Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675503	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beacon Hill	3515 S Park Ave Denison, TX 75020

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49427 Based on interview and record review, the facility to ensure that the residents had the right to and that the facility promoted and facilitated resident self-determination for 1 (Resident #23) of 7 resident who were reviewed for resident rights. The facility failed to ensure Resident #23's right to make choices about aspects of his life that were significant to the resident by not ensuring his right to schedule his own appointments and involve him in the rescheduling process. This failure could place residents with the ability to make choices at risk of having their rights violated, diminished quality of life and unmet needs. Findings included: Record review of Resident #23's Comprehensive MDS, dated [DATE], reflected he was a [AGE] year-old male admitted on [DATE] with a BIMS score of 11 (moderately impaired cognition). Review of Section GG, Functional Abilities reflected Resident #23 was independent with car transfers, walking at least 150 feet, walking on uneven surfaces stepping up on a curb and going up 12 steps with or without a rail. Resident #23's diagnoses included heart failure, cirrhosis (liver damage), diabetes mellitus (elevated blood sugar), and chronic obstructive pulmonary disease (lung disease that makes it difficult to breath). Record review of Resident #23's care plan, dated effected 09/10/2024, reflected he was usually understood in ability to express ideas and wants. Record review of Resident #23's admission packet, dated signed 09/11/2024, reflected, .Transportation. Where alternate means of transportation are not available, Facility shall transport Medicaid Residents to the Medicaid medical provider of choice in the service area for physician ordered non-emergency medical services, including routine ambulance services . Review of Resident #23's clinical notes revealed a nurse practitioner visit note, dated 9/12/24, reflected, . Portal hypertension/history of cirrhosis .Follow-up with hepatology (a branch of medicine concerned with the study, prevention, diagnosis, and management of diseases that affect the liver, gallbladder, biliary tree, and pancreas.) (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #23's progress note, dated 09/24/2024 at 3:02 PM, by LVN B reflected, .Resident informed nurse he had a doctor's appointment for Wednesday and can have his friend pick him up and taken him if we cannot make arrangements for transportation. Nurse instructed resident to please inform us if he scheduled appointments with physician so we may have adequate time. Schedulers reschedule appointment for 1 day later. Resident became angry slamming his fist on bed stating I do not want anyone rescheduling my appointments . Record review of Resident #23's progress note, dated 09/25/2024 at 6:35 PM, by the DON, reflected, . resident's appointment with [Physician L] was rescheduled from 09/25/2024 to 09/26/2024 so transportation can be provided since residents friend cannot accompany him on 09/25/24 and to accommodate the time resident wants to be seen which in the morning time. When the transportation staff reminded resident today that his appointment is for tomorrow morning, resident is refusing to go. [Physician M] suggestion is for facility to notify [Physician L's] office in the morning and to notify them of resident's refusal to go to his appointment and see if he can have a tele visit and re schedule the appointment. Transportation staff will contact doctors office in the morning . Interview on 09/24/2024 at 9:20 AM with Resident #23 revealed he was upset because the Driver rescheduled his appointment with Physician L, and he felt like people were making decisions for him. He stated it was important to him that he made his own appointments, as he had in the past. He stated he was his own responsible party. He stated it was important for him to have privacy during appointments and had been told by the Driver and the LVN B that the Driver was to attend his appointments with him and his physician. He stated he made an appointment about 2 weeks ago to see Physician L, a Hepatologist (a liver/gallbladder/pancreas specialist) and informed LVN B after he made the appointment. He stated he reminded LVN B on 09/23/2024 about his appointment on 09/25/2024 and she told him she was going to have the Driver talk to him about transportation. He stated the Driver came to speak with him and told him that she was not able to transport him due to a conflict and was not able to drop him off because she had to attend his appointment with him. He stated the Driver asked if he had any family that was able to transport him, and he stated he was going to see if his friend was able to take him. He stated his friend was unable to transport him to his appointment with Physician L and he informed LVN B. He stated that he saw a post-it on the dresser on 09/24/2024 that stated his appointment was rescheduled for 09/26/2024 at 10:45 AM and to, fast for 3 hours before the procedure. He stated he spoke to LVN B and the Driver and told them he was not going to the appointment, and he did not want anyone rescheduling his appointments for him or to be in the room with him during his appointments. He stated LVN B, and the Driver told him he needed to have the Driver in the appointment with him. He stated he spoke with the DON about his concerns about the Driver rescheduling appointments for him and he did not want the Driver to attend his appointments with him, and she told him he had an attitude problem and walked away from him. He stated he received a phone call from Physician L's office to ask why someone else called to reschedule his appointment. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/26/2024 at 10:38 AM with LVN B revealed Resident #23 was a newer admit to the facility and knew he had concerns about his appointments. She stated he said he told her two weeks ago about the appointment and that he needed transportation; she stated did not remember and it was possible he told her, and she forgot. She stated on Monday (9/23/24) he told her he had his appointment with the liver specialist on Tuesday (9/25/24) and she told him she would have the Driver talk with him about accommodating his appointment. She stated when transportation spoke with Resident #23, he became very upset and stated he wanted to schedule his own appointments. She stated he was ambulatory with a walker, does not use a wheelchair and was hardly in his room. She stated he said he did not want anyone to sit with him in his appointment and she told him if he was of sound body and mind, they would not have to sit with him. She stated that the Driver talked to the patient and scheduled their appointments and usually wrote the information on a post it for the resident. In an interview on 09/26/2024 at 10:38 AM with the DON revealed when a resident had an appointment, the Driver was to be informed by the resident or nurse. She stated that the Driver was responsible for confirming residents had an appointment with the physician's office and rescheduled resident appointments if there was a scheduling conflict. She stated the Driver transported the resident to their appointments and sat with the resident during appointments, unless a family member or representative was present, because the physician offices required it. She stated the Driver stayed with residents during their appointments because the Driver would take notes on a blank telephone physician orders sheet and returned it to the charge nurse to confirm any verbal orders with the physician. She stated she did not recall speaking with Resident #23 about concerns regarding appointments. In an interview on 09/26/2024 at 10:49 AM with the Driver revealed she was told on Monday (09/23/2024) afternoon that Resident #23 had an appointment with a liver specialist for the following day (09/24/2024) in the morning. She stated she had a scheduling conflict with another resident's appointment and Resident #23 did not have anyone else to take him to the appointment, so she rescheduled the appointment to be the following day (09/26/2024) in the morning. She stated that the resident was upset that she rescheduled his appointment and refused to go to the appointment on 09/26/2024 so she scheduled a tele visit for the resident for 09/27/2024 at 12:30 PM and had told LVN B. She stated the resident had made another appointment for 10/02/2024 which she had added to the schedule. She stated that physicians usually required her to attend the appointments because residents in wheelchairs were a fall risk. She stated that Resident #23 does not use a wheelchair and ambulates with a walker and was not sure if he was able to attend his appointments by himself. She stated there was not a specific time frame that residents needed to inform her in advance of appointments, and it depended on her schedule. She stated it was her responsibility to schedule resident appointments and transport them to their appointments. In an interview on 09/26/24 at 11:22 AM with Resident #23 revealed he had not been told about a tele visit for tomorrow (09/27/2024) yet and was open to speaking to the physician over the phone but his appointment was for a liver scan which needed to be in person. He stated he had made an appointment with the physician for 10/02/2024. In an interview on 09/26/24 at 11:41 AM with LVN B revealed the Driver called her a few minutes ago and informed her Resident #23 had a tele visit scheduled for tomorrow at 12:30 PM and an in person visit he scheduled for 10/02/2024. She stated she had not told him yet about the tele visit and was not aware he did not know about the appointment and was going to let him know right away. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/26/2024 at 1:37 PM with the Executive Director, he stated the Driver confirmed and scheduled physician appointments for residents and typically attended appointments with the residents unless a representative was present. He stated that there was not a specific time frame in which residents needed to request transportation and it depended on the schedule. He stated that they should be accommodating the residents and there were two other transportation companies they were able to reach out to when there were scheduling conflicts. In an interview on 09/26/2024 at 1:40 PM the Regional Director of Clinical Services stated that he could see why Resident #23 felt like his rights were violated and that it did not make sense for the Driver to sit with every resident. Record review of the facility's transportation policy, titled Transportation, Diagnostic Services, dated 2001, revised December 2008, reflected, .Our facility will assist residents in arranging transportation to/from diagnostic appointments when necessary .should it become necessary for the facility to provide transportation, the social service designee will be responsible for arranging the transportation through the business office .a member of the nursing staff, or social services, will accompany the resident to the diagnostic center when the resident's family is not available . requests for transportation should be made as far in advance as possible .

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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** 34399 Based on observations, interview and record review, the facility failed to develop and implement comprehensive person-centered care plans for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 24 (Resident #57) of 24 residents reviewed for comprehensive care plans. The facility failed to develop a care plan for Resident #57's bed bath preference and her preference to stay in bed. This failure could place residents at risk of not having their needs and preferences met. Findings include: Review of Resident #57's face sheet undated reflected Resident #57 was an [AGE] year-old-female admitted to the facility on [DATE] with diagnoses of Acute Kidney Failure (sudden decline in the functioning of your kidneys), Dementia (diseases that affect memory, thinking, and the ability to perform daily activities), hypertension, myocardial infarction (heart attack), cerebral infarction (stroke) and anxiety disorder. Review of Resident #57's quarterly MDS assessment dated [DATE] reflected Resident #57 had a BIMS score of 7 indicating she was severely cognitively impaired. Resident #57 was total dependent with ADLs of shower/bathing and toileting. She required substantial to maximal assistance with ADLs of dressing, transfers, and personal hygiene. Review of Resident #57's care plan undated reflected Resident #57 ADL functions bed mobility, transfer, dressing, toileting, hygiene, eating. Interventions included the following: set up, assist, give shower, shave, oral, hair, nail care schedule and prn and Assist with ADL's as needed. It did not reflect Resident #57 preference for bed baths and preference to stay in bed per her choice. Observation and Interview on 09/24/24 at 10:40 AM and 12:45 PM with Resident #57 revealed she was lying in bed and did not get up much. She stated she preferred to stay in her bed per her choice. Observation and Interview on 09/25/24 at 09:05 AM with Resident #57 revealed she was lying in bed. Resident #57 stated she had a bed bath yesterday (09/24/24) and did not like to be showered. Interview on 09/25/24 at 9:14 AM with CNA N revealed Resident #57 preferred to stay in bed and did not like to get out of bed. She was a 2 pm to 10 pm shower so she was not certain about her bed bath preference. Interview on 09/25/24 at 9:25 AM with LVN P revealed Resident #57 preferred to stay in bed and did not like to get up. She was not aware of Resident #57's preference for bed baths but did know she did not like to get up for showers. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/25/24 at 3:50 PM with CNA O revealed Resident #57's showers were scheduled on Tuesdays, Thursdays and Saturdays on the 2 pm to 10 pm shift, but Resident #57 preferred a bed bath. Interview on 09/25/24 at 4:30 PM with DON revealed Resident #57's preferences for bed baths and to stay in bed should be care planned. She thought they were care planned. Interview on 09/26/24 at 1:55 PM with Pt Care Coordinator S revealed she was responsible for updating the care plan but only became aware of Resident #57's preference for bed baths and staying in her bed yesterday when she was informed by the DON. Review of facility's policy Patient Care Management System .Assessments revised November 2017 reflected 6. A Comprehensive, Person-centered Plan of Care, consistent with the resident rights .Each Care Plan must be reviewed and updated by the interdisciplinary Care Plan team quarterly, upon each change in condition and upon re-admission. The care plan must be based on assessments completed within the previous 15 months in the patient's/residents active record and use the results of the assessments to develop, review and revise the Patient's/Resident's comprehensive care plan. The interdisciplinary Care Plan team members includes .as determined [NAME] the Patient's/Resident's needs.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34399 34918 Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 4 (Resident #16, Resident #93, Resident #94, Resident #57) of 21 residents reviewed for ADLs. The facility failed to ensure: 1. Resident #16 had his nails cut and cleaned. 2. Resident #93 had his fingernails cleaned and trimmed. 3. Resident #94 had his fingernails cleaned and trimmed. 4. Resident #57 had her fingernails cleaned and trimmed. These failures could place residents who were dependent on staff for ADL care at a loss of dignity and a decreased quality of life. Findings include: 1-Record review of Resident #16's admission MDS assessment, dated 08/01/24, reflected a [AGE] year-old male with an admitted [DATE]. Resident #16 had BIMS score of 9 which indicated he was moderately cognitively impaired. He required partial to moderate assistance of one person for personal hygiene and had not refused care. Diagnoses included osteoarthritis (chronic condition that breaks down the cartilage in the joints, causing pain and stiffness), heart failure and compression fracture of first lumbar vertebrae (break in the bones of the lower spine). Record review of Resident #16's care plan with an effective date of 07/26/24 reflected, [Resident #16] 's ADL functions bed mobility, transfer, dressing, toileting hygiene eating .Goals .Will maintain a sense of dignity by being clean, dry odor free and well-groomed over next 90 days .Interventions .set-up, assist, give shower, shave, oral, hair, nail care scheduled and prn . Record review of the undated shower schedule for hall 800 revealed Resident #16 was scheduled on the 2 pm to 10 pm shift on Monday-Wednesday and Friday. Record review of Resident #16's ADL Verification Worksheet for September 2024 reflected no personal hygiene had been provided for the month of September. In an observation and interview on 09/24/24 at 10:25 a.m. revealed Resident #16 laying in his bed. Resident's fingernails were about 1/2 inch long and the nails on his right hand had a brown substance under all his nails. Resident #16 stated his nails had not been cut in a long time and stated he would cut them if had some clippers. He stated no one had offered to trim his nails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 09/26/24 at 8:25 a.m. revealed Resident #16's nails remained long and dirty. Resident #16 stated he received a bath yesterday (09/25/24) but stated no one cut his nails. In an interview with CNA E on 09/26/24 at 8:30 a.m. she stated she had taken care of Resident #16 and he had not ever refused care for her. She stated he would sometimes ask you to come back later. She stated he was on the 2 p.m. to 10 p.m. shower schedule. She stated they were required to do nail care and personal hygiene on their shower days or whenever the residents needed it. She stated she had not noticed his nails needed clipping. In an interview with LVN C on 09/26/24 at 8:40 a.m. she stated the CNAs were responsible for nail care on the residents, unless they were diabetic, and the LVNs were responsible for the diabetics. She stated Resident #16 was not diabetic. She stated if the residents refused care the CNAs were supposed to let them know and they would re-attempt the care later. She stated she was not aware of Resident #16 refusing care per say, she stated he might ask you to come back later but would usually do whatever you asked him to do. She stated long dirty nails could pose a risk for infections, or skin tears. In an interview with CNA F on 09/26/24 at 9:00 a.m. she stated she worked the 2 p.m.to 10 p.m. shift on 09/25/24. She stated she did not do any showers, but stated another CNA did all the showers. She stated when they do showers, they were supposed to trim the nails of the residents and shave them if they wanted to be shaved. She stated they were to use orange sticks to clean under the nails. She stated if any resident refused their shower, they were supposed to let the nurse know. She stated Resident #16 used to refuse some care when he first got here but stated he had not refused care lately. In an interview with Unit Manager A on 09/26/24 at 11:00 a.m. she stated she reviewed the ADL flow sheet for Resident #16, and it appeared he had not had a shower or bath for the month of September. She stated she had looked for the CNA report they were supposed to turn in each shift and had not found one from CNA G, who was scheduled on 09/25/24. She stated the CNA reports were supposed to be turned in to the charge nurses and then to her for review. She stated going forward the staff were going to have to notify the charge nurse if someone refuses, and the nurse were going to have to document the refusal and what attempts were made for the resident to get the care. She stated if the resident continued to refuse then they were going to notify the family. She stated in addition the staff had to document the care they provided. She stated nail care was to be done on the resident's showers days or daily if needed. In an interview with CNA G on 09/26/24 at 1:31 p.m. she stated she worked 09/25/24 on 2-10 p.m. shift and was assigned to Resident #16. She stated she gave him a bed bath. She stated she asked him if he wanted a shower and he said not really, so she gave him a bed bath. She stated she did not even think about his nails and had noticed they were long or dirty. She stated she was supposed to document the care she gave in the computer and thought she had done that. She stated she was not aware she was supposed to turn in the CNA report to the charge nurse. She stated long, dirty nails were an infection risk. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2- A record review of Resident #93's Quarterly MDS assessment dated [DATE] reflected Resident #93 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses included cerebrovascular accident (a loss of blood flow to part of the brain, which damages brain tissue), arthritis, and elevated blood pressure. Resident #93 had a BIMS score of 03 which indicated Resident #93's cognition was severely impaired. He required extensive assistance of two-person physical assistance with personal hygiene. Record review of Resident #93's care plan with an effective date of 07/31/24 reflected, [Resident #93] 's ADL functions bathing, eating, transfer, positioning, dressing, and grooming .Goals .Will maintain a sense of dignity by being clean, dry odor free and well-groomed over next 90 days .Interventions .set-up, assist, give shower, shave, oral, hair, nail care scheduled and prn . An observation on 09/24/24 at 9:47 AM revealed Resident #93 was laying in his bed. The nails on the right hand were approximately 0.4 centimeter in length extending from the tip of his fingers. The nails were discolored tan and the underside had dark brown colored residue. The nails on the left hand were approximately 0.3 centimeter in length extending from the tip of his fingers, and nails were chipped on 4 fingers. Resident #93 was unable to answer questions. Interview on 09/24/24 at 10:07 AM, CNA K stated CNAs were allowed to cut the residents' nails if they were not diabetic. CNA K stated she would clean and trim Resident #93's nails right then. She stated she had not noticed his nails needed cleaning and trimming. She stated the risk for not performing nailcare was increased risk of infection. 3- A record review of Resident #94's Quarterly MDS assessment dated [DATE] reflected Resident #94 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses included diabetes mellitus, elevated blood pressure, and end-stage renal disease. Resident #94 had a BIMS score of 10 which indicated Resident #94's cognition was moderately impaired. He required extensive assistance with activity of daily living. Record review of Resident #94's care plan with an effective date of 07/3/24 reflected, [Resident #94] 's ADL functions - bathing, eating, transfer, positioning, dressing, and grooming .Goals .Will maintain a sense of dignity by being clean, dry odor free and well-groomed over next 90 days .Interventions .set-up, assist, give shower, shave, oral, hair, nail care scheduled and prn . In an observation and interview on 09/24/24 at 10:28 AM revealed Resident #94 laying in his bed. Nails on both hands were long and dirty, they were about 0.5 cm long and underside had dark brown colored residue. Resident #94 stated he would like his nails clean and trimmed. He stated no one had offered to cut his nails. In an interview with LVN J on 09/24/24 at 10:55 AM revealed Resident #94 was very vocal of his needs and Nurses trim his nails since Resident #94 had diagnosis of diabetes. She stated that she had not offered nailcare to the Resident#94 recently. She stated that nailcare should be provided on shower day or as needed. She stated Resident #94's fingernails were long and dirty and offered to clean them after the interview. She stated the risk of not providing adequate nail care was increased infections and skin break down. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4-Review of Resident #57's face sheet undated reflected Resident #57 was an [AGE] year-old-female admitted to the facility on [DATE] with diagnoses of Acute Kidney Failure (sudden decline in the functioning of your kidneys), Dementia (diseases that affect memory, thinking, and the ability to perform daily activities), hypertension, myocardial infarction (heart attack), cerebral infarction (stroke) and anxiety disorder. Review of Resident #57's quarterly MDS assessment dated [DATE] reflected Resident #57 had a BIMS score of 7 indicating she was severely cognitively impaired. Resident #57 was total dependent with ADLs of shower/bathing and toileting. She required substantial to maximal assistance with ADLs of dressing, transfers and personal hygiene. Review of Resident #57's care plan undated reflected Resident #57 ADL functions bed mobility, transfer, dressing, toileting, hygiene, eating. Interventions included the following: set up, assist, give shower, shave, oral, hair, nail care schedule and prn and Assist with ADL's as needed. Observation and Interview on 09/24/24 at 12:45 PM with Resident #57 revealed her fingernails were thick about 1/2 inch long and her thumbs about 1/4 inch long with brown substance under her fingernails. She stated she would trim them her fingernails if she could. She stated facility staff had not offered to her to trim her fingernails. She stated her feet were dry and toenails were thick and long about 1/2 inch. She stated she could not trim her toenails and no one had trimmed her toenails. Observation and Interview on 09/25/24 at 09:05 AM with Resident #57 revealed her fingernails were thick about 1/2 inch long and her thumbs about 1/4 inch long with brown substance under her fingernails. Resident #57 stated she had a bed bath yesterday (09/24/24) but no one had offered to trim her fingernails. Resident #57's feet were dry and flaky. She would like her fingernails trimmed and cleaned. Observation and Interview on 09/25/24 at 9:14 AM with CNA N revealed she was aware of Resident #57's dry and flaky skin on her feet. She stated she had informed LVN P of Resident #57's dry and flaky skin. She stated Resident #57 was a 2 pm to 10 pm shower as CNAs residents should be offered to trim resident fingernails if not a diabetic. She stated Resident #57 was not a diabetic. Interview on 09/25/24 at 9:18 AM with CNA N regarding Resident #57's fingernails revealed she was aware of Resident #57 having long fingernails, but she had not asked Resident # if she wanted them trimmed since Resident #57 had longer fingernails when she came to facility. She asked Resident #57 if she wanted her fingernails trimmed and Resident #57 stated she would like her fingernails trimmed. CNA N stated she told Resident #57 she would come back later to clean and trim her fingernails. Observation and Interview on 09/25/24 at 9:21 AM with LVN P regarding Resident #57's fingernails revealed resident can get her fingernails trimmed if resident asked CNA to trim them. Interview on 09/25/24 at 3:50 PM with CNA O revealed Resident #57's showers were scheduled on Tuesday, Thursday and Saturdays on the 2 pm to 10 pm shift. CNA O stated she was not able to trim Resident #57's nails since she could not see very well. She stated she reported to nurse she could not trim Resident #57's fingernails. Interview on 09/25/24 at 4:30 PM with the DON revealed Resident #57 had refused to have her fingernails trimmed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Beacon Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 3515 S Park Ave Denison, TX 75020	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/25/24 at 5:08 PM with the DON revealed CNAs should be offering to trim Resident #57's fingernails if she let them. She stated the risk factors for not getting fingernails trimmed could be it could cause skin and infection issues. In an interview with the DON on 09/26/24 at 11:16 AM revealed her expectation was that nail care should be provided on shower day or as needed. She stated that CNAs were responsible for doing nail care for non-diabetic residents and nurses were responsible to do diabetic residents. She stated that as the DON, either herself or her designee were responsible to do routine rounds for monitoring. The DON stated residents having long and dirty fingernails could be an infection control issue. Record Review of the facility policy titled Care of Fingernails/Toenails revised October 2010 reflected, The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections 1. Nail care included daily cleaning and regular trimming. 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. 42971

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34399 Based on observation, interview, and record review, the facility failed to ensure that residents receive proper treatment and care to maintain good foot health for 1 (Resident #57) of 8 residents reviewed for quality of care. The facility failed to ensure Resident #57 received foot care and treatment for her dry, flaky skin on her feet. The facility failed to ensure Resident #57 was referred and seen by podiatrist for her long thick toenails. These failures placed all residents at risk for not receiving foot care which is consistent with professional standards of practice. Findings include: Review of Resident #57's face sheet undated reflected Resident #57 was an [AGE] year-old-female admitted to the facility on [DATE] with diagnoses of Acute Kidney Failure (sudden decline in the functioning of your kidneys), Dementia (diseases that affect memory, thinking, and the ability to perform daily activities), hypertension, myocardial infarction (heart attack), cerebral infarction (stroke) and anxiety disorder. Review of Resident #57's quarterly MDS assessment dated [DATE] reflected Resident #57 had a BIMS score of 7 indicating she was severely cognitively impaired. Resident #57 was total dependent with ADLs of shower/bathing and toileting. She required substantial to maximal assistance with ADLs of dressing, transfers and personal hygiene. Review of Resident #57's care plan undated reflected Resident #57 ADL functions bed mobility, transfer, dressing, toileting, hygiene, eating. Interventions included the following: set up, assist, give shower, shave, oral, hair, nail care schedule and prn and Assist with ADL's as needed. Review of Resident #57's September 2024 physician orders dated 09/24/24 reflected Resident #57 was not referred to podiatrist. Resident #57 had no current wound treatment physician orders. Review of Resident #57's clinical record from January to September 24, 2024 reflected Resident #57 had not been referred or seen a podiatrist since admission. Review of September 2024 visit for podiatrist reflected Resident #57 was not seen by podiatrist. Observation and Interview on 09/24/24 at 10:40 AM with Resident #57 revealed her feet were dry and flaky with long thick toenails about 1/2 inch long. Observation and Interview on 09/24/24 at 12:45 PM with Resident #57 revealed her feet were dry and toenails were thick and long about 1/2 inch. She stated she could not trim her toenails and no one had trimmed her toenails. She stated she was dependent on staff to care for her feet and she would like her toenails trimmed. She stated she would like treatment to help with her dry skin on her feet. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and Interview on 09/25/24 at 09:05 AM with Resident #57 revealed her fingernails were thick about 1/2 inch long and her thumbs about 1/4 inch long with brown substance under her thumb nails. Resident #57 stated she had a bed bath yesterday (09/24/24) but no one had offered to trim her fingernails. Resident #57's feet were dry and flaky. She stated she could not trim her toenails and could not recall any doctor looking at them. Interview on 09/25/24 at 9:14 AM with CNA N revealed she was aware of Resident #57's dry and flaky feet ongoing since admission. She stated she had informed LVN P of Resident #57's dry and flaky skin. She stated Resident #57 was a 2 pm to 10 pm shower as CNAs residents should be offered to trim resident fingernails if not a diabetic. She stated Resident #57 was not a diabetic. She stated she did put lotion on Resident #57's feet but it did not seem to help any with her dry and flaky feet. Observation and Interview on 09/25/24 at 9:21 AM with LVN P of Resident #57 revealed she was aware of Resident #57's dry and flaky skin on her feet and the wound care nurse was responsible to ensure Resident #57 was referred to podiatrist since she was receiving wound care treatment. Interview on 09/25/24 at 9:25 AM with LVN P revealed after looking at current physician orders for Resident #57 revealed she could not find any current wound care treatment orders. She stated she thought podiatrist came last week and looked at Resident #57's feet. She stated she did not know what treatment podiatrist had done for Resident #57 and was unable to find any documentation of podiatrist coming to see Resident #57. Interview on 09/25/24 at 3:31 PM with Social Worker revealed Resident #57 was not referred to or seen by podiatrist. She stated nursing had not informed her of Resident #57 needing podiatrist. Interview on 09/25/24 at 3:50 PM with CNA O revealed she applied lotion to Resident #57's dry feet and nurse was aware of it. Interview on 09/25/24 at 4:30 PM with the DON revealed CNAs should report any dry/flaky skin to the charge nurse who should assess the skin and call the doctor. She stated toe nails should be trimmed but if resident is a diabetic he should be referred to the podiatrist. Observation on 09/25/24 at 5:05 PM with DON of Resident #57's feet revealed they were dry and flaky with long, thick toenails about 1/2 inch long. Interview on 09/25/24 at 5:08 PM with DON revealed she would contact the physician and inform him of Resident #57's feet to get a physician order to treat Resident #57's dry flaky skin on her feet. She stated she will contact physician about Resident #57's toenails and to get a referral to a podiatrist even a local one if the facility podiatrist was unable to come out. She stated the risk factors for not getting finger nails trimmed could be it could cause skin and infection control issues. She stated Resident #57 not seeing a podiatrist could lead to infection or open skin areas. In an interview with the DON on 09/26/24 at11:16 AM revealed her expectation was that nail care should be provided on shower day or as needed. She stated that CNAs were responsible for doing nail care for non-diabetic residents and nurses were responsible to do diabetic residents. She stated that as the DON, either herself or her designee were responsible to do routine rounds for monitoring. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of the facility policy titled Care of Fingernails/Toenails revised October 2010 reflected, The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections 1. Nail care included daily cleaning and regular trimming. 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for one of five residents (Resident # 47) reviewed for catheter and incontinence care. The facility failed to ensure Unit Manager A and CNA E maintained the foley catheter drainage bag below Resident #47's bladder during a mechanical lift transfer. This failure placed residents at risk for not receiving care appropriate to address their incontinence. Findings included: Record review of Resident #47's quarterly MDS assessment dated [DATE] reflected a [AGE] year-old female admitted to the facility on [DATE]. She had a BIMS score of 9 which indicted she was moderately cognitively impaired, was dependent for transfers which required 2-person assistance, had an indwelling catheter and always incontinent of bowel. Diagnoses included hypertension (high blood pressure) and pressure ulcers of the sacral region stage 4 (full thickness skin loss that may extend to muscle, bone, tendon or joint). Record review of Resident 47's care plan with an effective date of 05/17/24, reflected, [Resident #47 has Foley catheter and is at risk for increased UTI's .Goal- Foley will remain patent and [Resident #47] will not develop increased incidence of UTI's over the next 90 days .Interventions .Keep tubing/bag below the bladder . Record review of Resident #47's September 2024 Physician Order sheet dated 09/26/24, reflected, .Foley catheter .Check for patency and placement Q shift.with a start date of 05/29/24. In an observation on 09/26/24 at 11:05 a.m. revealed CNA E and Unit Manager A entered Resident #47's room to transfer the resident from the bed to her wheelchair. Both staff performed hand hygiene and put on gloves. CNA E placed the catheter drainage bag on the foot of the bed, next to the residents' foot that had a bandage on it. Both staff positioned the resident on the sling. CNA E then took the foley drainage bag, which had about 200 cc of urine in it, and hooked it to the arm of the mechanical lift. The staff raised the resident from the bed with the catheter drainage bag remaining on the arm of the mechanical lift, above the resident's bladder. Urine was observed flowing back toward the resident's bladder. The staff then positioned her over her wheelchair and lowered her into her chair and then placed the catheter bag onto the back of her wheelchair. In an interview with Unit Manger A on 09/26/24 at 11:15 a.m. she stated she knew the catheter drainage bag was to remain below the bladder but stated she honestly did not know what the staff should be doing to keep it below the bladder while doing a mechanical transfer. She stated the staff had asked her and she did not know where they should be placing the bag, unless maybe hooking onto their pockets. She stated it should not be laid in the bed due to the infection risk. She stated having it above the bladder caused risk of increase urinary tract infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with CNA E on 09/26/24 at 11:20 a.m. she stated she knew catheter drainage bag was supposed to be below the bladder but stated she had not been told how they were supposed to place the bag during a mechanical lift transfer. She stated she was just doing what she saw everyone else do with the catheter. She stated she did not realize they were not supposed to place the catheter bag on the bed, but stated she could see where it would be an infection risk. In an interview with the DON on 09/26/24 at 11:48 a.m. she stated the catheter drainage bag was to be always maintained below the bladder. She stated during a Mechanical lift transfer there were always 2 people so one should hold the catheter bag lower than the bladder during the transfer. She stated the risk of holding it above the bladder was an increased risk if Urinary tract infections. She stated they do skills checks annually and as needed when a training issue is identified. Review of the facility's policy titled, Catheter Care, Urinary , dated September 2014, reflected, The purpose of this procedure is to prevent catheter-associated urinary tract infections .The urinary drainage bag must be held or positioned lower than he bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder .Infection control .Use standard precautions when handling or manipulating the drainage system .Be sure the catheter tubing and drainage bag are kept off the floor .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for one of one resident (Resident #84) reviewed for medication administration for enteral feeding tubes. The facility failed to ensure LVN C clamped the tubing before it drained completely between each medication administration for Resident #84. This failure could affect residents by placing them at risk of abdominal discomfort and aspiration. Findings included: Record review of Resident #84's Significant change MDS assessment, dated 08/05/24, reflected a [AGE] year-old female with an admitted [DATE]. Resident #84's BIMS score was 7 which indicated she was severely cognitively impaired. She was totally depended on all ADLs and always incontinent of bowel and bladder and received 51% or more of total calories through a feeding tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach). Diagnoses included gastroesophageal reflux (regurgitation of gastric contents into the esophagus), cerebral vascular accident (stroke), seizure disorder, and multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves). Record review of Resident #84's Care Plan, with an effective date of 01/09/24, reflected, . [Resident #84] receiving tube feedings. Medication to be crushed for administration, G-tube medication water mix .Goals . will received adequate nutrition without side effects associated with tube feedings (aspiration, diarrhea, dehydration) over the next 90 days .Interventions Check tube placement by aspiration before giving feeding. Elevate head of bed . Record review of Resident #84's Physicians Order Sheet September 2024, dated 09/26/24 reflected, . G-tube-Flush before/after meds , with a start date of 01/09/24. Record review of Resident #84's medication administration record for September 2024, reflected, . G-tube Flush before /after meds-Flush G-tube with 50 cc of water before and after medication administration, with a start date of 01/09/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 09/25/24 at 08:25 a.m. revealed LVN C at the medication cart to prepare Resident #84's G-tube medications. LVN C pulled Amlodipine 5 mg (blood pressure medication) 1 tablet, Aspirin 81 mg (analgesic) 1 tablet, Multivitamin (supplement) 1 tablet, Clonazepam 0.25 mg ((antianxiety)1 tablet, Pregabalin 20 mg/ml 5 ml ((anticonvulsant). Metoprolol 100 mg (antihypertensive) tablet, Venlafaxine 75 mg (antidepressant), Levetiracetam 100 mg/ml 2.5 ml (anticonvulsant), and Valproic acid 250 mg/ml 5 ml, (anticonvulsant). LVN C placed each of the medications into a separate plastic cup, crushed the tablets and diluted them with 5cc of water and entered the resident's room with the medications. LVN C went to the resident's bathroom and filled two plastic cups with water and placed them on the bedside table with the medications. LVN C then donned gloves and retrieved the 60-cc piston syringe and placed the syringe in the end of the resident's G-tube and instilled approximately 30 cc of air and listened with a stethoscope for placement. LVN C then back to check for gastric residual, which showed none. LVN C then flushed the G-tube with 50 cc of water and poured the first medication allowing it to completely clear the tube before flushing it with 10 cc of water. LVN C continued with the next eight medications, allowing each time for the tube to completely empty prior to pouring the water flush and the next medication. After completion of the medication administration LVN C flushed the tube with 50 ccs of water. In an interview with LVN C on 09/25/24 at 9:30 a.m., she stated she was not aware she had let the tube completely emptied between each medication administration. She stated she was not supposed to let the tube empty completely between medications because it could add more air into the stomach and could cause reflux and discomfort. In an interview on 09/25/24 at 1:00 p.m. the DON stated the nurses were to clamp the tube when the medication was almost clear, then add the water flush in between and clamp before adding the next medication. She stated this kept the tube free of air until all the medications were administered. She stated by not keeping a consistent flow it can allow air in the resident's stomach which can cause aspiration and discomfort. Record Review of LVN C's skills check for Medication administration Via G-tube dated 03/14/24 reflected she was competent in the procedure. Review of [NAME] Potter's Nursing Interventions & Skills, 4th edition, 2007, page 390, reflected, .To administer more than one medication, give each separately and flush between medication with 15 ml to 30 ml of water.Clamp the tubing if a tube feeding is not being administered. Prevents air from entering the stomach . Record review of the facility's policy, Medication Administration through a Feeding Tube, dated May 2012, reflected, .Dilute liquid medications with 10 -30 cc of water .and dissolve or suspend crushed medications in 5-10 cc.Flush feeding tube with at least 30 cc of water. Pour medication into 60 cc syringe. Allow mediation to flow from syringe into tube. Flush the tube with 5-10 cc of water (or as ordered by physician) between each medication. After all medications have been administered, flush syringe with at least 330 cc of water to assure complete dose of medication will be administered. Clamp tubing and detach syringe .

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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** 34918 Based on observation, interview, and record review the facility failed to label drugs and biologicals used in the facility in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for one of two medication rooms (Medication Room X) reviewed for storage. The facility failed to ensure a vial of TB PPD that was opened and used was dated in the medication room refrigerator and failed to have 4 tuberculin syringes filled with an unknown liquid dated and labeled. These failures could affect residents and staff resulting in diminished effectiveness, and not receiving the therapeutic benefits of the medications. The findings included: An observation on [DATE] at 9:18 a.m. of the medication room refrigerator with LVN B revealed an open vial of Tuberculin Purified protein derivative and 4 tuberculin syringes with an unknown liquid drawn up. The syringes were not dated or labeled. LVN B stated Unit Manager D, who was the infection prevention nurse does all the TB test (skin test used to detect the presence of tuberculosis). She stated she did not know what was in the syringes. In an interview with Unit Manager D on [DATE] at 9:30 a.m., she stated she was the infection preventionist in the facility and she was responsible for doing the TB skin test on residents. She stated she had drawn up the 4 syringes of Tuberculin PPD (purified protein derivate). She stated she had overdrawn yesterday ([DATE]) when she was doing TB skin tests and stated she should had discarded them. She stated they were required to date the vial after they opened it and she failed to do that. In an interview with the DON on [DATE] at 11:55 a.m. she stated once a multi-use vial of medication was opened the staff were required to date it. She stated they were never to pre-draw any medication from a multi-use vial and not use it immediately. She stated the nurse should have discarded the syringes of TB PPD immediately when it was not going to be used. She stated by placing them back in the refrigerator without them labeled no one would know what was in the syringes, or how long it had been drawn up. She stated all medications had to be labeled and any TB PPD vial opened had to be dated once opened to prevent the risk of using an expired medication which would render it ineffective and give the incorrect reading of the PPD. The DON said all nurses were responsible to check the medication carts and the medication rooms for expiration and labeling of medication. Record review of the facility's policy titled Storage of Medications, dated [DATE], reflected, .The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed The nursing staff shall be responsible for maintaining medication storage

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34399 Based on observations, interviews and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's only kitchen for 3 of 4 Dietary Staff (Dietary [NAME] T, Dietary [NAME] U and Dietary Assistant [NAME] V) reviewed for kitchen sanitation. 1. The facility failed to ensure graham cracker crumbs were sealed in dry storage. 2. The facility failed to ensure sugar and flour container lids in dry storage were free of stickiness and white particles on them. 3. Dietary [NAME] T, Dietary [NAME] U and Dietary Assistant [NAME] V failed to perform hand hygiene during lunch meal service on 09/25/24. 4. The facility failed to ensure gravy was temped prior to being served on 09/25/24. These failures could place residents at risk for food contamination and food-borne illness. Findings include: 1. Observation and interview on 09/24/24 at 9:22 AM of the dry storage area revealed graham cracker crumb box was open not sealed. Interview with the Dietary Manager revealed the graham cracker crumb box should have been sealed. Observation revealed the Dietary Manager closing the box. 2. Observation and interview on 09/24/24 at 9:25 AM of the dry storage area revealed sugar and flour container lids were sticky with white particles and powder on them. Intereview with the Dietary Manager revealed the containers should be wiped and cleaned off. 3. Observation on 09/25/24 at 12:31 PM revealed Dietary [NAME] T touched the knob of the stove with gloved hand to turn down the gravy. Dietary [NAME] T kept same gloves on and did not wash hands. Dietary [NAME] T continued to put food on plates by scoping and touching the inner part of the plate with gloved hands. At 12:35 PM Dietary [NAME] T put his gloved hand on counter on steam table which had visible food particles on it. Dietary [NAME] T did not change gloves and wash hands. Dietary [NAME] T did not check the food temperature of white gravy on the stove which was poured on chicken fried steak on resident hall lunch trays. Observation on 09/25/24 at 12:33 PM revealed Dietary Assistant [NAME] V had no gloves on, pushed the hall tray cart to the food line up area and touched the top and side of the hall tray cart. Dietary Assistant [NAME] V touched the hall trays and placed them in the hall tray cart without washing hands. Dietary [NAME] V got another hall tray cart touching the outside and continued putting resident hall meal trays in the cart. She did not wash her hands. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Beacon Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 3515 S Park Ave Denison, TX 75020	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 09/25/24 at 12:36 PM revealed Dietary [NAME] U put his gloved hands on the counter where food particles and food spills were present. From 12:38 PM to 12:42 PM Dietary [NAME] U's left glove had a tear about 1/2 inch on top of left hand along with both gloves being wet while serving food by scooping mashed potatoes and carrots onto plate and touching the inner part of the plate with gloved hands. He did not change gloves or wash hands. Interview on 09/25/24 at 12:47 PM with Dietary [NAME] T revealed he should have tempered the white gravy prior to serving it to ensure it was hot enough to serve. He stated he should have changed his gloves and washed his hands after turning off the gravy and when contaminating his gloves. He stated usually the gravy was cooked ahead of time and temped at the beginning of meal service. Dietary [NAME] T stated Dietary [NAME] U was newer to the facility. Interview on 09/25/24 at 12:48 PM with Dietary [NAME] U revealed he was not aware his left glove was torn during meal service. He stated he should have changed gloves and washed his hands when he touched the counter with his gloved hands. Interview on 09/25/24 at 12:50 Pm with Dietary Assistant [NAME] V revealed she should have washed her hands after touching the outside of the hall tray cart. Interview on 09/26/24 at 10:25 AM with the Dietary Manager revealed the items being sealed in the dry storage area when not in use can help to keep anything from getting in it. She stated the sugar and flour containers not being cleaned off and having powder on it was a sanitation issue. She stated dietary staff not washing hands was a contamination issue. She stated the gravy should had been temped prior to serving to ensure the food temperature is hot enough to be served. Review of Dietary [NAME] T's Annual In-service Documenation dated 09/10/24 reflected he was in-serviced on infection control. Review of Dietary [NAME] U's Orientation Checklist for Nutrition Services Staff dated 09/17/24 reflected Dietary [NAME] U was in-serviced on hand washing. Review of Dietary Assistant [NAME] V's Annual In-service Documentation dated 09/07/24 reflected she was in-serviced on infection control. Review of facility's policy Food Storage undated reflected Food is stored, prepared, and transported at an appropriate temperature and by methods designed to prevent contamination. Review of facility's policy Hand Washing dated 11/03/2004 reflected Dietary staff will wash hands .after removing gloves and at other times hands have been soiled. Review of facility's policy Food temperatures dated May 2008 and last revised January 2019 reflected All hot and cold food items must be served to the patients/residents at a palatable temperature .4. Cooking temperatures must be reach and maintained according to regulations, lawas and standardized receipes while cooking .8. Temperatures should be taken periodically to ensure hot foods maintain proper temperatures during the tray line period. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility's policy Gloves dated 11/03/2004 and last revised 05/2024 reflected Nutrition Services employees will wear gloves as indicated by federal, state or local health guidelines for food safety and infection control .4) Gloves should be changed after they become soiled. Review of the FDA US Food Code 2022 reflected the following: -under section 2-3 Personal Cleanliness 2-301.11 Clean Condition Food Employees shall keep their hands and exposed portions of their arms clean.

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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** 34918 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 2 of 23 residents (Resident #257 and Resident #24) reviewed for infection control. 1. The facility failed to ensure LVN H sanitized a bottle of glucose level test strips when she carried the bottle into Resident #257's room and returned it to the medication cart without sanitizing it. 2. The facility failed to ensure LVN H failed to perform hand hygiene after removal of her gloves after completion of obtaining a fingerstick blood sugar test on Resident #257, after cleaning the glucometer, and after insulin administration to Resident #257. 3. The facility failed to ensure CNA I changed gloves and performed hand hygiene while providing incontinence care to Resident # 24. Theses failures could place residents at risk for infection and cross contamination. Findings include: 1. Record review of Resident #257's face sheet, dated 09/26/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #257 had a diagnosis which included diabetes. Observation during medication pass on 09/24/24 at 11:15 a.m. revealed LVN H at the medication cart preparing to obtain a fingerstick blood sugar test on Resident #257. LVN H pulled a glucometer and a bottle of test strips from the medication cart. She donned gloves and cleaned the glucometer with a germicidal wipe with a kill time of 4 minutes. LVN H removed her gloves and set the timer on her watch to 4 minutes. After 4 minutes, LVN H put on gloves without performing hand hygiene and entered the resident's room and placed the glucometer on a tissue on the bedside table and bottle of test strips on the bedside table without sanitizing the table or placing the bottle of strips on a clean barrier. LVN H proceeded to obtain the blood sugar reading. LVN H gathered the glucometer, lancet and used alcohol wipe and disposed the lancet in the sharps container and placed the glucometer and bottle of test strips on top of medication cart. LVN H then removed her gloves and without performing hand hygiene checked the computer to determine the dose of insulin required. LVN H then opened the medication cart, placed the un-sanitized bottle of test strips back into the medication cart and retrieved the Resident's insulin and drew up the required amount of insulin per sliding scale. LVN H put on gloves without performing hand hygiene and entered the Resident's room and administered the insulin. LVN H returned to the medication cart, disposed of the insulin syringe and removed her gloves without performing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with LVN H on 09/24/24 at 11:30 a.m. she stated she should of performed hand hygiene after she changed her gloves, but stated she forgot. She stated taking the bottle of test strips was like any other supply, once it entered the room it was considered contaminated. She stated she should of carried in only the amount of supplies she needed. She stated these failures could cause cross contamination and spread of infection. In an interview with the DON on 09/24/24 at 12:35 p.m. stated staff were to do hand hygiene after glove changes, after cleaning any equipment and when going from one procedure to the next. She stated they were only to carry in the supplies they needed to do a FSBS and were not supposed to carry in the whole bottle of test strips since it is for multi-use purposes. She stated the nurse should have performed hand hygiene after she had completed the FSBS and before she checked the computer and pulled out the insulin to give. She stated failing to do this posed a risk of cross contamination and increased risk of infections. Record review of LVN H Glucose Monitoring skills checklist dated 06/10/24 reflected she was competent in the procedure. 2. A record review of Resident #24's Quarterly MDS assessment, dated 09/19/2024, reflected Resident #24 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses included dementia (condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), sever obesity, and need for assistance with personal care. Resident #24 had a BIMS score of 07 which indicated Resident #24's cognition was severely impaired. Resident#24 was occasionally incontinent of bladder. In an observation on 09/24/24 at 10:04 AM revealed CNA I entered Resident #24's room to provide incontinence care. CNA I washed her hands and donned gloves, she unfastened the resident's brief and cleaned the front pubic area using several peri wipes. Without changing gloves, CNA I assisted Resident #24 onto her right side, she removed and discarded the soiled brief, and she cleaned the resident's buttocks area with peri wipes. Without changing gloves, CNA I placed a clean brief under resident, she repositioned the resident back on her back, she fastened the brief, she covered resident, and put the bed in low position. CNA I gathered the dirty clothes and trash, she removed her gloves, and washed her hands. In an interview on 09/24/24 at 10:14 AM, CNA I stated she was to wash hands before and after care. CNA I also stated she was supposed to change gloves and complete hand hygiene each time she moved from dirty to clean area during care. CNA I stated she did not change gloves during the incontinent care because she was nervous. CNA I stated she was supposed to change gloves and complete hand hygiene to prevent the spread of infection. In an interview on 09/26/24 at 11:16 AM with the DON, she stated during incontinent care the staff were to complete hand hygiene before and after care. The DON also stated in between care CNA was to complete hand hygiene and change gloves because her hands were considered dirty after cleaning the resident. The DON stated the staff were to complete hand hygiene during care to prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy, Handwashing/Hand Hygiene, dated August 2019, reflected, All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors .for the following situations .Before preparing or handling medications .Before performing any non-surgical invasive procedure .Before moving from a contaminated body site to a clean body site during resident care . After contact with blood or bodily fluids .after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident .After removing gloves .Hand hygiene is the final step after removing and dispose of personal protective equipment . 42971