and 1 of 2 residents reviewed for incontinent care (Resident #13) infection control practices. 1.The treatment nurse did not change her gloves when going from dirty to clean when providing catheter care to Resident #31. The treatment nurse did not sanitize or wash her hands after performing catheter care when she changed her gloves. 2. The facility failed to ensure CNA F changed her gloves and performed hand hygiene appropriately while providing incontinent care to Resident #13. 3. CNA D did not change her gloves or sanitize her hands after removing Resident #47's foley catheter stabilizer device. CNA D put the dirty towel back into the clean water and did not change her gloves when going from dirty to clean when providing catheter care. These failures could place residents at risk of exposure to communicable diseases, cross-contamination, and infections. Findings included: 1.Record review of Resident #31's undated face sheet indicated he was a [AGE] year-old male that admitted [DATE] with diagnoses that included: sepsis (a serious condition resulting from the presence of microorganisms in the blood or other tissues), pressure ulcer of sacrum, stage 4 (injury to skin and underlying tissue from prolonged pressure on the skin), Extended spectrum beta lactamase [ESBL] resistance (bacteria that cannot be killed by many of the antibiotics that are used to treat infections), and cellulitis of the perineum (bacterial skin infection). Record review of Resident #31's physician's orders indicated: 2/23/24 Foley catheter 16 fr, 10 cc bulb, change monthly and prn 2/23/24 Foley catheter care every shift Record review of the admission MDS assessment dated [DATE] indicated Resident #31 had clear speech, understood others, and was understood by others. He had a BIMS score of 12 indicating moderate cognitive impairment. He required partial/moderate assistance with personal hygiene and had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days. Record review of the care plan dated 2/23/24 indicated Resident #31 had the potential for complications and infection related to his indwelling catheter and closed drainage system due to urinary retention, cellulitis to perineum and scrotum, stage 3 pressure ulcer to left and right buttocks. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 4/30/24 at 3:38 PM, the treatment nurse provided foley catheter care for Resident #31. She did not change her gloves after performing catheter care and before getting a clean towel to dry him off. The treatment nurse did not change her gloves until she was finished with catheter care. When she changed her gloves, she did not sanitize or wash her hands. The treatment nurse said she knew she needed to change her gloves after a dirty procedure but once she realized she had not done it, it was too late. She said she knew she was supposed to sanitize or wash her hands after a dirty procedure and before putting on clean gloves but she did not. She said when she changed her gloves after finishing catheter care she should have washed or sanitized her hands. She said not changing her gloves or cleaning her hands was an infection control issue, and could have caused Resident #31 to have another infection. During an interview and record review on 5/01/24 at 9:13 AM, the Regional RN said their policies regarding male catheter care indicated that staff did not need to change gloves for a male before drying him or going to a clean procedure. She said she would provide their policies. The Regional RN provided a skills check off for the treatment nurse and said that was the only one she had regarding foley care/incontinent care for her. Record review of Providing Perineal Care skills check off for the treatment nurse dated 3/1/24 indicated she was competent with all skills checked. The skills check off did not indicate gloves needed to be changed until after the perineal care was performed. During an interview on 5/01/24 at 8:39 AM, LVN A said when she did foley care she always changed her gloves and sanitized or washed her hands after performing foley care (dirty procedure) and before going to clean. She said staff should never touch clean items with gloves that had been used for a dirty procedure. She said doing so could spread infection, bacteria, and possibly make the resident sick. During an interview on 5/01/24 at 11:27 AM, CNA B said she would change her gloves and sanitize or wash her hands after performing foley care and before drying the resident. She said drying the resident with dirty gloves would be an infection control issue and could spread germs. She said that was the procedure she was taught in CNA class. During an interview on 5/01/24 at 11:30 AM, ADON C said their policy indicated gloves were taken off after foley care was finished and did not indicate a gloves change was required before drying the resident or going to a clean procedure. She said she had to follow the policy and did not know if it was an infection control issue. She said she did not know if it would spread germs. ADON C refused to answer any more questions. During an interview on 5/01/24 at 11:35 AM, the DON said the policy and check off's indicated staff did not have to change gloves until foley care was complete. He said foley care was not a sterile technique, it was a clean procedure. He said he would follow the policy if he were doing the foley care. He said using the same gloves and not sanitizing hands could be an infection control issue and could spread infection. He said hand hygiene was the most important thing in the facility. He said he did not know if not changing the gloves during foley care would be an infection control issue. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/01/24 at 11:41 AM, the ADM said staff should always follow the policy, and if their policy was wrong then they needed more education so they could teach staff to do the right thing. He said he could not ask for more than staff following their policy. He said the treatment nurse should have sanitized or washed her hands when she changed her gloves. He said not cleaning her hands could cause an infection control issue which could cause a lot of problems from residents getting sick, sicker, or passing infection to another resident. 44933 2. Record review of a face sheet printed 04/29/24 indicated Resident #13 was a [AGE] year-old, female and was admitted on [DATE] and 04/08/24 with diagnoses including dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and chronic obstructive pulmonary disease (is a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of a Medicare 5-day Part A Stay MDS assessment dated [DATE] indicated Resident #13 was understood and understood others. The MDS indicated Resident #13 had a BIMS score of 07 which indicated severe cognitive impairment. The MDS indicated Resident #13 had a Mood score of 15 out of 27 which indicated moderately severe depression. The MDS indicated Resident #13's admission performance indicated maximal assistance for toilet hygiene, shower/bathe self, dressing, and supervision for oral hygiene and eating. The MDS indicated Resident #13 was always incontinent for urine and bowel. Record review of a care plan dated 01/12/24, reviewed/revised on 03/28/24 indicated Resident #13's ADL function for toileting was assist of 1 staff member to encourage and assist to toilet every 2 hours and prn, if incontinent of bowel and bladder with incontinent care after each incontinent episode. Intervention included assist with ADLs as needed. During an observation on 04/30/24 at 11:24 a.m., CNA F and CNA G provided Resident #13 incontinent care. CNA F cleaned and dried Resident #13 perineal area. CNA G turned Resident #13 with the help of CNA F. CNA F helped turn Resident #13 on her side without changing gloves. As CNA G held Resident #13 on her side, CNA F, with the same gloves, grabbed a washcloth, dipped it in the bucket of water, touched Resident #13's perineal cleaner then started to clean Resident #13 bottom. CNA F paused while cleaning Resident #13 and said, I should have changed my gloves. CNA F removed her gloves, washed her hands, and reapplied new gloves. CNA F finished cleaning Resident #13's bottom then dried it. CNA F, without changing her gloves, grabbed a new under pad and placed on the bed. CNA G placed Resident #13 back on her back. CNA F, without changing gloves, emptied, rinsed, and dried Resident #13's 2 plastic bucket used during incontinent care then removed gloves. During an interview on 05/01/24 at 1:10 p.m., CNA F said she changed her gloves after cleaning Resident #13's front area. She said during peri care on Resident #13, she did have to correct it though because she forgot to change her gloves before touching Resident #13. She said she realized her mistake and changed her gloves. She said with her dirty gloves, she touched Resident #13's side and butt with the washcloth. She said she washed her hands after changing her gloves. She said that was an infection control problem because it could transfer infection to the resident. She said an infection could make a resident sick. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/01/24 at 1:15 p.m., the DON stated incontinent care was to be done using universal precautions, which included washing/ sanitizing hands and changing gloves whenever they became soiled before moving to a clean portion of the task. He stated it was possible to spread germs from different parts of the body and introduce them into the urinary tract by providing peri care with dirty gloves. He stated this could in turn lead to an UTI and could cause the need for antibiotics, confusion, and weakness. During an interview on 05/01/24 at 1:35 p.m., the ADM stated infection control was just as important in peri care as it was in changing a dressing on a wound. He stated in services, education, and skills check offs were done to keep the staff educated on the latest infection control methods. He said improper peri care methods could lead to an UTI, which leads to confusion and possible falls. Record review of CNA F's Providing Perineal Care procedure and skills check off dated 04/05/24 indicated . yes .sets up supplies .yes .wash hands and put on gloves .yes .separate labia with one hand and with clean wipe cleans perineum front to back .yes .cleans skin folds thoroughly, rinses and pat dry .yes .assist patients to side lying position and with a clean wipe, cleans the rectum and buttocks from front to back using a clean wipe with each stroke .yes .change gloves .reposition and cover patient .place soil items in plastic bag for removal from the room .yes .removes gloves and washes hands .recommendation .pass .Instructor LVN H . 48958 3. Record review of Resident #47's undated face sheet indicated a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #47 had diagnoses which included: chronic kidney disease, stage 4 (your kidneys are moderately or severely damage and are not working as well as they should to filter waste from your blood), retention of urine, unspecified (difficulty urinating and completely emptying the bladder) and disorder of prostate, unspecified-BPH (enlargement of the prostate and prostate cancer). Record review of the admission MDS assessment, dated 3/13/24, indicated Resident #47 had clear speech, was understood by others, and understood others. Resident #47 had a BIMS score of 9, which indicated moderate cognitive impairment and required moderate assistance with shower and personal hygiene, substantial assistance with toileting hygiene. Record review of the care plan, dated 3/04/24, indicated Resident #47 required an indwelling urinary catheter related to obstructive uropathy urinary retention. Assistance was to be provided to Resident #47 for catheter care. Provide catheter care every shift. Resident #47 had a urinary catheter and was at risk for potential complications and infection related indwelling catheter and closed drainage system. Wash hands before and after handling any part of the urinary drainage system. Wear clean disposable gloves when handling the drainage system. During an observation on 4/30/24 at 9:38 AM, CNA D and LVN E donned gowns and after washing their hands, donned gloves. CNA D performed foley care for Resident #47. She touched Resident #47's foley catheter stabilization device, with the same gloves prior to catheter care. LVN E assisted CNA D. CNA D performed foley care, put a dirty towel back into clean water twice, and did not change her gloves when going from dirty to clean part of the catheter care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/30/24 at 9:57 AM, CNA D said she should have changed her gloves after removing the catheter device. CNA D said she normally changed her gloves during foley care. CNA D said she should not have put the towel back into the water during foley care, but she was nervous. During an interview on 04/30/24 at 10:02 AM, LVN E said when performing foley or incontinent care it was an infection control issue to touch Resident #47's catheter stabilizer device before starting foley catheter care without sanitizing hands and changing gloves. LVN E said CNA D should not have put a dirty towel in clean water during catheter care. She said anything could be spread by contact and could cause urinary tract infection. Record review of Providing Perineal Care skills check off for CNA D dated 3/1/2024 indicated she was competent with all skills checked. The skills checked off did not indicate gloves needed to be changed until after the perineal care was performed. Record review of Revised dated 01/2024 Texas Health and Human Services Evidence-Based Best Practices: Indwelling Bladder Catheter. Provide catheter care to a female resident who has an indwelling urinary catheter. Provide perineal care to a female resident who is incontinent of urine. Care of an Indwelling Catheter: Complete hand hygiene before and after handling the catheter system to prevent transmission of pathogens. Review of the steps determined gloves did not need to be changed until after foley catheter care was completed. Record view of Revised dated August 2015, facility Handwashing/Hand Hygiene policy statement: This facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of health care-associated infections. All personnel shall follow the handwashing/ hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. Record review of undated facility Daily Catheter Care Policy: To prevent infection and to reduce irritation. Wash hands. Explain procedure and screen resident for privacy. Place protective pad or towel under the resident. Position appropriately and drape so only perineal area is exposed. Put on gloves. Wash perineal area well with soap and warm water, taking care to wash from front to back. Rinse thoroughly. Clean catheter at insertion site while removing all debris from catheter. Take care not to pull on the catheter or advance further into urethra. Rinse thoroughly with warm water and gently pat dry with towel. Clean and store equipment used. Remove and dispose of gloves. Make sure resident comfortable. Place call bell within reach. Wash hands. Record review of undated facility Infection Control Policy. Infection control program: The facility has established and maintains an infection control program designed to provide a safe, sanitary and comfortable environment. The infection control program is designed to help prevent development and transmission of disease and infection. Infections are investigated, controlled and prevented through implementation of the infection control program. Staff performances will be monitored to ascertain the proper procedures are followed for handling food, laundry, and disposal of the environmental waste, pest control, traffic control, visiting rules and resident care to avoid possible sources of infection.