STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675527	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whisperwood Nursing & Rehabilitation Center	5502 W 4th St Lubbock, TX 79416

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42515 Based on observations, interviews, and record reviews, the facility failed to ensure each resident was treated with respect, dignity, and care for each resident in a manner and in an environment that promotes the maintenance or enhancement of their quality of life, recognizing each resident's individuality and the facility failed to protect and promote the rights of the resident for 4 of 21 residents (Resident #9, Resident #26, Resident #41, and Resident #231) reviewed for resident rights in that: 1. CNA H failed to knock on the door prior to entering Resident #41's room during wound care. 2. CNA I failed to provide full privacy while providing peri care for Resident #9 3. CNA E and CNA F failed to provide full privacy while providing peri care for Resident #231. 4. Resident #26 was observed with no clothes on, just a brief and right sock on while in his room with the door open on 11/05/2024 and 11/06/2024. These failures could place residents at risk for diminished quality of life and loss of dignity and self-worth. The findings included: Resident #9: Record Review of Resident #9's face sheet revealed an [AGE] year-old female, admitted on [DATE] with diagnoses of: acute respiratory failure with hypoxia (impairment of gas exchange between the lungs and the blood causing an absence of enough oxygen in the tissues to sustain bodily functions), hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone), hyperlipidemia (a condition in which there are high levels of fat particles in the blood), dementia, high blood pressure, heart failure, acid reflux. Record review of Resident #9's Quarterly MDS assessment dated [DATE], revealed Resident #9 had a BIMS Score of 03, meaning Resident #9 had severe cognitive impairment. Under section for Bowel & Bladder listed Resident #9 as always being incontinent for urinary and bowel. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of CNA I providing peri care for Resident #9 on 11/6/2024 at 11:20 am. CNA I failed to pull the privacy curtain all the way before proceeding with providing peri care for Resident #9. CNA I did close the door but did not close the privacy curtain all the way, just half way, dividing the resident from roommate. During an interview with CNA I on 11/06/2024 at 11:37 am. CNA I stated that she should have closed the privacy curtain all of the way providing full privacy. CNA I stated that she had been trained in providing privacy for resident by in-services, approximately every couple of weeks. CNA I stated that the negative potential outcome of not providing full privacy is that someone could walk in and it may make the resident feel embarrassed and invaded of privacy. Resident#26: Record Review of Resident #26's face sheet revealed a [AGE] year-old male, admitted on [DATE] with an initial admitted [DATE] with diagnoses of: dementia, constipation, muscle weakness, insomnia, acid reflux, schizoaffective disorder (a chronic mental illness), high blood pressure, hypothyroidism (low thyroid hormone levels), type 2 diabetes, congestive heart failure, hyperlipidemia (high lipids/fats in blood), depression. Record review of Resident #26's Quarterly MDS assessment, dated 08/12/2024, revealed Resident #26 had a BIMS Score of 00, meaning Resident #26 had severe cognitive impairment. Under section for Bowel & Bladder listed Resident #26 as always incontinent with urinary continence. During an observation of Resident #26 on 11/5/2024 at 12:57 pm. Observed Resident #26 laying in his bed with no sheet, no clothes on, with a brief and one sock on the right foot. Observed the resident's door open with other residents walking by. Resident #26's room is located next to the dining room. During an observation of Resident #26 on 11/5/2024 at 4:11 pm. Observed Resident #26 laying in his bed with no sheet, no clothes on, with a brief and one sock on the right foot. Observed the resident's door open with other residents walking by. Resident #26's room is located next to the dining room. During an observation of Resident #26 on 11/6/2024 at 7:29 am. Observed Resident #26 in his room, laying in his bed with no sheet, no clothes on, with a brief and one sock on the right foot. Observed the resident's door open with other residents walking by. Resident #41 Record review of Resident #41's face sheet, dated 11/7/24, revealed a [AGE] year-old male who was admitted to the facility on [DATE] with the following diagnoses: cerebral infarction (stroke), projectile vomiting (forceful vomiting), and peripheral vascular disease (poor blood circulation). Record review of Resident #41's comprehensive MDS assessment, dated 04/17/24, revealed Resident #41 has a BIMS score of 13, which indicates intact cognition. Resident #41 was checked off on having a diabetic foot ulcer. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 11/06/24 at 10:35 AM of wound care performed by the WCN, CNA H was heard talking outside Resident #41's room and the door opened as she continued talking with her head turned towards the hallway. CNA H turned her head and saw the surveyor in the room, then 3 small knocks were heard on the door. CNA H did not knock prior to entering Resident #41's room. Interview on 11/06/24 at 10:55 AM, Resident #41 stated staff rarely knocks on his door before entering. Resident #41 stated sometimes it bothers him when the staff don't knock before entering his room. Interview on 11/07/24 at 12:59 PM, CNA H stated sometimes the residents get mad at them for knocking too hard when entering their rooms. CNA H stated she has been trained on knocking on the resident's door prior to entering. CNA H stated there are not many potential negative outcomes to the residents by not knocking on their door prior to entering as the residents can usually hear the staff talking in the hallways before going in their rooms. Resident #231 Record Review of Resident #231's face sheet revealed a [AGE] year-old male, admitted on [DATE] with diagnoses of: dementia, depression, anxiety, high blood pressure, acid reflux, muscle weakness, amnesia. Record review of Resident #231's Admission MDS assessment, dated 09/27/2024, revealed Resident #231 had a BIMS Score of 14, meaning Resident #231 was cognitively intact. Under section for Bowel & Bladder listed Resident #231 as occasionally being incontinent for urinary and bowel. During an observation of CNA E and CNA F providing peri care for Resident #231 on 11/6/2024 at 10:25 am. CNA E and CNA F failed to pull the privacy curtain all the way before proceeding with providing peri care for Resident #231. CNA F opened the door and left it completely open in the middle of peri care to go get some more wipes, leaving Resident #231 uncovered and completely exposed. CNA E failed to cover Resident #231. CNA E stood next to the bed while Resident #231 was exposed, waiting for CNA F to get back with wipes while the door was open the entire time. When CNA F returned to Resident #231's room with the wipes she then closed the door. During an interview with CNA E on 11/6/2024 at 4:54 pm. CNA E stated that she had been trained in privacy and dignity by in-services, monthly. CNA E stated that it is usually a verbal in-service provided by the DON. CNA E stated that she knows that she should provide privacy by pulling the privacy curtain completely. CNA E stated that she did not think to do that. CNA E stated that she does not know why Resident #26 was left in his room with only a brief and one sock on with no sheet, with the door open. CNA E stated that the negative potential outcome of not providing privacy to a resident is that it could leave them feeling anxious and embarrassed and may put them in an awkward position by being seen by others. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with CNA F on 11/07/2024 at 3:04 pm. CNA F stated that she does not know why Resident 26 was left in nothing with a brief and one sock on with the door open for two days. CNA F stated that she does not really like going around Resident #26 because he shows sexual behaviors. CNA F stated that she is not sure why she did not pull the privacy curtain while assisting with peri care for Resident #231. CNA F stated, My mind went blank. CNA F stated that she had been trained in dignity by in-services, approximately every few weeks. CNA F stated that the negative potential outcome of not providing dignity is that the resident would be embarrassed or be worried if someone may see them undressed or it may even embarrass them if their roommate were to see them like that. During an interview with the admin on 11/07/24 at 2:27 PM, the admin stated she expects the staff to always provide privacy to everyone with any type of care being provided. The admin stated she expects staff to shut the doors when providing care, and knock and introduce themselves. The admin stated this is their house [the residents], not ours [the staff]. The admin stated the staff have been trained on privacy and dignity. The admin stated a potential negative outcome to the residents was it could cause mental anguish or embarrassment for them. Record review of the facility policy titled, Resident Rights undated, reflected the following: .A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the residents 43150

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43150 Based on observation, interview and record review, the facility failed to assist the resident in making appointments to ensure residents receive proper treatment and assistive devices to maintain hearing abilities for one of one resident (Resident #47) reviewed for hearing devices. The facility failed to assist Resident #47 in locating missing hearing aids, and did not make an appointment to replace them, leaving Resident #47 to struggle to hear causing Resident #47 to become frustrated and depressed. Staff did not know that Resident #47 had hearing aids and were not assisting him with aids to hear. This failure could place residents at risk for limited social interactions and a decline in hearing. The findings included: Record review of Resident # 47's Face sheet reflected a [AGE] year-old male readmitted to the facility on [DATE] with an initial admitted [DATE]. Diagnoses included dementia, hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone), stroke, depression, vitamin D deficiency, hyperlipidemia (a condition in which there are high levels of fat particles in the blood), high blood pressure, acid reflux. Review of Resident #47's care plan dated 08/10/2023 revealed that Resident #47 was listed as having a communication/hearing deficit and stated that Resident #47 had a hearing deficit due to sensorineural hearing loss. The care plan stated that Resident #47 throws hearing aids away. Interventions listed as: do not cut off or interject when the resident is speaking, if resident has a device to assist them with hearing, encourage them to use it, maintain eye contact while speaking to resident, monitor hearing ability and report any changes to the physician, notify MD/family of any changes, speak in a clear voice and face them when speaking to the resident, the resident uses a hearing aid. Record Review of Resident #47's MDS assessment dated [DATE] revealed that Resident #47 had a BIMS of 3 meaning that Resident #47 had severe cognitive impairment. Under section O of the MDS labeled, Special treatments, Procedures, and Programs, for Speech-Language Pathology and Audiology Services were left blank and incomplete. Under the section titled, Hearing, revealed that Resident #47 was listed as highly impaired for hearing. Under the section titled, Hearing Aid, revealed that Resident #47 was listed as not having a hearing aid. Record Review of Resident #47's Physician Orders dated 11/07/2024 obtained by verbal consent, revealed: assist resident with putting hearing aides on in the am one time a day, assist resident with taking out hearing aids at bedtime. Record Review of Resident #47's Physician Orders as of 11/07/2024 did not indicate an order for hearing aids. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident #47 on 11/05/2024 at 4:12 PM. Resident #47 stated that he could not hear anything. Observed Resident #47 struggling to hear questions from Surveyor by Resident #47 saying, What, I can't hear you. Resident #47 stated that someone took his hearing aids and he had not had his hearing aids since right after coming to the facility. Resident #47 stated that he keeps asking staff about the hearing aids and no one will help. Resident #47 stated that it does not matter what anyone says because Resident #47 can't hear them anyway. During an interview with Resident #47 on 11/06/2024 at 9:39 AM. Resident #47 voiced frustration of not being able to hear and stated that he needs help to get some hearing aids. Resident #47 stated he can not hear what people are saying. Resident #47 stated that he can hear that people are saying something, but he cannot hear the words. Resident #47 stated it makes it hard to do anything. During an attempted interview call with RP for Resident #47 on 11/06/2024 at 10:30 AM. Attempted to make contact with RP to verify if Resident #47 had a hearing aid device. No answer. Left return contact information. No return call. During an observation of Resident #47 on 11/06/2024 at 11:50 AM. Observed CNA E trying to get Resident #47 to the dining room for lunch and CNA E had to talk loudly and Resident #47 struggled to hear what CNA E was saying. Observed CNA E had to repeat herself a couple of times before Resident #47 was able to hear her. During an interview with Social Worker on 11/07/2024 at 9:50 AM. The Social Worker stated that she believes that Resident #47's hearing aids went missing right after Resident #47 got to the facility. The Social Worker stated that Resident #47 came into the facility with hearing aids. The Social Worker stated that Resident #47 will have to wait until the ENT doctor orders the hearing aids at the six-month re-evaluation appointment in order for Medicaid to pay for them. The Social Worker stated that the next appointment for Resident #47 is in February 2025. The Social Worker stated that there is nothing else that they can do until then. During an observation of Resident #47 in activity group in the dining room on 11/07/2024 at 10:52 AM. Observed Resident #47 sitting in activities against the wall and Social Worker assisting with putting hearing aids in Resident #47's ears. During a resident council meeting on 11/07/2024 at 11:00 AM, Resident #47 stated several times that he could not hear. The State Surveyor positioned herself in front of him and spoke louder, however Resident #47 stated several times he could not hear and asked if the service was over. Resident #47 stated he was leaving the meeting because he could not hear and then exited the meeting. Observed that Resident #47 was not wearing hearing aids. During an interview with CNA E on 11/07/2024 at 11:08 AM. CNA E stated that she had not known Resident #47 to ever have hearing aids. CNA E stated that she had worked on D hall for three months and was trained by a former CNA to just raise her voice to talk to Resident #47. CNA E stated that no one in the facility had told her that Resident #47 had to have hearing aids. CNA E observed the new hearing aids that the speech therapist stated she found in Resident #47's room and CNA E stated that she had never seen the hearing aids before. CNA E stated that she knew that Resident #47 could not hear hardly at all but thought that was how it was. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA F on 11/07/2024 at 11:12 AM. CNA F stated that she had worked on D hall for several weeks and was not aware that Resident #47 needed to wear hearing aids. CNA F stated that no one told her that Resident #47 wore hearing aids. CNA F stated that Resident #47 would state that someone took his hearing aids but stated that she had never seen any hearing aids. CNA F stated she had never assisted Resident #47 with hearing aids. CNA F stated that she would have to talk louder and sometimes Resident #47 would still not hear what she said. During an interview with Social Worker on 11/07/2024 at 11:19 AM. The Social Worker stated that she had went and talked to SLP with speech therapy and she had brought those hearing aids to her, stating that she had found them in Resident #47's room. The Social Worker stated that the SLP stated that she had found the hearing aids on top of Resident #47's nightstand. The Social Worker stated that she had helped Resident #47 put them in his ears in the dining room during activities because she believed that he was struggling to hear anything, which would make it difficult to participate in activities. The Social Worker stated that she understands how this could be frustrating for Resident #47. During an attempted interview with RP on 11/07/2024 at 11:27 AM. Attempted to contact RP for Resident #47 with no answer. Left message with return contact information. No return call. During an interview with SLP on 11/07/2024 at 11:40 AM. The SLP stated that the Social Worker came to her and stated that Surveyor was asking questions about Resident #47's hearing aids and no one could find them. The SLP stated that she went to Resident #47's room and found them on his nightstand. The SLP stated that she was not sure why none of the other staff could find them to assist Resident #47 with the devices. The SLP stated that these are the hearing aids that she had known Resident #47 to always have. The SLP stated that she does not see Resident #47 on a day-to-day basis and only evaluated Resident #47 on a quarterly basis. The SLP stated that she had not seen Resident #47 since April 2024. During an interview with CNA D on 11/07/2024 at 11:50 AM. CNA D stated that she had worked on D hall for several months and she had never known Resident #47 to wear hearing aids. CNA D observed the hearing aids that were brought to Resident #47's room and stated that she had never seen the hearing aids before. CNA D stated that she had always known that Resident #47 could not hear hardly at all because he would get really frustrated by it. CNA D stated that she would always just have to talk louder with Resident #47. CNA D stated that she does think that by Resident #47 not having hearing aids would affect the quality of life and cause the resident to become depressed and not want to socialize. During an interview with ADON B on 11/07/2024 at 12:00 PM. ADON B stated that she was not seeing an initial inventory list in Resident #47's medical history file. ADON B stated that she is not sure why this had not been completed but could verify that there was not one. During an interview with ADON C on 11/07/2024 at 12:03 PM. ADON C stated that she was not seeing an initial inventory list in Resident #47's PCC file. ADON C stated that she could also verify that there had not been one completed for Resident #47. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident #47 on 11/07/2024 at 2:12 PM. Resident #47 stated, I got some new hearing aids, Do you see, I can hear now. Resident #47 showed excitement that he could hear by smiling and talking cheerfully. Resident #47 stated that he had not seen these hearing aids before but guessed the facility bought them. Resident #47 stated that it took a long time to get some hearing aids but Resident #47 was glad to be able to hear. During an interview with the DON on 11/07/2024 at 3:09 PM. The DON stated that she did not think that an initial inventory list was ever completed for Resident #47's items upon admission. The DON stated that she was not sure why this had not been done. The DON stated that she had now completed an inventory list of Resident #47's belongings, as of 11/07/2024. The DON stated that she would make sure that the inventory lists are completed from now on. The DON stated that she had just completed an in-service for assisting with hearing aids. The DON stated that she would expect staff to notify someone if they noticed that Resident #47 was struggling to hear. The DON stated that the negative outcome for the resident not being able to hear is that it could be frustrating for him, causing behaviors due to the frustration and that struggling to hear could potentially cause the hearing to get worse. During an interview with the Administrator on 11/07/2024 at 4:09 PM. The Administrator stated that she would expect that staff would assist the resident with putting in the hearing aids, replacing batteries, or cleaning them. The Administrator stated that she would expect that if Resident #47 was struggling with hearing that they would report to the DON, herself, or social services. The Administrator stated that the negative outcome of the resident not being able to hear would be that it could affect all areas of quality of life and communication. Record review of the facility's policy titled, Sensory or Perceptual Alteration (auditory), Revised July 1, 2005, reflected, Change in the characteristics of auditory stimuli to altered sensory reception, transmission, or integration. Assessment may include history of ear disorders, trauma, surgery, and age. Access to basic health care services is the right of every resident and access to information regarding basic services is one essential element of that right. Facility will make provisions to optimize all aspects of resident rights and quality of life issues. Goals: 4. The resident compensates for auditory loss by use of signing, gestures, lip-reading, hearing aid, and other measures. Procedure: 1. Assess the resident upon admission and in conjunction with IDT meetings thereafter. Document any auditory deficits and plan for care accordingly. 3. Determine how to communicate effectively with the resident. You may use gestures, written words, signing, lip-reading, etc. If the resident has a hearing aid, encourage its use. Planned communication with resident improves care delivery. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Refer resident to appropriate ancillary services (speech therapy) for evaluation and treatment. Ancillary services have specialty training to facilitate communication with residents experiencing sensory deficits. 5. Ancillary services will facilitate education of staff as necessary with communication techniques and specialty equipment. 6. The physician may refer the resident for evaluation and treatment for sensory deficits. The facility will assist the resident with transfer and treatment compliance issues. 8. Provide sensory stimulation by using tactile and visual stimuli to help compensate for hearing loss. Encourage family to bring familiar objects from home. Sensory stimulation of resident's other senses helps compensate for hearing loss. 10. Make sure other staff members are aware of residents hearing deficit. Record information on resident's medical record and chart cover. This ensures effective nursing care delivery by staff. 12. Educate resident in alternative ways of coping with hearing loss, care of hearing aid, if prescribed, and safety and protective measures to avoid harm or injury (use amplifier or signal devices on telephone, visual cues in environment). Knowledgeable residents will be better able to cope with hearing loss. 15. The facility will provide the resident with a picture communication device and/or communication boards as needed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43150 Based on observation, interview, and record review, the facility failed to ensure residents were offered sufficient fluid intake to maintain proper hydration and health for 5 of 12 residents (Resident # 26, Resident #49, Resident #53, Resident #67, Resident #231) reviewed for hydration. The facility failed to ensure Resident #26, Resident #49, Resident #53, Resident #67, and Resident #231 received adequate fluid intake on 11/5/24, 11/6/24, and 11/7/24. This failure could place residents at risk for dehydration, decline in health, organ problems, seizures, and failure to thrive. Findings included: Resident #26: Record Review of Resident #26's face sheet revealed a [AGE] year-old male, admitted on [DATE] with diagnoses of: dementia, constipation, muscle weakness, hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone), insomnia, acid reflux, schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), high blood pressure, type 2 diabetes, hyperlipidemia (a condition in which there are high levels of fat particles in the blood), heart failure, inflammation, depression. Record review of Resident #26's Quarterly MDS assessment dated [DATE], revealed Resident #26 had a BIMS Score of 00, meaning Resident #49 was unable to recall. Record review of Resident #26's care plan dated 08/7/2023 revealed that Resident #26 had potential fluid deficit due to oral intake, diuretic use, and poor oral intake with the interventions of: Monitor/document/report to MD PRN s/sx of dehydration: decreased or no urine output, concentrated urine, strong odor, tenting skin, cracked lips, furrowed tongue, new onset confusion, dizziness on sitting/standing, increased pulse, headache, fatigue/weakness, dizziness, fever, thirst, recent/sudden weight loss, dry/sunken eyes. Notify Physician if: Persistent symptoms of diarrhea, nausea/vomiting unresolved past 48 hours; persistent output exceeding intake past 48 hours; abnormal lab. Record Review of Resident #26's active physician orders as of 11/07/2024 revealed no fluid restrictions. During an observation of Resident #26 in the dining room on 11/06/2024 at 9:55 am. Observed Resident #26 sitting in his wheelchair in the dining room, stating he is thirsty. Made CNA E aware that Resident #26 was thirsty. Resident #49: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whisperwood Nursing & Rehabilitation Center	5502 W 4th St Lubbock, TX 79416

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #49's face sheet revealed a [AGE] year-old male, admitted on [DATE] with diagnoses of: high blood pressure, acid reflux, psychotic disorder (a mental disorder characterized by a disconnection from reality), anxiety, edema, dysphagia (difficulty swallowing foods or liquids), aphasia (a language disorder that affects a person's ability to communicate), urinary tract infection. Record review of Resident #49's Quarterly MDS assessment dated [DATE], revealed Resident #49 had a BIMS Score of 03, meaning Resident #49 was severely cognitively impaired. Record review of Resident #49's care plan dated 11/08/2022 revealed that Resident #49 had potential fluid deficit due to oral intake and diuretic use with the interventions of: encourage the resident to drink fluids of choice, invite the resident to activities that promote additional fluid intake, offer drinks during one-on-one visits, ensure that all beverages offered comply with diet/fluid restrictions and consistency requirements, Monitor/document/report to MD PRN s/sx of dehydration: decreased or no urine output, concentrated urine, strong odor, tenting skin, cracked lips, furrowed tongue, new onset confusion, dizziness on sitting/standing, increased pulse, headache, fatigue/weakness, dizziness, fever, thirst, recent/sudden weight loss, dry/sunken eyes. Record Review of Resident #49's active physician orders as of 11/07/2024 revealed no fluid restrictions. During an observation of hydration for Resident #49 on 11/06/2024 at 9:48 am. Observed Resident #49 with an empty pitcher sitting on his bedside table with no liquid in the pitcher. Resident #49 stated he would like some water when asked. Surveyor made CNA F aware that Resident #49 would like some water. During an observation of Resident #49 on 11/7/2024 at 7:29 am. Observed Resident #49 laying in his bed awake. Observed Resident #49 smacking his lips, stating he needs water. Observed no water in Resident #49's pitcher. Made CNA E aware that Resident #49 needed water. Resident #53: Record Review of Resident #53's face sheet revealed an [AGE] year-old male, admitted on [DATE] with diagnoses of: chronic kidney disease, dehydration, depression, gout (a form of arthritis that causes severe pain, swelling, redness and tenderness in the joints), retention of urine, hypothyroidism, type 1 diabetes, hyperlipidemia, dementia, high blood pressure. Record review of Resident #53's Quarterly MDS assessment dated [DATE], revealed Resident #53 had a BIMS Score of 11, meaning Resident #53 was moderately cognitively impaired. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #53's care plan dated 07/14/2023 revealed that Resident #53 had potential for fluid deficit due to dementia, diuretic use, and poor oral intake with the interventions of: encourage the resident to drink fluids of choice, ensure the resident has fluids in reach, inform the nurse if the resident is refusing to drink fluids, invite the resident to activities that promote additional fluid intake, offer drinks during one on one visits, ensure that all beverages offered comply with diet/fluid restrictions and consistency requirements, monitor/document/report to MD PRN s/sx of dehydration decreased or no urine output, concentrated urine, strong odor, tenting skin, cracked lips, furrowed tongue, new onset confusion, dizziness on sitting/standing, increased pulse, headache, fatigue/weakness, dizziness, fever, thirst, recent/sudden weight loss, dry/sunken eyes. Record Review of Resident #53's active physician orders as of 11/07/2024 revealed no fluid restrictions. During an observation of hydration for Resident #53 on 11/06/2024 at 9:50 am. Observed Resident #53 with an empty pitcher sitting on his bedside table with no liquid in the pitcher. During an observation of Resident #53 on 11/7/2024 at 7:32 am. Observed Resident #53 lying in bed, awake. Resident #53 stated he would like something to drink. Made CNA F aware that Resident #53 would like some water. Observed Resident #53 with an empty pitcher with no water. Resident #67: Record Review of Resident #67's face sheet revealed a [AGE] year-old male, admitted on [DATE] with diagnoses of: depression, schizophrenia, anxiety, bipolar disorder. Record review of Resident #67's Annual MDS assessment dated [DATE], revealed Resident #67 had a BIMS Score of 9, meaning Resident #67 was moderately cognitively impaired. Record review of Resident #67's care plan dated 09/12/2024 revealed that Resident #67 had potential for fluid deficit due to dementia and poor oral intake with the interventions of: monitor and document intake and output as per facility policy, monitor/document/report to MD PRN s/sx of dehydration decreased or no urine output, concentrated urine, strong odor, tenting skin, cracked lips, furrowed tongue, new onset confusion, dizziness on sitting/standing, increased pulse, headache, fatigue/weakness, dizziness, fever, thirst, recent/sudden weight loss, dry/sunken eyes. Record Review of Resident #67's active physician orders as of 11/07/2024 revealed no fluid restrictions. During an initial tour on 11/5/2024 at 10:32 am, Resident #67 stated he would like some water. Observed an empty pitcher on his bedside table. Made CNA D aware that Resident #67 would like some water. During an observation of hydration for Resident #67 on 11/6/2024 at 9:46 am. Observed Resident #67 with an empty pitcher with no water. Observed the empty pitcher sitting on top of the refrigerator across the room. Resident #67 stated that he was thirsty and wanted water. Surveyor had to get CNA E to get some water. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of Resident #67 on 11/7/2024 at 7:42 am. Observed Resident #67 laying in bed and his empty pitcher sitting in the same place as the day before, empty. Observed the empty water pitcher sitting on top of the refrigerator in the room, under the tv, across the room. Resident #231: Record Review of Resident #231's face sheet revealed a [AGE] year-old male, admitted on [DATE] with diagnoses of: dementia, depression, anxiety, high blood pressure, acid reflux, muscle weakness, amnesia. Record review of Resident #231's Admission MDS assessment dated [DATE], revealed Resident #231 had a BIMS Score of 14, meaning Resident #231 was cognitively intact. Record Review of Resident #231's active physician orders as of 11/07/2024 revealed no fluid restrictions. During an observation of hydration for Resident #231 on 11/06/2024 at 9:52 am. Observed Resident #231 with an empty pitcher sitting on his bedside table with no liquid in the pitcher. During an observation of the hydration station in the dining room on 11/06/2024 at 9:56 am. Observed no pitcher of water available in the dining room for residents. During an interview with CNA E about the hydration station on 11/06/2024 at 9:59 am. CNA E stated that they have no water right now because the DON came to get the jug to take to the kitchen to get cleaned and filled with water. CNA E stated that the DON came to get the water container earlier that morning. During an observation of the hydration station in the dining room on 11/7/2024 at 8:00 am. Observed a large container of water full of ice and water with cups. During an interview with CNA D on 11/5/2024 at 11:49 am. CNA D stated that there was no water or hydration set up at this time. CNA D stated that she is not sure why. CNA D stated that she had been having to run to the kitchen to get water for the residents. CNA D stated that she had fallen behind is why it had not been done. CNA D stated that the negative outcome for not keeping residents hydrated is they could become dehydrated. During an interview with the Administrator on 11/7/2024 at 4:18 PM. The Administrator stated that she expects staff to offer hydration rounds frequently. The Administrator stated that the staff have been trained to make hydration rounds by in-services every couple of weeks. The Administrator stated that the negative potential outcome of not providing hydration rounds is that it could cause multiple issues for the resident, and it affects all systems including skin integrity. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with CNA F on 11/7/2024 at 2:58 PM. CNA F stated that normally hydrations rounds are to be made every couple of hours. CNA F stated that they usually have a hydrations station completely set up. CNA F stated that she does not know why it had not been set up and what was taking the kitchen staff so long to clean the water container and get it filled and returned. CNA F stated that the DON came to get the water container earlier that morning of 11/6/2024 to get it cleaned and filled. CNA F stated that if there is no water on D hall then she will have to go to the kitchen to get the resident something to drink. CNA F stated that she had not done that because she was busy. CNA F stated that if the resident is wanting something to drink, they can come ask her and she will go to the kitchen to get them something. CNA F stated that the negative potential outcome of a resident not having access to water is that they can become dehydrated and have a decline in health. During an interview with DON on 11/7/2024 at 3:12 PM. The DON stated that she expects staff to make hydration rounds hourly. The DON stated that the staff have been in-serviced on hydration rounds. The DON stated that training is approximately monthly. The DON stated that the negative potential outcome of not providing hydration rounds is that it could affect the health of the resident. During an interview with CNA E on 11/7/2024 at 3:58 pm. CNA E stated that the DON came and got the water container and took it to the kitchen to get cleaned and filled and she had not seen it since then. CNA E stated that it had been taking too long to get the water container back from the kitchen. CNA E stated that she checked with the kitchen, and they told her that they were busy and that is why it was taking so long but that they would get her the water container. CNA E stated that eventually a guy from the kitchen brought the water container full of water and ice. CNA E stated that she would go to the kitchen to get residents water if they needed it. CNA E stated that she had gotten busy and that is why it had not been done. CNA E stated that the negative potential outcome of not providing hydration rounds frequently could cause the resident to become dehydrated. Record review of a facility Policy, labeled, Hydration,, dated 2023, revealed: The facility provides each resident with sufficient fluid intake to maintain proper hydration and health. The resident will receive sufficient amounts of fluid based on assessed need to prevent dehydration and promote optimum psychological functions daily. Goals: 1. The resident will maintain adequate hydration. 4. Fluid intake is monitored routinely. 5. The resident will not demonstrate signs or symptoms of dehydration. Procedure: 2. Staff should offer hydration, unless contraindicated, at the following intervals. 1. Direct care interaction with the resident in the resident's room. 2. Prior to, during, and following meals. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During medication pass. 4. During activities. 3. The facility may utilize fine dining programs to encourage fluids prior to, during, and following meals. The facility may use education and encouragement to increase fluid intake with intermittent direct care duties. Fresh water will be maintained at bedside when not contraindicated. The facility may implement a dehydration cart system designed to offer appropriate fluids every shift to residents except where contraindicated. Alternative treatment approaches may include use of popsicles, gelatin, and other similar non-fluid foods as recommended by the Dietician. 4. Residents who demonstrate a risk for dehydration will be care planned and treated accordingly. 6. Residents will also be frequently monitored for indications of dehydration.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42515 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services. 1) The facility failed to keep food properly sealed in the refrigerator. 2) The facility failed to properly store bowls, plates and pans in the kitchen area. 3) The facility failed to keep the microwave handles and buttons and the deep fryer clean and ready for use. 4) The facility failed to store Liquid Steel [NAME] (cleaning solution) separately from where food is stored. These failures could place residents at risk for food contamination and foodborne illness. The findings included: Observation during a kitchen tour on 11/05/24 at 9:46 AM revealed 1 pack of King Hawaiian Rolls 24 count not properly sealed in the small refrigerator. 1 bottle of Liquid Steel [NAME] was noted to be sitting on top of the small refrigerator. 6 silver preparation bowls and 3 silver pots were noted to be sitting right side up on the bottom shelf of food preparation tables in the kitchen. The microwave handle was noted to have dry substances stuck on the inside of the handle. The microwave buttons were noted to have dry sticky substances stuck on them. The deep fryer was noted to have dried substances on the fryer basket and on the back and sides where the oil is stored. Observation on 11/05/24 at 12:04 PM of the food temperature checks on the food line revealed 7 small bowls sitting right side up and 14 small plates sitting right side up where dishes are stored outside of the kitchen behind the steam table. Observation of the kitchen on 11/06/24 at 11:04 AM, 3 silver pots were noted to be sitting right side up on a bottom shelf. Interview on 11/06/24 at 4:20 PM, the DM stated the FSS was out for the day and would not be available for interview. Interview on 11/07/24 at 9:52 AM, the DM stated the FSS was out for the day and would not be available for interview. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/07/24 at 2:11 PM, the DM stated that he is mainly responsible for ensuring kitchen foods and items are stored properly and chemicals are not stored in food areas, but all the kitchen staff should be more mindful. The DM stated the Liquid Steel [NAME] was probably left over from the night cleaning and was not properly stored. The DM stated the King Hawaiian Rolls should have been sealed all the way when stored. The DM stated the microwave handle and buttons probably got dirty as he made breakfast and lunch that day. The DM stated the deep fryer should be cleaned after each use so it is ready to use the next time it is needed. The DM stated he does not know why the deep fryer was not cleaned after it was last used. The DM stated he was not trained on storing bowls, pots or plates upside down. The DM stated a potential negative outcome for storing the Liquid Steel [NAME] in the food area was the bottle could leak and cause issues if it gets into food. The DM stated microscopic bacteria, dust or allergens could get onto plates and bowls not stored properly and the resident could get sick, cause an allergic reaction or cause fatality. The DM stated cleaning and sanitizing in the kitchen was his top priority. Interview on 11/07/24 at 2:27 PM, the admin stated chemicals should not be stored in food preparation or food storage areas. The admin stated she did not know why the Liquid Steel [NAME] was stored in a food storage area. The admin stated the deep fryer and the microwave should be kept clean and the bowls, plates and pots should be stored properly. The admin stated she expects the kitchen staff to follow their cleaning schedules and keep the kitchen clean. The admin stated all the kitchen staff have been trained on storing items and kitchen cleanliness. The admin stated a potential negative outcome to the residents was a risk for unsanitary conditions. Record review of the facility's policy and procedure title, Food Storage and Supplies dated 2012, reflected the following: All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. We will ensure storage areas are clean, organized, dry and protected from vermin, and insects. Procedure: 2. Insecticides, sprays, and cleaning supplies are stored separately from food products and disposable supplies. 4. Open packages of food are stored in closed containers with covers or in sealed bags, and dated as to when opened Record review of the facility's policy and procedure titled, Equipment Sanitation dated 2012, reflected the following: We will provide clean and sanitized equipment for food preparation. The facility will clean all food service equipment in a sanitary manner

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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** 43150 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 to help prevent the development and transmission of communicable diseases and infections for 2 of 2 Residents observed for infection control practices (Resident #9, and Resident #231) in that: 1. CNA I failed to use proper hand washing techniques before and after assisting with resident during peri care for Resident #9. CNA I washed her hands for 15 seconds and 17 seconds with soap and friction before rinsing. CNA I used the same paper towel to dry hands to turn off faucet. 2. CNA E and CNA I failed to wash hands prior to gathering peri care supplies. 3. CNA F and CNA E failed to use proper hand washing techniques before, during, and after assisting with Resident #231's peri care. 4. CNA I failed to wash hands or use hand sanitizer prior to gathering peri care supplies 5. CNA E put on a new pair of gloves without washing hands or using hand sanitizer These failures could place residents at risk for infection through cross contamination of pathogens. The findings included: Resident #9: Record Review of Resident #9's face sheet revealed an [AGE] year-old female, admitted on [DATE] with diagnoses of: acute respiratory failure with hypoxia (impairment of gas exchange between the lungs and the blood causing an absence of enough oxygen in the tissues to sustain bodily functions), hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone), hyperlipidemia (a condition in which there are high levels of fat particles in the blood), dementia, high blood pressure, heart failure, acid reflux. Record review of Resident #9's Quarterly MDS assessment dated [DATE], revealed Resident #9 had a BIMS Score of 03, meaning Resident #9 had severe cognitive impairment. Under section for Bowel & Bladder listed Resident #9 as always being incontinent for urinary and bowel. Under Skin Conditions listed Resident #9 as being at risk for pressure ulcers but does not currently have pressure ulcers. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #9's Care Plan dated 08/28/2024 revealed Resident #9 had bowel and urinary incontinence with the interventions of: apply barrier cream after every incontinent episode, provide peri care after each incontinent episode, report any skin change to the nurse immediately, monitor and document intake and output as per facility policy, monitor/document for s/sx of UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating habits. During an observation of CNA I providing peri care for Resident #9 on 11/06/2024 at 11:20 am. CNA I failed to wash hands or use hand sanitizer prior to gathering peri care supplies. CNA I washed hands prior to proceeding with peri care. CNA I turned on faucet, and wet hands. CNA I rubbed hands together for 15 seconds and rinsed hands. CNA I used three clean paper towels to dry hands and then used the same paper towel to turn off faucet. CNA I proceeded in providing complete peri care for Resident #9. After CNA provided peri care she discarded used gloves in the trash. CNA washed hands after providing peri care for Resident #9. CNA I turned on water and wet hands. CNA I used two squirts of soap and rubbed hands together for 17 seconds. CNA I used three clean paper towels to dry her hands and then used the same paper towel to turn off faucet. CNA I discarded the used paper towels in the trash. CNA I gathered used laundry and trash and removed from Resident #9's room. During an interview with CNA I on 11/06/2024 at 11:39 AM. CNA I stated that she realized that she should have washed her hands for 20 to 25 seconds and used a clean paper towel to turn off the water faucet. CNA I stated that she had been trained in infection control practices/ hand washing by in-services monthly and proficiency checks every few months. CNA I stated that the DON is responsible for providing training. CNA I stated that the negative potential outcome for not providing adequate hand washing techniques would be the spread of bacteria. Resident #231: Record Review of Resident #231's face sheet revealed a [AGE] year-old male, admitted on [DATE] with diagnoses of: dementia, depression, anxiety, high blood pressure, acid reflux, muscle weakness, amnesia. Record review of Resident #231's Admission MDS assessment dated [DATE], revealed Resident #231 had a BIMS Score of 14, meaning Resident #231 was cognitively intact. Under section for Bowel & Bladder listed Resident #231 as occasionally being incontinent for urinary and bowel. Under Skin Conditions listed Resident #231 as being at risk for pressure ulcers but does not currently have pressure ulcers. Record Review of Resident #231's Care Plan dated 08/28/2024 revealed Resident #231 had urinary incontinence with the interventions of: apply barrier cream after each incontinent episode, monitor/document for s/sx of UTI: pain burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Monitor/document/report to MD as needed medical causing incontinence: bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, stroke, medication side effects. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 11/6/2024 at 10:44 am CNA E failed to wash her hands prior to gathering peri care supplies. CNA E and CNA F were providing peri care for Resident #231. CNA F turned on water faucet and wet her hands, used two squirts of soap and used friction for nine seconds and rinsed. CNA F grabbed a clean paper towel to dry her hands and then used the same paper towel to dry hands to turn off the faucet and then discarded the paper towel. CNA E washed hands correctly before beginning peri care. CNA E and CNA F put on clean gloves. CNA E unfastened Resident #231's brief from the front and tucked it up under the resident between the legs. CNA E provided peri care to the front side of Resident #231 by using one swipe per wipe beginning at the top groin, the left groin, and groin area, and then the penis. CNA E discarded each wipe after use. CNA E and CNA F rolled Resident #231 to the right side and removed the remainder of the backside of the brief and discarded in the trash. CNA E removed gloves and discarded in the trash, while CNA F kept the same gloves on. CNA E put on a new pair of gloves without washing hands or using hand sanitizer. CNA E provided peri care to the backside buttocks for Resident #231. CNA E used one wipe per swipe to the buttocks area beginning at the center buttock, right buttock, left buttock. CNA F had to stop and get more wipes during the procedure because Resident #231 was having a bowel movement. CNA F removed gloves and discarded them in the trash. CNA F left the room and came back a few minutes later with more wipes. CNA went to the resident's restroom to wash hands. CNA F turned on faucet and wet hands. CNA F used two squirts of soap to wash hands. CNA F rubbed her hands together for six seconds and then rinsed hands. CNA F used three paper towels to dry hands and used the same paper towel to turn off faucet, then discarded the used paper towels in the trash. CNA F put on clean gloves and proceeded with peri care. CNA E proceeded in using clean wipes to continue wiping the center buttocks. CNA E discarded each wipe in the trash after use. CNA F placed a clean brief underneath Resident #231 and then rolled him on his back and then pulled the remainder of the brief through the front between the legs and then fastened the brief. CNA E and CNA F removed gloves and discarded in the trash. CNA E washed hands correctly after peri care. CNA F turned on the water faucet and wet hands. CNA F used two squirts of soap, rubbed hands together for 5 seconds, and then rinsed hands. CNA F used four clean paper towels to dry hands and then used the same paper towels to turn off faucet. CNA F discarded in the trash. CNA E gathered all trash and used laundry and removed from Resident #231's room. During an interview with CNA E on 11/6/2024 at 4:54 pm. CNA E stated that she had been trained in infection control practices/ hand washing by in-services through verbal communication and the training is monthly. CNA E stated that proficiency checks had been provided every few months. CNA E stated that the negative potential outcome of not washing hands is the spread of bacteria and contamination. During an interview with CNA F on 11/06/2024 at 5:11 PM. CNA F stated that she had been trained in infection control practices/ hand washing approximately every two to three weeks. CNA F stated that she had been trained by proficiency checks monthly. CNA F stated that the policy states to wet hands, scrub, use clean napkins to dry hands, dispose, and grab a new napkin to turn off the faucet. CNA F stated that the policy stated to wash hands for 45 to 60 seconds. CNA F stated that the negative potential outcome of not washing hands correctly is spreading germs and you could spread germs to everyone. During an interview with the DON on 11/07/2024 at 3:09 PM. The DON stated that staff had been trained in infection control practices by in-services monthly and proficiency checks quarterly. The DON stated that she expects staff to provide complete and correct hand washing techniques. The DON stated that the negative potential outcome of not providing hand washing is the spread of infections and germs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675527	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whisperwood Nursing & Rehabilitation Center	5502 W 4th St Lubbock, TX 79416

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Administrator on 11/07/2024 at 4:10 pm revealed that the Administrator expected staff to wash their hands. The Administrator stated that all staff had been trained in hand washing and infection control practices by proficiency checks and in-services and all training is ongoing and regularly quarterly. The Administrator stated that the negative potential outcome is the spread of infection. Record review of the facility policy titled; Hand Washing undated, revealed: We will ensure proper hand washing procedures are utilized. Employees are to frequently perform hand washing as outlined below. Procedure: 2. The hand washing technique is as follows: a. Remove ring and watch if they cannot be sanitized during the hand washing process. b. Turn on water, adjusting to warm temperature and forceful flow. d. Deliver soap in palm. e. Lather up soap. f. Cup fingertips within the palms of the hands and rub vigorously. g. Interlock fingers and work them back and forth and side to side. h. Scrub back of hands, wrists, and lower arms. i. Rinse hands, wrists, and lower arms thoroughly. 3. Dry hands and arms with paper towel, then turn off the faucets with a new paper towel. 4. Discard used paper towels in trash receptacle. Record Review of website for handwashing revealed: US Centers for Disease Control and Prevention. (2024, February 16). About Handwashing. Clean Hands. https://www.cdc.gov/clean-hands/about/index.html Why it's important: Washing hands can keep you healthy and prevent the spread of respiratory and diarrheal infections. Germs can spread from person to person or from surfaces to people. How it works: Washing your hands is easy, and it's one of the most effective ways to prevent the spread of germs. Follow these five steps every time. 1. Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675527	A. Building B. Wing	11/07/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails. 3. Scrub your hands for at least 20 seconds. Need a timer? Hum the Happy Birthday song from beginning to end twice. 4. Rinse your hands well under clean, running water. 5. Dry your hands using a clean towel or an air dryer