STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675560	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Village Nursing and Rehabilitation Center	169 Lake Park Rd Lewisville, TX 75057

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 - Few	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** 47743 Based on observations, interviews, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for one (Resident #45) of twenty residents reviewed for Dignity. The facility failed to ensure CNA F did not stand behind Resident #45 while assisting the resident to eat during lunchtime on 03/04/2025. This failure placed residents at risk of not having their right to a dignified existence maintained. Findings included: Review of Resident #45's Face Sheet, dated 03/05/2025, reflected an [AGE] year-old female admitted on [DATE]. The resident was diagnosed with lack of coordination and muscle weakness. Review of Resident #45's Quarterly MDS Assessment, dated 02/27/2025, reflected the resident was unable to complete the interview to determine the BIMS score. The Quarterly MDS Assessment indicated that the resident required moderate assistance (refers to providing assistance that is approximately 50% of the task) in eating. Review of Resident #45's Comprehensive Care Plan, dated 01/26/2025, reflected the resident was dependent on staff for activities and one of the interventions was to provide assistance with activities of daily living. Observation on 03/04/2025 at 12:12 PM revealed CNA F was assisting Resident #45 during lunch. It was observed that CNA F was standing behind the resident and would give the food to the resident while standing behind the resident. She stood behind the resident until the resident was done with lunch. CNA F was not interacting with the resident and the only thing she asked the resident was if she was done eating. After the resident was done eating, CNA F ushered the resident to her room. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/04/2025 at 12:29 PM, CNA F stated she assisted Resident #45 during lunchtime. She said when assisting a resident in the dining room, the staff should sit beside the resident and not stand up beside or at the back of the resident. She said they needed to sit down beside the resident to see if the resident was swallowing the food, there was a problem in swallowing, or if the resident was pocketing the food. She said there was no room for another chair in the table, but she should have transferred the resident to another table that could accommodate both of them. She said it was a dignity issue because it was as if she was in a hurry to finish feeding the resident. Observation and interview on 03/04/2025 at 1:09 PM revealed Resident #45 sitting on her wheelchair inside her room. When asked how was lunch, The resident did not reply. When asked if it was okay for any staff to stand when assisting her for lunch, the resident did not reply. In an interview on 03/05/2025 at 4:48 PM, ADON B stated the staff assisting a resident during mealtime should be sitting alongside the resident to provide dignity. She said sitting beside the resident would allow better observation of the resident's needs during mealtime. She said sitting beside the resident encouraged interaction and promoted safety when eating. When a staff was behind the resident, the staff would not know, at once, if the resident was in distress, or she was too fast in assisting the resident to eat and may cause the resident to be frustrated. She said the expectation was for the staff to provide dignity, not only during mealtime but every time the staff provide care to the residents. She said they would do an in-service about dignity. In an interview on 03/06/2025 at 6:30 AM, the Administrator stated staff should not stand behind or beside the residents when feeding the residents. He said the staff should sit beside the resident to convey respect and to show the residents that the staff were there to support them. He said if a staff stood behind a resident seems disrespectful and a dignity issue. He said he would collaborate with the DON and the ADONs to re-educate the staff about dignity of the residents. In an interview on 03/06/2025 at 7:17 AM, the DON stated staff should sit down next to the resident when assisting or feeding the resident. She said sitting beside the resident promoted dignity and respect, allowed close observation of the resident's eating habits, and ensured the resident was not in any distress. She said standing up behind the resident gave the impression that the staff was in a hurry. She said she would do an in-service regarding dignity specifically about sitting down when providing assistance during mealtime. Record review of facility's policy, Dignity and Respect Policy/Procedure - Nursing Administration revised 07/2024 revealed POLICY: It is the policy of this facility that all residents be treated with kindness, dignity, and respect . PROCEDURES . 1. The staff shall display respect for Resident's when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observation, interview, and record review, the facility failed to secure confidential and personal medical records for one (Residents #8) of twenty residents reviewed for Privacy and Confidentiality. The facility failed to ensure LVN G closed, locked, or minimized her laptop's monitor while administering medication to Resident #8 on 03/04/2025. This failure could place the residents at risk of exposure of their personal and medical information to unauthorized individuals. Findings included: Review of Resident #8's Face Sheet, dated 03/05/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with anxiety disorder (intense or excessive fear or worry). Review of Resident #8's Quarterly MDS Assessment, dated 12/23/2024, revealed the resident was unable to complete the interview to determine the BIMS score. The Quarterly MDS Assessment indicated the resident had anxiety disorder. Review of Resident #8's Comprehensive Care Plan, dated 01/08/2025, reflected the resident was on anti-anxiety medication and one of the interventions was to monitor side effects and effectiveness. Review of Resident #8's Physician Order, dated 12/12/2024, reflected Lorazepam Oral Concentrate 2 MG/ML (Lorazepam) *Controlled Drug* Give 0.25 ml by mouth three times a day for anxiety. Review of Resident #8's Physician Order, dated 09/26/2024, reflected (AA)- MONITOR FOR SIDE EFFECTS OF ANTI-ANXIETY/ANXIOLYTICS (medications to prevent anxiety): COMMON S/E: SEDATION (making a person calm), DROWSINESS (a feeling of being sleepy), ATAXIA (poor muscle control), DIZZINESS, NAUSEA, CONFUSION, NASAL CONGESTION. LESS COMMON S/E: VOMITTING, SKIN RASH, FALLS, AGITATION. RARE S/E: HYPOTENSION, BLURRED VISION, ATAXIA, MOOD SWINGS. NOTIFY PROVIDER IF PRESENT every shift. Observation on 03/04/2025 at 9:32 AM revealed a nurse's cart was in the middle of hall 300 hallway. There was a laptop on top of the cart. The laptop was open and displayed Resident #8's name, status, location, gender, date of birth, age, name of physician, latest vital signs, allergies, code status, emergency instructions, and physician orders. The screen of the computer was facing the hallway. Observation and interview with ADON A on 03/04/2025 at 9:38 AM revealed ADON A saw the computer was open and Resident #8's information was visible to everybody that would pass by. ADON A closed the computer. She stated the staff should close the computer or minimize the monitor before leaving the cart unattended. She said the resident's information was confidential and should not be seen by unauthorized individuals. She said some residents might be embarrassed that others would know they had such sickness or was taking a certain type of medication. She said she would collaborate with the DON about the issue on privacy and confidentiality. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/04/2025 at 10:26 AM, LVN G stated the monitor of her computer should be locked, minimized, or closed every time she left the cart. She said the purpose was to protect the health or personal information of the residents. She said ADON A told her that she left the monitor open when she was in hall 300 and Resident #8's information was displayed. She said the resident's information was confidential. She said she should be mindful to close her computer every time she left it. In an interview on 03/06/2025 at 6:30 AM, the Administrator stated the staff must make sure the residents' information was not exposed and protected because it was a violation of the resident's privacy and confidentiality of the care they were receiving. He said the expectation was for all the staff to make sure the resident's information and treatment were not visible to unauthorized individuals. He said she would collaborate with the DON to do an in-service about privacy and confidentiality. In an interview on 03/06/2025 at 7:17 AM, the DON stated personal and medical information about a resident should not be exposed for everybody to see. She said the health information of a resident should be protected and could not be shared without the permission of the resident or the resident's responsible party. She said all employees were expected to provide full privacy and confidentiality of information for all residents. The DON stated the failure to not protect the resident information could cause poor self-esteem and embarrassment for the resident. The DON stated she would start an in-service about privacy and confidentiality of the residents' information. Record review of facility's policy, Confidentiality of Resident Information Policy/Procedure revised 7/2024 revealed POLICY . The types and amount of information gathered from the resident shall be limited to that information necessary to carry out the function of the person or service requesting the information . PROCEDURES: 1. All individuals engaged in collection, handling, or dissemination of resident-related information shall be specifically informed of their responsibility to protect the confidentiality of the information.

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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** 47743 Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that 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 a resident for one (Resident #62) of eight residents reviewed for Care Plans. The facility failed to ensure Resident #62's care plan, dated 02/23/2025, included her CPAP (continuous positive airway pressure: machine used to deliver pressurized air through a mask to keep airways open) usage. This failure could place the residents at risk of not receiving the necessary care and services. Findings included: Record review of Resident #62's Face Sheet, dated 03/04/2025, reflected a [AGE] year-old female admitted on [DATE]. The resident was diagnosed with obstructive sleep apnea (a sleep disorder where breathing is interrupted repeatedly during sleep). Record review of Resident #62's Quarterly MDS Assessment, dated 02/27/2025, reflected the resident was unable to complete an interview to determine the BIMS score. The Quarterly MDS Assessment indicated the resident was on non-invasive mechanical ventilator while a resident of the facility. Record review of Resident #62's Comprehensive Care Plan, dated 02/23/2025, reflected no care plan for CPAP usage. Record review of Resident #62's Physician Order on 03/04/2025 reflected no physician order for the CPAP. Observation and interview on 03/04/2025 at 9:28 AM revealed Resident #62 was in her wheelchair inside her room. The resident stated she was using her CPAP every night and every time she took a nap. She said she had been using the CPAP for months. Observation and interview on 03/05/2025 at 11:22 AM, LVN H stated Resident #62 had a diagnosis of sleep apnea and that was why she used a CPAP at night. She said the resident was capable of putting the CPAP on at night and taking it off in the morning. LVN H said she would check if the resident had a care plan for the CPAP. LVN H opened her computer and opened the resident's care plan. LVN H checked the list of the resident's physician orders and said the resident did not have a care plan for the CPAP. She said there should be a care plan so the staff would know the goal and intervention with regards to the resident's CPAP. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/05/2025 at 2:22 PM, The MDS Nurse stated she was the one responsible in doing the care plans of the residents. She said the care plan was the facility's contract with the resident of what care and services would be provided for the resident. She said the care plan should be in place so the staff know the interventions and goal for the resident and would be in sync in terms of the care to be provided. The MDS Nurse said she would check if Resident #62 had a care plan for the CPAP. She logged on to her computer and checked if the resident had a care plan for the CPAP. She said she did not see any care plan for the CPAP. She said she also did not see any order for the CPAP and that was why she was not able to do a care plan for the CPAP. She then checked if there was any documentation about the resident's CPAP and said there was documentation about the resident's CPAP. She said the documentation should have prompted her to ask or personally assess the resident if the resident was using a CPAP. She then checked the resident's MDS and saw the resident was coded for non-invasive mechanical ventilator and said she coded it but was not able to do the care plan. She said if the residents do not have a care plan, there would be a possibility of confusion about the care to be provided or the care would be not provided at all. She said would do an audit of the care plans of the residents. In an interview on 03/05/2025 at 5:06 PM, ADON A stated if a resident was using a CPAP, there should be a care plan for the CPAP or sleep apnea. She said the care plan is important so the staff are in sync with the care of the residents. She said without the care plan, appropriate intervention might not be provided. She said the expectation was all the issues of the residents were care planned. She said she would coordinate with the DON and the MDS Nurse on how to make sure the residents were care planned accordingly. In an interview on 03/06/2025 at 6:30 AM, the Administrator stated all the residents should have a care plan appropriate to their needs. He said without the care plan, the staff would not know the goals and the interventions needed by the residents. The Administrator concluded that the expectation was for the staff to ensure that the residents were care planned appropriately. He said he would coordinate with the DON to make sure all the residents were care planned. In an interview on 03/06/2025 at 7:17 AM, the DON stated every resident needed a comprehensive care plan to make sure the residents received the applicable and appropriate care needed. The DON said the care plan should be in place so that the staff providing care would be on the same page. The DON stated the care plan was important because it reflected the resident's problem lists, goals, and interventions. She said the care plan should be resident-centered and should show what specific care the resident needed. She said the expectation was for all residents to have a complete and detailed care plan. She said she would coordinate with the MDS Nurse to audit the care plans of the residents. Record review of the facility's policy, Comprehensive Person-Centered Care Planning Policy and Procedure revised 1.2022 revealed Policy: It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment . Procedure . 4. The facility IDT will develop and implement a comprehensive person-centered care plan for each resident within seven (7) days of completion of the Resident Minimum Data Set (MDS) and will include resident's needs identified in the comprehensive assessment.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observation, interview, and record review the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one (Resident #62) of twelve residents reviewed for Respiratory Care. The facility failed to ensure Resident #62 had an order for her CPAP (continuous positive airway pressure: machine used to deliver pressurized air through a mask to keep airways open) on 03/04/2025. This failure could place residents at risk for not having their respiratory needs met. Findings included: Record review of Resident #62's Face Sheet, dated 03/04/2025, reflected a [AGE] year-old female admitted on [DATE]. The resident was diagnosed with obstructive sleep apnea (a sleep disorder where breathing is interrupted repeatedly during sleep). Record review of Resident #62's Quarterly MDS Assessment, dated 02/27/2025, reflected the resident was unable to complete an interview to determine the BIMS score. The Quarterly MDS Assessment indicated the resident was on non-invasive mechanical ventilator (respiratory support such as CPAP) while a resident of the facility. Record review of Resident #62's Comprehensive Care Plan, dated 02/23/2025, reflected no care plan for CPAP usage. Record review of Resident #62's Physician Order on 03/04/2025 reflected no physician order for the CPAP. Observation and interview on 03/04/2025 at 9:28 AM revealed Resident #62 was in her room sitting in a wheelchair. The resident stated she was using her CPAP every night and every time she took a nap. She said she had been using the CPAP for months. Observation and interview on 03/05/2025 at 11:22 AM, LVN H stated Resident #62 had a diagnosis of sleep apnea that was why she used a CPAP at night. She said the resident was capable of putting the CPAP on at night and taking it off in the morning. LVN H said she would check if the resident had an order for the CPAP. LVN H opened her computer and opened the resident's physician orders. LVN H checked the list of the resident's physician orders twice and said the resident did not have an order for the CPAP. She said there should be a physician order. In an interview on 03/05/2025 at 5:06 PM, ADON A stated there should be a physician order for the CPAP because it was a treatment, and the staff must make sure it was tailored to the needs of the resident like the correct setting and if the resident knew proper placement. She said even though the resident was the one putting it on and taking it off, there should be an order for the CPAP. She said without the order, the staff might not know she was on a CPAP and would not be able to assess the CPAP's effectiveness. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/06/2025 at 6:30 AM, the Administrator stated there should be a Physician Order for the resident's CPAP. He said there should be an order for everything that was done for the resident. There should be physician orders for medications, treatment, diet, and therapies. He said a CPAP is a medical device and there should be medical supervision to ensure a safe and effective treatment. He said without a physician order, the staff would not be aware that the resident was using a CPAP. He said he would coordinate with the DON and would find out the reason why the resident did not have a physician order for the CPAP and would do an in-service about it. In an interview on 03/06/2025 at 7:17 AM, the DON stated there should be an order for Resident #62's CPAP. She said the staff knew she was using a CPAP but was not able to check if she had an order. She said it was also her responsibility to check the orders of the residents. She said the physician orders were fundamental and served as instructions on how to ensure the residents were receiving proper care. She said she would do an in-service about making sure there was a physician order on everything done for the residents. Record review of undated facility policy, Oxygen delivery & Maintenance revealed Procedure: The administration of oxygen will follow professional guidelines for safe administration . against provider orders . 10. Monitor . respiratory status per physician orders. Record review of facility policy, Physician Orders Pharmacy Services revised 10/2022 revealed POLICY: It is the policy of this facility that drugs and treatments shall be administered/carried out upon the order of a person duly licensed and authorized to prescribe such drugs and treatments . 6. Orders for medications must include . A. Name and strength of the drug; B. Quantity or specific duration of therapy; C. Dosage and frequency of administration; D. Route of administration if other than oral; and E. Reason or problem for which given.

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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** 47743 Based observation, interview, and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals for one (Resident #36) of five residents reviewed for Pharmaceutical Services. The facility failed to ensure LVN J disposed of Resident #36's Tramadol properly on 03/05/2025. This failure could place residents at risk of not receiving medications as ordered by the physician. Findings included: Record review of Resident #36's Face Sheet, dated 03/05/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with polyneuropathy (a condition that damages many nerves in the body) and osteoarthritis (inflammation of one or more joints). Record review of Resident #36's Quarterly MDS Assessment, dated 02/04/2025, reflected the resident was cognitively intact with a BIMS score of 14. The Quarterly MDS Assessment indicated the resident had polyneuropathy and osteoarthritis. Record review of Resident #36's Quarterly Care Plan, dated 02/03/2025, reflected the resident was on pain medication and one of the interventions was administer medication as ordered. Record review of Resident #36's Physician Order, dated 03/07/2025, reflected Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) *Controlled Drug* Give 1 tablet by mouth three times a day for pain. Observation and interview on 03/05/2025 at 7:19 AM revealed LVN J was preparing Resident #36's pain medication. When she pushed the medication out of the blister card, the medication fell on top of the nurse's cart. She said she would waste the medication because it was already dirty. She placed the tramadol tablet inside a pill crusher pouch and crushed it. She then said she would look for another nurse to co-sign the wasted tramadol. After signing the wasted tramadol, she placed drops of water to the pouch and then threw it in the trash can at the side of the nurse's cart. It was observed that the pouch thrown in the trash can still had residuals and uncrushed particles of the tramadol. She said she threw it in the trash can because she did not have the solution used for wasted narcotics. She said the medication aide's cart had one on the cart. She said she would ask MA I where she could get the solution. In an interview on 03/05/2025 at 8:08 AM, MA I stated there was a solution inside the medication room for wasting narcotics. She said she had not wasted a narcotic, but she knew in case she needed to it, it must be placed in the solution. She said she told LVN J where she could get the solution used for wasting a narcotic. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/05/2025 at 8:18 AM, the DON stated narcotics were not disposed of in the trash can. She said there was solution where the staff could use to dispose the narcotics. She said the narcotics were placed in a locked box inside the carts so nobody unauthorized could access them. She said the same principle applied in disposing of the narcotics. She said the residual or particles of the tramadol should not be accessible to the residents, staff, and visitors. She said she was already doing an in-service about proper disposal of narcotics. In an interview on 03/05/2025 at 5:06 PM, ADON A stated narcotics were not disposed of in the trash can. She said the facility had solutions for the wasted narcotics. She said if tramadol was disposed of in a trash can, confused residents might access it and could lead to adverse reactions. She said the expectation was not to throw any narcotics in the trash can. She said she would coordinate with the DON to do an in-service regarding proper disposal of narcotics. In an interview on 03/06/2025 at 6:30 AM, the Administrator stated narcotics should be disposed of properly to prevent untoward incidents. He said a confused resident that was allergic to tramadol might pick it up and consume it. He said discontinued narcotics were given to the DON and were locked inside her office. The DON would dispose of them along with the pharmacist that would come once a month. He said if a staff needed to waste a narcotic, the facility had a solution where the wasted narcotics could be placed. He said the expectation was for staff to dispose of the narcotics properly. He said another expectation was if the staff did not know where to get the solution or how to properly dispose of narcotics, the staff should ask somebody how to dispose of the narcotics. He said he would collaborate with the DON to do an in-service about how to dispose of narcotics. Record review of the facility's policy, Controlled medications - Storage and Reconciliation Pharmacy Services revised 01.2022 revealed Policy: It is the policy of this facility to safeguard access and storage of controlled drugs . this facility will maintain a process for monitoring, administration, documentation, reconciliation and destruction of controlled substances.

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	675560	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Village Nursing and Rehabilitation Center	169 Lake Park Rd Lewisville, TX 75057

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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. 47743 Based on observations, interviews, and record review, the facility failed to ensure that drugs and biologicals were stored in locked compartments and permit only authorized personnel to have access to the keys for one cart (nurse's cart) of seven carts observed. The facility failed to ensure that LVN G locked her nurse's cart while passing medication at hall 300 on 03/04/2025. This failure could place the residents at risk of accessing/opening the cart causing accidental overdose or misuse of medications. Findings included: Observation on 03/04/2025 at 9:32 AM revealed a nurse's cart was in the middle of hall 300 hallway. The nurse's cart was left unlocked. The drawers of the cart contained various blister packs of medication, eyedrops, insulin, and insulin paraphernalia. Several staff passed by the nurse's cart and did not notice the cart was unlocked. Observation and interview with ADON A on 03/04/2025 at 9:38 AM revealed ADON A saw the nurse's cart was not locked. She pushed the cart's lock and said the cart should not be left unlocked. She said the staff should lock the cart to prevent untoward incidents. She said residents might be able to open it and ingest something that they were allergic to. She said, if it was a medication cart that was left unlocked, any resident, staff, or visitor could open it and get some medications. She said the expectation was for the staff to lock the carts before leaving them. She also said the carts should not be left in the middle of the hall where they could be easily accessed by others. She said she would collaborate with the DON about the issue on locking the cart. In an interview on 03/04/2025 at 10:26 AM, LVN G stated she was not aware that she left her cart unlocked. She said the cart should be locked every time a staff left it because anybody could open it and could get anything from the cart. She said residents could open it and accidentally ingest a medication the resident was allergic to or choke on some medication. She said she would be mindful next time to always lock the cart every time she left it unattended. In an interview on 03/06/2025 at 6:30 AM, the Administrator stated the carts should always be locked so residents, other staff, and visitors could not open them and have access to the medications. He said it could result in accidental ingestion and overdose, especially if nobody was monitoring the cart. He said the residents could also choke and nobody would know. He said the expectation was for the staff to make sure the carts were locked every time they leave them. She said she would collaborate with the DON to do an in-service about locking the cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/06/2025 at 7:17 AM, the DON stated any cart should always be locked when left unattended to prevent any residents from opening it and taking something from it. She said residents could accidentally drink or ingest something from the cart that could result in allergic reactions and choking. She said the expectation was the cart would be always locked and secured. The DON stated she would start an in-service about the importance of locking the cart. Record review of the facility's policy, Medications - Storage and Reconciliation Pharmacy Services revised 01.2022 revealed Policy: It is the policy of this facility to safeguard access and storage of . drugs . Procedure . 2. Medications stored . in locked cabinet . medications in the medication cart . locked drawer on the cart.

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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** 47743 Based observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for six (Residents #35, #36, #49, #168, #169, and #171) of twenty residents reviewed for Infection Control. 1. The facility failed to ensure CNA D and CNA E changed their gloves and performed hand hygiene while providing incontinent care to Resident #35 on 03/04/2025. 2. The facility failed to ensure LVN J sanitized the blood pressure cuff and the pulse oximeter while administering medications and checking the vital signs of Residents #36, #49, #168, #169, and #171 on 03/05/2025. These failures could place residents at risk of cross-contamination and development of infections. Findings included: 1. Record review of Resident #35's Face Sheet, dated 03/04/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body). Record review of Resident #35's Comprehensive MDS Assessment, dated 12/12/2024, reflected the resident had a score of 99 on her BIMS summary implying that the resident was not able to complete the interview to determine the BIMS score. The Comprehensive MDS Assessment indicated the resident was always incontinent for both bowel and bladder. Record review of Resident #35's Comprehensive Care Plan, dated 02/03/2025, reflected the resident had bowel/bladder incontinence and one of the interventions was to check as required for incontinence. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/04/2025 at 11:20 AM revealed CNA D and CNA E were about to do incontinent care for Resident #35. Both CNAs washed their hands before putting on the gloves. CNA D positioned herself on the right side of the resident and CNA E went to the left side of the resident. CNA E unfastened the resident's brief, pushed it at the middle of the legs, and cleaned the lower abdomen of the resident. CNA E then cleaned the resident's perineal area (area between the legs) using the front to back technique. After cleaning the perineal area, CNA E assisted the resident to turn to her right side. CNA D assisted in turning the resident. It was observed that the resident was heavily soiled. CNA E cleaned the resident's bottom. After cleaning the resident's bottom, CNA E pulled the soiled brief, threw it inn the trash can, and rolled the soiled padding towards the middle of the bed. CNA E removed her gloves and put on a new pair of gloves. She did not sanitize her hands before putting on a new pair of gloves. CNA D then put a new padding beneath the resident and placed the new brief on top of the new padding. CNA D and CNA E then assisted the resident to turn to her other side. This time, CNA D cleaned the other side of the resident's bottom and placed the soiled wipes on the soiled padding. After cleaning the resident's bottom, CNA D pulled the soiled padding and handed it over to CNA E. CNA E placed the soiled padding on top of the trash can. CNA D pulled the other half of the padding and the brief and fixed them. CNA D did not change her gloves after cleaning the resident's bottom. CNA E fastened the brief on both sides. CNA E did not change her gloves after touching the soiled padding and before fixing the new brief. Both CNAs washed their hands after incontinent care. In an interview on 03/04/2025 at 11:35 AM, CNA E stated hand hygiene was important to prevent cross contamination and to prevent infection. She said she did wash her hands before doing Resident #35's incontinent care. She said during the process, she changed her gloves but did not sanitize her hands before putting on a new pair of gloves. She said after putting the soiled padding on top of the trash can, she should have changed her gloves. She said she would be mindful the next time she does incontinent care to do hand hygiene and change her gloves after touching something soiled during incontinent care. In an interview on 03/04/2025 at 11:40 AM, CNA D stated she assisted CNA E during Resident #35 incontinent care. She said she did clean the other half of the resident's bottom. She said after cleaning the resident's bottom, she pulled the soiled padding and handed it over to CNA E. She said after handing the soiled padding to CNA E, she assisted in fixing the new brief. She said she should have changed her gloves. She said the gloves should be changed after she cleaned the resident's bottom and before touching the new brief because the gloves that she used to clean the resident's bottom were already soiled. She said she would be mindful the next time she does incontinent care to change her gloves after touching something soiled during incontinent care. She said she had trainings for pericare but did not know why she forgot to wash her hands and change her gloves. 2. Record review of Resident #168's Face Sheet, dated 03/05/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with atherosclerotic (the buildup of fats, cholesterol, and other substances in and on the artery walls) heart disease. Record review of Resident #168's Physician Order, dated 02/22/2025, Vitals q shift for skilled charting. Record review of Resident #169's Face Sheet, dated 03/05/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with hypertension (high blood pressure). (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 #169's Physician Order, dated 03/04/2025, reflected Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25 MG (Metoprolol Succinate) Give 1 tablet by mouth one time a day for HTN hold for SBP less than 110 or HR less than 60 (Do not crush). Record review of Resident #36's Face Sheet, dated 03/05/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with congestive heart disease (condition in which the heart cannot pump blood well enough to meet the body's needs). Record review of Resident #36's Physician Order, dated 01/27/2025, reflected Digoxin Tablet 125 MCG Give 1 tablet by mouth one time a day for heart failure hold medication if Apical Pulse is less than 60. Record review of Resident #171's Face Sheet, dated 03/05/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with hypertension. Record review of Resident #171's Physician Order, dated 01/27/2025, Metoprolol Tartrate Oral Tablet 25 MG (Metoprolol Tartrate) Give 1 tablet by mouth two times a day for High blood pressure HOLD SBP LESS THAN 110 HOLD DBP LESS THAN 60 HOLD HR LESS THAN 60. Record review of Resident #49's Face Sheet, dated 03/05/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with cardiac murmur. Record review of Resident #49's Physician Order, dated 01/31/2025, reflected Metoprolol Tartrate Oral Tablet 25 MG (Metoprolol Tartrate) Give 1 tablet by mouth two times a day for hypertension related to CARDIAC MURMUR, UNSPECIFIED HOLD IF SBP IS LESS THAN 110 OR DBP IS LESS THAN 60 OR HR IS LESS THAN 60. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/05/2025 from 6:46 AM to 7:58 AM revealed LVN J was passing medication. She went inside Resident #168's room and checked the resident's blood pressure using a mobile floor stand for the blood pressure cuff. She also checked Resident #168 oxygen saturation. The mobile floor stand had a small basket where the blood pressure cuff and the pulse oximeter where placed. There were no sanitizing wipes in the mobile floor stand basket. After taking the blood pressure and the oxygen saturation, she administered Resident #168's medication and put back the blood pressure cuff and the oximeter on the basket. She did not sanitize the blood pressure cuff and the pulse oximeter. After administering Resident #168's medication, LVN J went to Resident #169's room, took the resident's blood pressure and the O2 saturation, and then prepared the resident's medication. She went back inside the resident's room to administer the medications. She did not sanitize the blood pressure cuff and the pulse oximeter after use. After administering Resident #169's medication, she went to Resident #36's room, took the resident's blood pressure and the O2 saturation, and then prepared the resident's medication. She went back inside the resident's room to administer the medications. She did not sanitize the blood pressure cuff and the pulse oximeter after use. After administering Resident #36's medication, she went to Resident #171 's room, took the resident's blood pressure and the O2 saturation, and then prepared the resident's medication. She went back inside the resident's room to administer the medications. She did not sanitize the blood pressure cuff and the pulse oximeter after use. After administering Resident #171's medication, she went to Resident #49's room, took the resident's blood pressure and the O2 saturation, and then prepared the resident's medication. She went back inside the resident's room to administer the medications. She did not sanitize the blood pressure cuff and the pulse oximeter after use. In an interview on 03/05/2025 at 7:58 AM, LVN J stated she obtained the blood pressures of the residents before giving the medication for hypertension to know if the medication needed to be held or not. She said she would also obtain the heart rate if the resident was on digoxin. She also said, for some residents, she would just get the vital signs for documentation. She said she did sanitize her hands before preparing residents' medication but was not able to sanitize the blood pressure cuff and the pulse oximeter after using them in between residents. She said not sanitizing the blood pressure cuff and the pulse oximeter in between residents could cause infection to transfer from one resident to another. LVN J opened the last drawer of the cart of her nurse's cart, pulled some wipes, and sanitized the blood pressure cuff and the pulse oximeter. In an interview on 03/05/2025 at 4:48 PM, ADON B stated hand hygiene was the most effective way to prevent cross contamination and infection. She said gloves should be changed after cleaning the resident's bottom and after touching the soiled padding. She said hands should also be sanitized before putting on a new pair of gloves. She added the blood pressure cuff should be sanitized before using or after every use. She said the above issues could cause cross contamination and infections. She said the expectations were for the staff to be mindful with how they take care of the residents. She said she would collaborate with the DON to do in-service regarding infection control and hand hygiene. In an interview on 03/06/2025 at 6:30 AM, the Administrator stated not changing the gloves when going from soiled to clean, not sanitizing the hands before putting on a new pair of gloves, and not sanitizing the blood pressure cuff and the pulse oximeter could contribute to cross contamination and infection. He said the expectation was for the staff to follow the policy and procedures pertaining to infection control. He said the DON already started an in-service for the staff about hand hygiene and infection control. (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 on 03/06/2025 at 7:17 AM, the DON stated hand hygiene was the most effective way to prevent cross contamination and spread of infection. She said staff should do hand hygiene before and after any care. She said gloves should be changed after cleaning the resident's bottom and after throwing the soiled padding because the gloves were already deemed dirty. She said the expectation was for the staff to wash their hands before and after any care, change their gloves when going from dirty to clean, sanitize their hands before putting on a new pair of gloves, and sanitize the blood pressure cuff after use. She said she already started an in-service about infection control and hand hygiene. She said she would personally monitor the staff's adherence to the policy and procedure of infection control. Record review of facility policy, Handwashing-Hand Hygiene Policy and Procedures revised 10-2020 revealed Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections . 7. Use an alcohol-based hand rub . f. Before donning sterile gloves . h. Before moving from a contaminated body site to a clean body site during resident care . j. After contact with blood or bodily fluids . k. After handling used dressings, contaminated equipment, etc. Applying and removing Gloves . 1. Perform hand hygiene before and after applying non-sterile gloves. Record review of facility policy, Perineal Care revised 04/16/2024 revealed Purpose: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation . Steps in the Procedure . 2. Wash and apply gloves . For a female resident . b. wash perineal area . 10. Remove gloves . 11. Wash and dry hands thoroughly. Record review of facility policy, Infection Control Plan: Overview Infection Control Policy & Procedure updated 3/2023 revealed Infection Control: The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection . Implement hand hygiene (hand washing) practices consistent with accepted standards of practice, to reduce the spread of infections and prevent cross-contamination . Fundamentals of Infection Control Precautions . Hand Hygiene: Hand hygiene continues to be the primary means of preventing the transmission of infection . Before and after assisting a resident with personal care . After contact with a resident's mucous membranes and body fluids or excretions . After removing gloves . Wearing gloves does not replace the need for hand washing because gloves may have small inapparent defects or be torn during use, and hands can become contaminated during removal of gloves . Resident care equipment . Non-invasive resident care equipment is cleaned daily or as needed between use.