STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675603	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Haven Retreat	200 Live Oak St Atlanta, TX 75551

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062 Based on interviews and record reviews, the facility failed to ensure the residents had the right to be informed of the risks and participate in, his or her treatment which included the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or options he or she preferred, for 1 of 20 residents (Resident #102) reviewed for resident rights. The facility failed to obtain informed consent from Resident #102's RP prior to administering Prozac (antidepressant medication used to treat depression-persistent sadness) to Resident #102. This failure could place residents at risk of receiving medications without their prior knowledge or consent, or that of their responsible party and could place the residents at an increased risk for adverse reactions to the medications. Findings included: Record review of Resident #102's face sheet dated 4/15/24 indicated Resident #102 was an [AGE] year-old female and admitted to the facility 4/01/24 with diagnoses including dementia (a group of thinking and social symptoms that interferes with daily functioning) with agitation, anxiety (intense, excessive, and persistent worry and fear about everyday situations), malignant neoplasm (cancer) of female breast, and depression (persistent sadness). Record review of Resident #102's quarterly MDS assessment dated [DATE] indicated Resident #102 was usually understood and understood others. The MDS indicated Resident #102's BIMS score was 7 which indicated she had severe cognitive impairment. The MDS indicated Resident #102 received an antidepressant medication. Record review of Resident #102's undated care plan indicated Resident #102 resisted care, refused bathing and changing soiled clothes, refused to staff to provide nail care with a problem start date of 4/15/24; Resident #102 wandered and was placed on the secure unit with a problem start date of 4/15/24; Resident #102 had behavioral symptoms not directed toward others, was sexually inappropriate would come into hallway take off her clothes and brief and start masturbating with a problem start date of 4/15/24; Resident #102 had a history of depression with a problem start date of 4/10/24; Resident #102 had cognitive impairment and poor decision making and placed on a special care unit for safety due to elopement attempts related dementia with a problem start date of 4/10/24. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675603	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2024
NAME OF PROVIDER OR SUPPLIER Rose Haven Retreat		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Live Oak St Atlanta, TX 75551	

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #102's undated Orders revealed an order for Prozac (fluoxetine) 40 mg 1 capsule by mouth once a morning with a start date 4/14/24. Record review of Resident #102's Medication Flowsheet dated 4/01/24-4/30/24 revealed Prozac (fluoxetine) 40 mg every AM had been handwritten on the flowsheet as a new order and was initialed as being given on 4/16/24 and 4/17/24 by LVN F and sertraline 50 mg 1 tablet at bedtime was discontinued with last dose administered 4/15/24. Record review of Resident #102's nurse's notes dated 4/13/24 at 4:00 PM revealed LVN E documented Resident #102 was in the hallway, showing all of her peri area (private areas) and was masturbating (sexual self-stimulation), very difficult to redirect, would not go to her room, now covered, very argumentative with staff. LVN E then documented on 4/13/24 at 4:10 PM, Resident #102 attempted to go out of the side door and LVN E notified the DON and Resident #102 was moved to the back (secured) unit. LVN E documented on 4/13/24 at 5:45 PM, she notified the attending MD and received orders to discontinue Resident #102's sertraline and start Prozac 40 mg by mouth every AM. LVN E documented on 4/13/24 at 17:45 PM, she notified Resident #102's RP to inform him of Resident 102's behaviors and being moved to the secure unit and she talked to Resident #102's RP about giving verbal consent for the new order of Prozac. LVN E documented Resident #102's RP did not feel comfortable giving verbal consent and said he would come to the facility on [DATE] to sign the consent. During an interview on 4/16/24 at 9:55 AM, the RP for Resident #102 said Resident #102 lived with him in his guest house semi-independently for 4 1/2 years until about two weeks ago when he placed her in the facility. Resident #102's RP said Resident #102's dementia had progressed to the point that she could not walk about a month ago. Resident #102's RP said his only concern was the facility called and asked him to move Resident #102 to the dementia unit because she tried to leave the building and he did not see how she could have done that if she could not walk. Resident #102's RP said the facility also called him to change one of her psych meds to Prozac and they said she was hitting and refusing her medications. Resident #102's RP said he did not feel comfortable giving verbal consent over the phone and wanted to lay eyes on Resident #102 before he would consider giving consent. Resident #102's RP said if Resident #102 was refusing to take the medications she was already on, how would changing to a different medication help if she was refusing to take it. Resident #102's RP said he told them she took medications for him crushed and put in juice. Resident #102's RP said the facility told him they could not crush certain meds and he said he was just talking about her psych medications, so they could get the desired behaviors. Resident #102's RP said she would refuse to do things if they tried to do to many things at once and they needed to give her psych medications first thing in the morning to give the medications time to work before trying to get her dressed or feed her because she would refuse care. During an interview on 4/17/24 at 12:07 PM, Resident #102's RP said the facility notified him on 4/13/24 of wanting to change her antidepressant medication to Prozac and he told them he did not feel comfortable giving verbal consent over the phone without laying eyes on Resident #102. Resident #102's RP said he had planned to come see Resident #102 on 4/14/24 to review the need for Resident to change her antidepressant to Prozac, but he was not able to come on 4/14/24 and he was planning to come the weekend of 4/20/24. Resident #102's RP said he still had not given consent. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/24 at 8:30 AM, the ADON said the nurses should obtain written consent for psychotropic medications (antidepressants, antianxiety, antipsychotics, mood stabilizers, and stimulants) during the resident's admission or prior to starting a new psychotropic medication. The ADON said the nurses should obtain written signatures but if the family was not available, then they could obtain verbal phone consents with two nurses as witnesses. The ADON said then they would get the RP to physically sign the consents and when/if they came into the facility. The ADON said she reviewed consents to ensure they were done for required medications. The ADON said Resident #102 was to start on Prozac, but Resident #102's RP said he was not comfortable with giving verbal consent over the phone and he was supposed to come and sign the consent for the Prozac on Sunday (4/14/24). The ADON said Resident #102's RP had not come to the facility yet and Resident #102 had not started the Prozac. The ADON said psychotropic medications were not ever administered to a resident without consent. During an interview on 4/17/24 at 11:50 AM, LVN F said she had worked at the facility since August 2023 full time and had worked as needed for a couple years. LVN F said the nurses were responsible for obtaining consents for psychotropic medications upon admission and prior to starting a new psychotropic medication. LVN F said an antidepressant should not be administered without consent of the resident or the resident's RP. LVN F said Resident #102 had been receiving Prozac. LVN F said she did not know if consent had been received for Resident #102 to receive Prozac. During an interview on 4/17/24 at 11:55 AM, the ADON said they had not received consent for Resident #102 to receive Prozac because her RP did not feel comfortable giving verbal consent and was supposed to have come to the facility last Sunday (4/14/24) to sign the consent, but he did not come. The ADON said an antidepressant should not have been given without consent of RP. The ADON said she was not aware Resident #102 was administered Prozac without consent of her RP. During an interview on 4/17/24 at 2:19 PM, the DON said a consent should have been obtained from Resident #102's RP prior to administering the Prozac to Resident #102. The DON said the nurse should have notified the MD and the order for Prozac should have been placed on hold until consent was given by Resident #102's RP. The DON said obviously the physician felt the resident needed the medication due to exacerbation of behaviors. The DON said she did not know how being given Prozac without the Resident #102's RP's consent negatively affected Resident #102. During an interview on 4/17/24 at 2:35 PM, the Regional Nurse Consultant said she talked to LVN F and LVN F said she popped the Prozac out of the medication card, but Resident #102 refused to take the medication and LVN F said she had not been able to document Resident #102 had refused the Prozac because they had Resident #102's chart. The Regional Nurse Consultant said, however, the Prozac should not have been placed on Resident #102's MAR without obtaining consent. Surveyor informed the Regional Nurse Consultant that LVN F had stated to Surveyor, Resident #102 had been receiving Prozac. The Regional Nurse Consultant said she would go with what LVN F stated to Surveyor. During an interview on 4/17/24 at 2:55 PM, the ADM said she would expect staff to obtain consents for required medications prior to administering the medication. The ADM said by not obtaining consent, the resident could be given medications that the resident or their RP did not want them to have. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled Resident Rights with a revised date of December 2016 revealed . employees shall treat all residents with kindness, respect, and dignity . federal and state laws guarantee certain basic rights to all residents of the facility . rights include the resident's right to . be supported by the facility in exercising his or her rights . exercise his or her rights without interference, coercion, discrimination or reprisal from the facility . be informed about his or her rights and responsibilities . appoint a legal representative of his or her choice . be notified of his or her medical condition and of any changes in his or her condition . be informed of, and participate in, his or her care planning and treatment . Record review of a facility provided document from Texas Health and Human Services titled Classes of Medications Frequently Used for Psychiatric Indications with a reviewed date of January 2023, revealed . consent was required for any medication that was used in the treatment of psychiatric diagnosis or symptom, whether or not the medication was included on this list or not . listed under Antidepressants . fluoxetine (Prozac) .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128 Based on observation, interview, and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 16 residents (Resident #1) reviewed for resident rights. The facility failed to ensure Resident #1 had access to a call light. This failure could place residents at risk for unmet needs and decreased quality of life. Findings included: Record review of a face sheet dated 04/16/24 indicated Resident #1 was [AGE] years old and was admitted on [DATE] with diagnoses including high blood pressure, anxiety disorder, pain, and shortness of breath. Record review of the MDS dated [DATE] indicated Resident #1 was understood and understood others. The MDS indicated a BIMS score of 6 indicating severe cognitive impairment . The MDS indicated Resident #1 required substantial/maximal assistance with ADLs. Record review of a care plan last revised on 03/14/24 indicated Resident #1 was at risk of falling related to cognitive impairment, poor safety awareness, fatigued easily with episodes of shortness of breath, had a history of angina, and took anti-anxiety medication and had episodes of incontinence. There was an intervention to keep call light in reach at all times. During an observation on 04/15/24 at 9:49 a.m., Resident #1 was in bed. Resident #1's call light was draped over the head of the mattress. The call light was between the mattress and the fitted sheet. It appeared the fitted sheet had been placed on the bed without moving the call light from the mattress. Resident #1 could not access the call light. During an observation on 04/15/24 at 2:40 p.m., Resident #1 was in bed. The call light was between the mattress and the fitted sheet. Resident #1 could not access the call light. During an observation 04/15/24 at 3:50 p.m., Resident #1 was in bed. The call light was between the mattress and the fitted sheet. Resident #1 could not access the call light. During an observation and interview on 04/16/24 at 9:46 a.m., Resident #1 was in bed. Her call light was hanging between her mattress and the foot board, out of reach of the resident. She said she did not know where her call light was. She said she did not know how she would call for assistance if she could not reach her call light. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/16/24 at 1:34 p.m., CNA A said she was the CNA for Resident #1 on 04/15/24. She said she did not put sheets on Resident #1's bed on 04/15/24. She said while providing care she did not notice the call light was between the fitted sheet and the mattress. She said Resident #1 would put the call light under her covers and that was where she thought the call light was. She said she would have gotten the call light out from under the fitted sheet if she had realized that was where it was. During an interview on 04/17/24 at 10:34 a.m., RN D said she would not expect for any call light to be between the fitted sheet and the mattress. She said she would expect call lights to be within the resident reach so the resident could the call and call for help. She said residents could potentially fall or be injured if they could not reach their call light. She said, or they could need to be toileted. During an interview on 04/17/24 at 11:02 a.m., the DON said the CNAs were primarily responsible for residents being able to reach their call lights. She said call lights should be in reach and functional. She said residents not being about to reach their call light could cause them to be unable to voice their needs via call light. She said she would have expected for Resident #1's call light to have not been under the fitted sheet and within reach. During an interview on 04/17/24 at 1:17 p.m., the Administrator said CNAs and anybody that goes into a resident's room was responsible for residents having their call lights. She said she would have expected the call light to have been within reach of Resident #1. She said a resident not having a call light could cause the resident to not to be able to alert staff that they needed care or wanted something. Review of an Answering the Call Light facility policy dated October 2010 indicated, .The purpose of this procedure is to respond to the resident's request and needs .When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident .

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128 Based on interview and record review, the facility failed to promote resident self-determination through support of resident choice for 1 of 16 residents (Resident #6) reviewed for resident rights. The facility did not assist Resident #6 out of bed when he requested. This failure could place dependent residents at risk for feelings of depression, lack self-determination and decreased quality of life. Findings included: Record review of the face sheet dated 04/16/24 indicated Resident #6 was [AGE] years old and admitted on [DATE] with diagnoses including diabetes, acquired absence of right leg and left leg above the knee, and quadriplegia (paralysis of all four limbs). Record review of the MDS dated [DATE] indicated Resident #6 was understood and understood others. The MDS indicated a BIMS score of 7 which indicated severe cognitive impairment. The MDS indicated Resident #6 required substantial/maximal assistance with ADLs. The MDS indicated Resident #6 was dependent on staff for chair/bed-to-chair transfers. Record review of a care plan last revised on 04/13/24 indicated Resident #6 had an active diagnosis of depression with an intervention to provide assistance with mobility. The care plan indicated the resident refused to be placed back in bed for incontinent care. There was an intervention allow the resident to have control over situations, if possible. During an observation and interview on 04/15/24 at 2:00 p.m., Resident #6 was in bed. He said his only concern was that he wanted to go outside. He said he used to be outside all of the time. He said he asked at least once a week to go outside. During an observation on 04/16/24 at 9:44 a.m., Resident #6 was in bed. During an observation on 04/16/24 at 11:00 a.m., Resident #6 was in bed. During an observation and interview on 04/16/24 at 3:33 p.m., Resident #6 said he was not gotten out of bed on 4/14/24 or 4/15/24. He said he wanted to get out of bed every day. He said he was told by an aide that he could not get up out of bed because he had a sore on his bottom and he needed to be in bed so it would get well. Resident #6 said, If I could get myself out of this bed, I would be out of here. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/24 at 10:10 a.m., CNA C said she tried to get Resident #6 up as much as he could get up. She said she had not been getting him up out of bed because he had a bedsore on his bottom, and he could not wear a brief. She said once he was up out of bed he wanted to stay up and did not like getting back in bed to be changed. She said she had not known him to be out of bed for the last two weeks. She said every shift she had worked during this time he had asked to be gotten out of bed. She said she had not gotten him out of bed. She said he loved to go outside and sit outside. During an interview on 04/17/24 at 10:34 a.m., RN D said Resident #6 rarely wanted to get out of bed. She said it had been approximately 2 weeks since she had seen him out of bed. She said she did not know why he was not gotten up when he had asked. She said if he wanted out of bed, he should have been gotten up. She said she was not aware of any reason he could not get out of bed. During an interview on 04/17/24 at 11:02 a.m., the DON said Resident #6 did get out of bed. She said when he was up he wanted to stay out of bed for hours and go outside. She said he did not want to get back in the bed for incontinent care and this had caused his wound to get worse. She said he still had the right to get up. She said Resident #6 not being gotten up could have come from the wound care doctor. She said Resident #6 not being gotten up could have a psychosocial impact. During an interview on 04/17/24 at 1:09 p.m., the Wound Care Nurse said Resident #6 did want to get out of bed. She said she had educated him on his positioning and sitting in his chair for hours. She said the last time she saw him up out of bed was 04/11/24 or 04/12/24. She said CNA C told her she misunderstood and thought he was not supposed to have been gotten out bed at all. She said other than him being non-compliant with his wound care, there was no reason for him not to have been gotten out of bed. During an interview on 04/17/24 at 1:17 p.m., the Administrator said the CNAs were responsible for getting Resident #6 out of bed. She said nurses could have gotten him up if he asked. She said if he asked to get out of bed every day, she would have expected him to be gotten up every day. She said he was up most days and he wanted to sit outside when the weather was nice. She said she would not have expected for the CNAs to have refused to get him up. She said he wanted to get up he has the right no matter what. Review of a Resident Rights facility policy dated December 2016 indicated, .Federal and state laws guarantee certain basic rights to all resident of this facility. These rights include the resident's right to . self-determination .exercise his or her rights as a resident of the facility .be supported by the facility in exercising his or her rights .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128 Based on observation, interview, and record review, the facility failed to ensure assessments accurately reflected the status for 1 of 16 residents reviewed for assessments. (Resident #36). The facility failed to complete an accurate resident assessment for Resident #36. Resident #36's resident assessment did not reflect that he was a tobacco user. This failure could place residents at risk of not having individual needs met and a decreased quality of life. Findings included: Record review of the face sheet dated 04/16/24 indicated Resident #36 was [AGE] years old and was admitted [DATE] with diagnoses including post-traumatic stress disorder, unspecified mood disorder, and high blood pressure. Record review of the most recent MDS dated [DATE] indicated Resident #36 was understood and understood others. Resident #2 had a BIMS score of 10 indicating moderate cognitive impairment. The MDS indicated Resident #36 was not a current tobacco user. Record review of Resident #36's care plan dated 03/25/24 did not indicate Resident #36 was a smoker. Record review of a Safe Smokers list dated 04/12/24 indicated Resident #36 was a safe smoker. During an observation and interview on 04/16/24 at 10:55 a.m., Resident #36 was standing by the door leading to the smoking area. He said he was a smoker and was waiting to go out on his smoke break. During an interview on 04/17/24 at 9:09 a.m., the MDS Nurse said she was responsible for completing the MDS assessments for each resident. She said someone being a smoker should be marked on the MDS. She said she tried to keep an updated list of all smokers. She said tobacco use not being marked on the MDS of a resident that smoked would cause it not to be on the care plan and the resident might not be monitored for safety. She said she was told Resident #36 was not a smoker. She said thought his clinical records indicated he was an everyday smoker. During an interview on 04/17/24 at 11:02 a.m., the DON said Resident #36 was a smoker. She said she would have expected tobacco use to have been triggered on Resident #36's MDS and care planned for smoking. She said there was a safe smoking assessment completed for Resident #36. She said an inaccurate MDS could cause the care plan to be incorrect. She said a care plan not being correct could cause staff to not be able to meet residents needs properly. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/24 at 1:17 p.m., the Administrator said the MDS nurse was responsible for completing MDS assessments. She said she expected all MDS assessments to be accurate. She said she would have expected Resident #36 to have been identified as a tobacco user on his MDS. She said an MDS assessment not being accurate would not show what care a resident needed. She if he was not identified as a smoker, a smoking assessment might not have been done and he may not have been made aware of smoking times. Review of the facility's undated policy titled Minimum Data Set (MDS) Policy for MDS assessment Data Accuracy indicated . the purpose of the MDS policy was to ensure each resident received an accurate assessment by qualified staff to address the needs of the resident who were familiar with his/her physical, mental, and psychosocial well-being . according to CMS's RAI Version 3.0 Manual . the MDS was a core set of screening, clinical, and functional status elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes . Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) required that . the assessment accurately reflected the resident's status . the assessment process included direct observation, as well as communication with the resident and direct care staff on all shifts .

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128 Based on interview and record review, the facility failed to ensure individuals with mental health disorders were provided an accurate Preadmission Screening and Resident Review (PASRR) Screening for 1 of 4 residents (Resident #27) reviewed for PASRR. The facility failed to review Resident #27's PASRR level 1 assessment for accuracy. Resident #27 had a diagnosis of schizophrenia (a mental disorder that affects a person's ability to think, feel, and behave clearly) not reflected on PASRR Level 1. This failure could place residents at risk of not receiving needed assessments (PASRR Evaluation), individualized care and specialized services to meet their needs. Findings included: Record review of a face sheet dated 04/16/24 indicated Resident #27 was [AGE] years old and was admitted on [DATE] with diagnoses including schizophrenia, delusional disorders, and unspecified intellectual disabilities - severe. Record review of an annual MDS assessment dated [DATE] indicated Resident #27 was not currently considered by the state level II PASRR process to have serious mental illness but did have an intellectual disability. The MDS indicated Resident #27 was understood and understand others. The MDS indicated Resident #27 had unclear speech. The MDS indicated a BIMS score of 7 which indicated severe cognitive impairment. The MDS indicated an active diagnosis of schizophrenia. Record review of a care plan dated 03/14/2024 indicated Resident #27 had a diagnosis of schizophrenia and cerebral palsy. The care plan indicated Resident #27 was PASSR positive. There was an intervention to be monitored for outbursts related to schizophrenia. Record review of a PASRR Lever 1 Screening dated 04/19/18 indicated, .Mental Illness .Is there evidence or an indicator this is an individual that has a mental illness .No .Developmental Disability .Is there evidence or indicators that this individual has a Developmental Disability (Related Condition) other than an Intellectual Disability (e.g., Autism, Cerebral Palsy, Spina Bifida) .Yes . During an interview on 04/17/24 at 9:09 a.m., the MDS Nurse said she was responsible for making sure PASRR level 1 assessments were correct. She said she took a training in November or December 2023. She said she was responsible for reviewing the PASRR level 1 assessment to make sure they were correct before submission. She said if someone had a mental illness she would expect for it to have been marked yes on the PASRR level 1 assessment. She said if she found an error, she was to report it to the local authority. She said if a PASRR level 1 assessment was not correct, residents could go without the specialized services they were entitled to. She said because Resident #27 was already PASSR positive she had not reviewed his PASRR level 1 assessment. She said his P1 was completed before she was employed at the facility. She said in July 2023, she reviewed all PASSR negative residents but not PASSR positive. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/24 at 11:02 a.m., the DON said the MDS Nurse was responsible to making sure PASRR level 1 assessments were accurate. She said the process was that she would send the MDS Nurse the medical records and the PASSR to the MDS Nurse. She said she thought when residents came to the facility for the PASSR Evaluation, it was also their responsibility to verify the information. During an interview on 04/17/24 on 1:17 p.m., the Administrator said the MDS nurse, and the DON were responsible for reviewing PASRR level 1 assessments. She said they had meetings where the services were discussed. She said when a resident was PASSR positive on one PASRR level 1 assessment they were positive. She did not feel Resident #27's mental illness being triggered would have made a difference. She said she felt he was offered the services he needed. She said he refused his services and just wanted to be left alone. She said a PASRR level 1 assessment not being correct might cause services to have not been offered that a resident had a right to. Review of an undated Preadmission Screening and Resident Review (PASRR) facility policy indicated, . Nursing and medical needs of individuals with mental disorders or intellectual disabilities will be determined by coordination with the Medicaid Pre-Admission Screening and Resident Review program (PASRR) to the extent possible . The policy did not address the accuracy of the PASRR level 1 assessments.

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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** 46062 Based on observation, interview, and record review the facility failed to develop, and implement a comprehensive care plan to meet the medical, nursing, mental and psychosocial needs for 2 of 20 residents reviewed for care plans (Resident #36 and Resident #102). 1. The facility failed to develop the comprehensive person-centered care plan for Resident #36 indicating the resident was a smoker. 2.The facility failed to implement Resident #102's comprehensive person-centered care plan when LVN E did not notify the hospice agency of Resident #102's behavioral changes and moving her to the secured unit. These failures could place residents in the facility at an increased risk of a decline in physical or functional well-being, of not receiving necessary care or services, and having personalized plans developed/implemented to address their needs. Findings included: 1. Record review of the face sheet dated 04/16/24 indicated Resident #36 was [AGE] years old and was admitted [DATE] with diagnoses including post-traumatic stress disorder, unspecified mood disorder, and high blood pressure. Record review of the most recent MDS dated [DATE] indicated Resident #36 was understood and understood others. Resident #2 had a BIMS score of 10 indicating moderate cognitive impairment. Section J1300 indicated Resident #36 was not a current tobacco user. Record review of Resident #36's care plan dated 03/25/24 did not indicate Resident #36 was a smoker. Record review of a Safe Smokers list dated 04/12/24 indicated Resident #36 was a safe smoker. During an observation and interview on 04/16/24 at 10:55 a.m., Resident #36 was standing by the door leading to the smoking area. He said he was a smoker and was waiting to go out on his smoke break. During an interview on 04/17/24 at 9:09 a.m., the MDS Nurse said she was responsible for responsible for creating the care plans. She said she created Resident #36's care plan. She said Resident #36 not being marked as a tobacco user on the MDS caused him not to be care planned for smoking. She said Resident #36 not being care planned as a smoker could be a safety issue. She said a care plan is to be a complete picture of the resident and to meet their needs and provide care for them. She said staff should follow the care plan to provide care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/24 at 11:02 a.m., the DON said care plans were used to coordinate care and properly care for someone. She said the MDS nurse was primarily responsible for care plans and MDSs. She said Resident #36 was a smoker. She said she would have expected Resident #36 to have been care planned as a smoker. She said there was a safe smoking assessment completed for Resident #36. During an interview on 04/17/24 at 1:17 p.m., the Administrator said a care plan was used for directing residents' care. She said the care plan listed goals, who was responsible, and how to achieve those goals. She said she would have expected Resident #36 to have been care planned for smoking. She said the MDS nurse was responsible for care plans. 2. Record review of Resident #102's face sheet dated 4/15/24 indicated Resident #102 was an [AGE] year-old female and admitted to the facility 4/01/24 with diagnoses including dementia (a group of thinking and social symptoms that interferes with daily functioning) with agitation, anxiety (intense, excessive, and persistent worry and fear about everyday situations), malignant neoplasm (cancer) of female breast, and depression (persistent sadness). Record review of Resident #102's quarterly MDS assessment dated [DATE] indicated Resident #102 was usually understood and understood others. The MDS indicated Resident #102's BIMS score was 7 which indicated she had severe cognitive impairment. The MDS indicated Resident #102 received hospice services. Record review of Resident #102's undated care plan indicated Resident #102 was receiving hospice services with a problem start date of 4/10/24 and had interventions to communicate with hospice when any changes were indicated in the plan of care, coordinate plan of care with hospice agency reflecting hospice philosophy, ensure the facility and the hospice agency were aware of the other's responsibilities in implementing the plan of care, identify the care and services to be provided by the facility and the hospice agency, and notify hospice when there was any change in Resident #102's condition. Resident #102 resisted care, refused bathing and changing soiled clothes, refused for staff to provide nail care with a problem start date of 4/15/24; Resident #102 wandered and was placed on the secure unit with a problem start date of 4/15/24; Resident #102 had behavioral symptoms not directed toward others, was sexually inappropriate would come into hallway take off her clothes and brief and start masturbating with a problem start date of 4/15/24. Record review of Resident #102's nurse's notes dated 4/13/24 at 4:00 PM revealed LVN E documented Resident #102 was in the hallway, showing all of her peri area (private areas) and was masturbating (sexual self-stimulation), very difficult to redirect, would not go to her room, now covered, very argumentative with staff. LVN E then documented on 4/13/24 at 4:10 PM, Resident #102 attempted to go out of the side door and LVN E notified the DON and Resident #102 was moved to the back (secured) unit. LVN E documented on 4/13/24 at 5:45 PM, she notified the attending MD and received orders to discontinue Resident #102's sertraline and start Prozac 40 mg by mouth every AM. LVN E documented on 4/13/24 at 17:45 PM, she notified Resident #102's RP to inform him of Resident 102's behaviors and being moved to the secure unit and she talked to Resident #102's RP about giving verbal consent for the new order of Prozac. LVN E documented Resident #102's RP did not feel comfortable giving verbal consent and said he would come to the facility on [DATE] to sign the consent. There was no documentation LVN E notified the hospice agency of Resident #102's behavioral changes or moving her to the secured unit. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/16/24 at 9:55 AM, the RP for Resident #102 said his only concern was the facility called 4/13/24 and asked him to move Resident #102 to the dementia unit because she tried to leave the building and he did not see how she could have done that if she could not walk. Resident #102's RP said the facility also called him 4/13/24 to change one of her psych meds to Prozac and they said she was hitting and refusing her medications. Resident #102's RP said Resident #102 was on hospice services and the facility should be contacting the hospice agency with any changes in Resident #102's care. During an interview on 4/16/24 at 11:12 AM, a Hospice Representative said Resident #102 was admitted to the hospice agency on 4/04/24. The Hospice Representative said she came to the facility to visit Resident #102 on 4/15/24 and when she went to Resident #102's last known room, Resident #102 was not in her room, the bed was stripped, and there was a few of her personal items in the room. The Hospice Representative said she thought maybe they had taken Resident #102 to the shower or something. The Hospice Representative said she asked a staff member where Resident #102 was and was told Resident #102 was moved to the memory care unit. The Hospice Representative said she was told the resident had some behavioral issues, was combative, and was exit seeking over the weekend (4/13/24). The Hospice Representative said the facility did not notify the hospice agency over the weekend (4/13/24). The Hospice Representative said the facility should notify the hospice agency at the time of the behavior changes and their nurse could have intervened and contacted their MD for interventions. The Hospice Representative said since the hospice agency was not informed of the room change or of the behavioral changes, they were not able to intervene. The Hospice Representative said the facility's attending MD also changed her psych medication without going through the hospice MD. The Hospice Representative said the facility should be coordinating with hospice with any changes with Resident #102. During an interview on 4/17/24 at 9:15 AM, the MDS Coordinator said the purpose of the care plan was to have a complete picture of the resident to show what care was needed to meet the needs of the resident. The MDS Coordinator said the nurses should follow the care plan to provide care to the resident. During an interview on 4/17/24 at 10:13 AM, LVN E said if a resident was on hospice services, the hospice agency should be notified for any change or if something is going on with the resident, so the hospice nurse could come put another set of eyes on the resident and notify the hospice MD. LVN E said the purpose of the care plan was so staff would know how to take care of the resident. LVN E said the care plan should be followed by staff. LVN E said Resident #102 was being sexually inappropriate in the hallway and had tried to exit out the side door a total of three times in a 24-hour period saying she wanted to go home, and she thought her car was in the parking lot over the weekend (4/13/24). LVN E said after the third time of Resident #102 opening the door trying to exit, but she did not get out of the building, she notified her DON. LVN E said her DON told her to move Resident #102 to the locked unit. LVN E said she notified Resident #102's RP and the attending MD. LVN E said Resident #102 was fairly new to her and she did not even think about calling the hospice agency and had forgot Resident #102 was on hospice services. LVN E said her main concern at the time was for Resident #102's safety. LVN E said the care plan to notify hospice should have been followed to allow for Hospice to lay another set of eyes on Resident #102 and they may have been able intervene and curb the resident's behaviors. LVN E said if the care plan was not followed, the resident may not receive the help they needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/24 at 2:19 PM, the DON said the purpose of the care plan was to tell staff how to take care of the resident in addition to the MAR/TARs and orders. The DON said she would expect staff to follow the care plan. The DON said LVN E should have notified the hospice agency with Resident #102's behavioral changes and moving her to the secured unit. During an interview on 4/17/24 at 2:55 PM, the ADM said the care plan gave guidelines to improve the resident's outcomes with goals and interventions, and how they planned to accomplish it. The ADM said she would expect the resident's care plan to be followed. The ADM said the hospice agency should have been notified with any changes of condition and the room change of Resident #102. The ADM said if the care plan was not followed there was risk of the resident not receiving needed care. Record review of the facility's policy titled Care Plans, Comprehensive Person-Centered with a revised date of December 2016, revealed . a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident . each resident's comprehensive person-centered care plan would be consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to . receive the services and/or items included in the plan of care . the comprehensive, person-centered care plan will . describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . identify the professional services that were responsible for each element of care . 44128

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview, and record review, the facility has failed to ensure that the resident environment remains as free of accident hazards as possible and provide supervision to prevent avoidable accidents for 1 of 3 residents (Resident #13) and 1 of 4 staff (CNA A) reviewed for transfer. The facility failed to ensure CNA A performed a safe mechanical lift transfer (devices used to assist with transfers and movement of individuals who require support for mobility beyond the manual support provided by caregivers alone) for Resident #13. This failure could place residents at risk of injury from accident and hazards. Findings included: Record review of a face sheet printed 04/17/24 indicated Resident #13 was a [AGE] year-old, female and was admitted on [DATE] with diagnoses including dementia (a group of thinking and social symptoms that interferes with daily functioning), cerebral infarction (stroke), hemiplegia (paralysis of one side of the body), affecting left nondominant side, and age-related osteoporosis (is a bone disease that develops when bone mineral density and bone mass decreases, or when the structure and strength of bone changes). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #13 was usually understood and usually had the ability to understand others. The MDS indicated Resident #13 had minimal difficulty hearing, unclear speech, and moderately impaired vision. The MDS indicated Resident #13 had a BIMS score of 06 which indicated severe cognitive impairment. The MDS indicated Resident #13 was dependent (helper does all of the effort) for chair/bed to chair transfer, toilet transfer, and tub/shower transfer. Record review of a care plan dated 11/10/19, revised 04/10/24, indicated Resident #13 was transferred per staff x 2 with mechanical lift. Resident #13 required substantial/maximal assistance. Staff did more than half the effort and staff lifted or held trunk or limbs and provide more than half effort for ADLs. Intervention included Resident #13 was up in wheelchair as needed per staff transfer with mechanical and 2 staff members. During an observation on 04/15/24 at 12:49 p.m., CNA G and CNA A lifted Resident #13 in the mechanical lift from her wheelchair. The mechanical lift base legs were in the opened position. CNA A operated the mechanical lift controller and shifter handle (is used to open or close the legs of the base for stability when lifting a patient). CNA A moved the mechanical lift from Resident #13's wheelchair to her bed. CNA A placed the mechanical lift over Resident #13's bed with the base legs opened, underneath the bed frame. CNA A locked the mechanical lift brakes, closed the base legs with shifter handle then lowered Resident #13 into her bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/24 at 10:51 a.m., LVN F said when the mechanical lift was under a resident's bed and the resident was being lowered into a wheelchair or bed, the legs of the base should be opened. She said the legs of base needed to be opened because the center of gravity was better. She said if the legs of the base were not opened during use of the mechanical lift, the machine could tip. She said if the machine tipped during mechanical lift transfer the resident could get hurt and injured leading to hospitalization . During an interview on 04/17/24 at 11:18 a.m., CNA A said legs of the base for mechanical lift should be closed when underneath a resident's bed and lowering the resident. She said she was taught at another facility, to close the legs of base when lowering a resident. She said she could understand why the legs should be opened to provide a stronger base when lowering a resident in the bed. She said if the base legs were not positioned right then the mechanical lift could tip and hurt or injury the resident. She said she had completed a CNA checkoff when she was hired, on mechanical lift transfers. During an interview on 04/17/24 at 11:37 a.m., the DON said mechanical lift base legs should be opened during use and closed when not. She said the legs of the base should be opened underneath a resident's bed and lowering the resident in the bed. She said opened legs of the base provided stability. She said if the mechanical lift was not stable, it could fall and injure the resident. She said the previous CNA coordinator had gone over mechanical lift transfers with the CNAs. She said CNAs were monitor if they operated the mechanical lift correctly by doing check offs upon hire and annually. During an interview on 04/17/24 at 11:56 a.m., the CNA Coordinator K said he had been in his position for 1-2 weeks. He said he was still working on observing CNAs skills. He said it was important for the mechanical lift base legs to be opened when lowering a resident to the bed or wheelchair. He said the opened leg base position provided balance to the machine. He said when the base of legs was opened, if it started to rock, the base legs would balance it out. He said if the mechanical lift was not used correctly, then the resident was at risk for harm, fracture, fall, or concussion. He said the staff also had the potential to hurt themselves during an improper mechanical transfer. During an interview on 04/17/24 at 12:10 p.m., the ADM said she was not familiar enough with mechanical lift to comment on its use. Record review of CNA A's Departmental Orientation checklist dated 02/13/24 indicated .transferring patients . 2 person transfers with lift .completed . Record review of an undated operation guide Manual/Electric Portable Patient Lift indicated .the legs of the lift must be in the maximum open position and the shifter handle locked in place for optimum stability and safety . Review of Best Practices for Using Patient Lifts by the U.S. Food and Drug Administration, www.fda.gov was accessed on 04/22/24 indicated on slide 7, .keep the base (legs) of the patient lift at maximum open position . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of How to Properly Operate a Hoyer Lift dated 4/10/2019 at https://medical-stretchers.com/articles/how-to-properly-use-a-wheelchair-n104 and was accessed on 04/22/24 indicated, A Hoyer Lift is a device that is designed to easily transfer or lift a person with minimal physical effort. There are many safety tips and precautions one needs to follow while operating a Hoyer lift .When using the lift, you should always ensure that the base is open to ensure that the equipment remains stable during the lift .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview and record review, the facility failed to ensure that it was free of medication error rate of 5 percent or greater. The facility had a medication error rate of 12.5%, based on 4 errors out of 32 opportunities, which involved 4 of 6 residents (Resident #8, Resident #22, Resident #36, Resident #44) reviewed for medication administration. 1. MA L administered Acetaminophen-codeine 300-30mg (is a prescription pain medicine) at 10:30 a.m. instead of 8:00 a.m. as ordered on 04/15/24 for Resident #8. 2. MA L administered Aspirin 81mg (is an antiplatelet (make it harder for blood clots to form); effective at preventing heart attack or stroke) at 9:31 a.m. instead of 8:00 a.m. and without food as ordered on 04/15/24 for Resident #22. 3. MA L administered Esomeprazole Magnesium 20mg (is used to treat conditions where there is too much acid in the stomach) at 9:23 a.m. instead of 7:00 a.m. as ordered on 04/15/24 for Resident #36. 4. MA L administered Omeprazole 40mg (is used to treat certain conditions where there is too much acid in the stomach) at 9:56 a.m. instead of 7:00 a.m. and did not give it 30-60 minutes prior to eating food as ordered on 04/15/24 for Resident #44. These failures could place residents at risk for not receiving the intended therapeutic benefit of their medications or receiving them as prescribed, per physician orders. Findings included: 1. Record review of a face sheet printed 04/17/24 indicated Resident #8 was a [AGE] year-old, female and was admitted on [DATE] with diagnoses including gout (is a type of inflammatory arthritis that causes pain and swelling in your joints), pain in left knee, chest pain, and pain. Record review of an admission MDS assessment dated [DATE] indicated Resident #8 was understood and understood others. The MDS indicated Resident #8 had a BIMS score of 09 which indicated moderate cognitive impairment. The MDS indicated Resident #8 required partial/moderate assistance for oral hygiene, toilet hygiene, shower/bathe self, dressing, and personal hygiene. The MDS indicated Resident #8 did not receive scheduled pain medication regimen, prn pain medication, or non-medication intervention for pain. Record review of a care plan dated 01/10/24 indicated Resident #8 had potential for complaints of chronic pain related to left knee and gout. Intervention included administer medications as directed. Record review of Resident #8's consolidated physician orders printed 04/17/24 indicated acetaminophen-codeine tablet 300-30mg, 1 tablet every 8 hours, 8:00 a.m., 4:00 p.m., 12:00 a.m. Start date 02/20/24, with no end date. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #8's MAR dated 04/01/24-04/30/24 indicated acetaminophen-codeine tablet 300-30mg, 1 tablet every 8 hours, DX: pain, 12:00 a.m., 8:00 a.m. Start date 02/20/24, with no end date. During an observation on 04/15/24 at 10:30 a.m., MA L prepared and administered Resident #8's acetaminophen-codeine tablet 300-30mg, 1 tablet with 12 other prescribed medications. 2. Record review of a face sheet printed 04/17/24 indicated Resident #22 was a [AGE] year-old, male and was admitted on [DATE] with diagnosis including cerebral infarction (stroke). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #22 was understood and understood others. The MDS indicated Resident #22 had a BIMS score of 07 which indicated moderate cognitive impairment. The MDS indicated Resident #22 required substantial/maximal assistance for oral hygiene, toileting hygiene, shower/bathe self, dressing, and personal hygiene. Record review of a care plan dated 09/14/23 indicated Resident #22 had Atrial Fibrillation with potential for abnormal bleeding and bruising related to antiplatelet therapy. Intervention included administer antiplatelet as ordered. Record review of Resident #22's consolidated physician orders printed 04/17/24 indicated Aspirin 81mg, 1 tablet, special instruction: **with food**, once a morning, 8:00 a.m. Start date 02/20/24, no end date. Record review of Resident #22's MAR dated 04/01/24-04/30/24 indicated Aspirin 81mg, 1 tablet, special instruction: **with food**, DX: cerebral infarction, once a morning, 8:00 a.m. Start date 02/20/24, no end date. During an observation on 04/15/24 at 09:31 a.m., MA L prepared and administered Resident #22's, Aspirin 81mg, 1 tablet with 3 other prescribed medications. Resident #22 was not eating at the time of the administration. 3. Record review of a face sheet printed 04/17/24 indicated Resident #36 was a [AGE] year-old, male and was admitted on [DATE] with diagnosis including gastro-esophageal reflux disease (means stomach acid is rising into your esophagus). Record review of an admission MDS assessment dated [DATE] indicated Resident #36 was understood and understood others. The MDS indicated Resident #36 had a BIMS score of 10 which indicated moderate cognitive impairment. The MDS indicated Resident #36 required partial/moderate assistance for oral hygiene, toilet hygiene, shower/bathe self, dressing, and personal hygiene. Record review of a care plan dated 03/25/24 indicated Resident #36 ADL functions partial/moderate assistance. Intervention assist with ADLs as needed. The care plan did not address Resident #36's gastro-esophageal reflux. Record review of Resident #36's consolidated physician order printed 04/17/24 indicated Esomeprazole Magnesium 20mg, 1 capsule, oral, once a day, 7:00 a.m. Start date 03/19/24, no end date. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #36's MAR dated 04/01/24-04/30/24 indicated Esomeprazole Magnesium 20mg, 1 capsule, oral, once a day, DX: gastro-esophageal reflux disease 7:00 a.m. Start date 03/19/24, no end date. During an observation on 04/15/24 at 09:23 a.m., MA L prepared and administered Resident #36's, Magnesium 20mg, capsule with 1 other prescribed medication. 4. Record review of a face sheet printed 04/17/24 indicated Resident #44 was a [AGE] year-old, female and was admitted on [DATE] with diagnosis including gastro-esophageal reflux disease (means stomach acid is rising into your esophagus). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #44 was understood and understood others. The MDS indicated Resident #44 had a BIMS score of 07 which indicated severe cognitive impairment. The MDS indicated Resident #44 required substantial/maximal assistance for oral hygiene, toilet hygiene, shower/bathe self, dressing, and personal hygiene. Record review of a care plan dated 09/14/23 indicated Resident #44's ADL functions substantial/maximal assistance. Intervention included assist with ADLs as needed. The care plan did not address Resident #44's gastro-esophageal reflux. Record review of Resident #44's consolidated physician order printed 04/17/24 indicated Omeprazole 40mg, 1 capsule, oral, special instruction: *Give 30-60 mins prior to eating food*, twice a day, 7:00 a.m., 5:00 p.m. Start date 09/07/23, no end date. Record review of Resident #44's MAR dated 04/01/24-04/30/24 indicated Omeprazole 40mg, 1 capsule, oral, special instruction: *Give 30-60 mins prior to eating food*, DX: gastro-esophageal reflux disease, twice a day, 7:00 a.m., 5:00 p.m. Start date 09/07/23, no end date. During an observation on 04/15/24 at 09:56 a.m., MA L prepared and administered Resident #44's, Omeprazole 20mg, 2 capsule with 5 other prescribed medications. During an interview on 04/15/24 at 11:00 a.m., the Regional Nurse Consultant said medications with a specified administration time could be given 1 hour before and after the ordered time. She said the medications with a time range had to be given within that window of time. During an interview on 04/17/24 at 10:45 a.m., MA L said medication with specified time had to be given 1 hour before or after the ordered administration time. She said if a medication was scheduled for 7:00 a.m., she had to give it by 8:00 a.m. She said Resident #36 and Resident #44's medications were acid reducer so she should have given at 7:00 a.m. or before the resident ate. She said it was important to give the acid reducer before the resident ate to prevent acid erosion of the throat and stomach form the reflux. She said Resident 22's Aspirin should be given with food to prevent an upset stomach. She said after med pass with surveyor on 04/15/24, she realized she needed to revamp her med pass routine. She said she had to educate herself and the residents on the importance of giving certain medication at certain times. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/17/24 at 10:51 a.m., LVN F said the facility allowed scheduled medication with specified times to be given 1 hour before and after. She said acid reducers should be given at 7:00 a.m. and without food. She said acid reducers were more effective on an empty stomach and helped reduce the acid for food. She said Aspirin should be given with food reduced the chances of the rest getting an upset stomach. She said if medications were not given as ordered, resident could experience the symptoms the medication was trying to prevent. During an interview on 04/17/24 at 11:37 a.m., the DON said there was a 1 hour before and after window scheduled medications could be given. She said a scheduled medication given after the 1-hour window was considered late. She said acid reducer medication was supposed to be given before the reside ate to prevent acid reflux. She said if the medication was not given before the resident ate, the resident could experience ingestion. She said she did not know why Resident #22's Aspirin had to be given with food. She said she would have to do some digging to see why Resident #22 needed his Aspirin with food. She said some residents GI bleed could need their Aspirin with food. She said Resident #22's Aspirin should be given with food if that is what the order said. During an interview on 04/17/24 at 12:10 p.m., the ADM said she did not know about nursing to comment of medication administration times and the purpose of certain medications. Record review of a facility's Administering Medications policy revised 12/2012 indicated .medication shall be administered in a safe and timely manner, and as prescribe .medications must be administered in accordance with the orders, including any required time frame .medications must be administered within 1 hour of their prescribed time, unless otherwise specified .for example, before and after meals orders .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062 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 the facility's only kitchen reviewed for food safety requirements. 1. The facility failed to ensure an opened bag of potato chips was securely closed or stored in a secure container. 2. The facility failed to ensure the tin pan with stuffed green peppers in beef sauce was securely closed in the freezer. 3. The facility failed to ensure two measuring cups were stored with the top openings facing down. 4. The facility failed to ensure there was minimal carbon buildup on approximately 7 baking sheet pans. These failures could place residents at risk of foodborne illness and food contamination. Findings included: During initial tour observations in the kitchen on 4/15/24 beginning at 8:57 AM and accompanied by DM, there was an opened bag of potato chips with top of bag folded over and not securely closed in the dry goods pantry. DM went and got a plastic zipper bag and put the opened bag of potato chips in it. In the freezer, there was a silver tin pan labeled green peppers in beef sauce with the top cover lifted revealing approximately a fourth of the food and it had small pieces of what appeared to be ice on the top of the stuffed bell peppers in beef sauce. The DM then securely closed the top of the stuffed bell peppers in beef sauce. There were approximately 7 baking sheet pans with thick black carbon buildup on the outside of the pans and rim. There were two measuring cups hanging from the ceiling potholder rack with the top openings facing up toward the ceiling. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/17/24 at 1:13 PM, Cook H said she had worked at the facility for about [AGE] years in the kitchen. Cook H said all kitchen staff were responsible for ensuring there was an open date on packages of food that had been opened and the opened packaged should be placed in a zip lock bag to keep anything from getting in the package of food. Cook H said all kitchen staff were responsible for ensuring food items were stored properly in the freezer. Cook H said the black stuff on the baking sheet pans were from years of use and they have scrubbed and scrubbed, and it would not come off. Cook H said they lined the baking sheet pans with foil before using them. Cook H said she was not sure what the risk of carbon buildup on the baking sheet pans was for the resident. Cook H said the if the chip bag was not securely closed or placed in a plastic zippered bag, the potato chips could become stale and would not be good and/or anything could get into the opened package of chips. Cook H said they used to have a problem with pests/roaches, but she had not seen any in a long time. Cook H said if the stuffed bell peppers were not securely closed in the freezer, they could get freezer burnt and it would not be good. Cook H said the ice particles on food normally meant it was freezer burnt, and it would not be good for the residents and should not be served. Cook H said the measuring cups hanging with the top openings facing up toward the ceiling could collect dust and should be stored with the top opening facing down. During an interview on 4/17/24 at 1:28 PM, the DM said she had worked at the facility since 1992. The DM said the opened bag of potato chips should have been stored in a plastic zippered bag with an open date on it to keep anything from getting into the bag and to preserve the quality of the bag of chips. The DM said the lid of bell peppers should have been tightly secured because it was unused. The DM said she checked the bell peppers and resecured the packaging to ensure the quality of the meal. The DM said they used a degreaser to try to remove the carbon buildup from the cookware, but it would not come off. The DM said she was working on replacing the pans but had not placed an order yet due to financial reasons. The DM said the carbon build up was not on the inside of the pans and they lined them with foil prior to using them, therefore there was not a risk to the residents. The DM said they washed the measuring cups prior to using them and did not see an issue with them hanging with the tops facing up on the hanging rack. The DM said she had not seen any pests/roaches in about a week when she saw one roach. The DM said they have a pest control company come spray weekly. The DM said she ended up tossing the opened bag of potato chips, because she did not know how long they had been open. The DM said the stuffed bell peppers had been delivered to the facility last Friday (4/12/24) and she inspected them and determined they were not freezer burnt and served them as an alternate on 4/16/24. During an interview on 4/17/24 at 2:55 PM, the ADM said she would expect food to be securely closed because anything could get in it and contaminate the food if not stored properly. The ADM said she would expect the baking pans to be free of carbon buildup due to it could contaminate the food. The ADM said they had been fighting a battle with pests/roaches in the facility, but it had gotten much better, and they had the pest control company come weekly. The ADM said if food was not stored properly or if the baking pans were not free of carbon buildup, it placed the residents at risk. Record review of the facility's policy titled Dietary Services dated 2007 indicated . the purpose . to prevent contamination of food products and therefore prevent foodborne illness . provide safe food services for residents . provide for the proper receipt and storage of all food supplies . utensils, cups, glasses and dishes must be handled in such a way as to avoid touching surfaces with which food or drink will come into contact .

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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** 46062 Based on observation, interview, and record review the facility failed to ensure an infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections for 5 of 16 residents reviewed for infection control. (Resident #35, Resident #6, Resident #7, Resident #103, Resident #18) 1.The facility failed to ensure CNA G changed her gloves and performed hand hygiene appropriately while providing incontinent care to Resident #35. 2.The facility failed to ensure CNA G changed her gloves after providing incontinent care to Resident #35 prior to touching Resident #35's bare hip, bare leg, clean brief, clothing, bedding, pillow, 2 drinking cups, bedside table, and bed remote. 3. The facility failed to ensure CNA G and CNA J followed the Enhanced Barrier Precaution to don gown and gloves for incontinence care for Resident #6. 4. The facility failed to ensure CNA A changed her gloves and performed hand hygiene appropriately while providing incontinent care to Resident #7. 5. The facility failed to ensure CNA A changed her gloves after providing incontinent care to Resident #7 prior to touching Resident #7's POTUS boot (is designed to reduce heel ulcers (and skin sores) and turning her. 6. The facility failed to ensure CNA B changed her gloves and performed hand hygiene appropriately while providing incontinent care to Resident #103. 7. The facility failed to ensure CNA B changed her gloves after providing incontinent care to Resident #103 prior to touching Resident #103's covers. 8. The facility failed to isolate Resident #18 after urine cultures (test checks urine for germs (microorganisms) that cause infections) revealed ESBL (enzymes break down and destroy some commonly used antibiotics) in his urine. These failures could place residents at risk for cross-contamination, increased risk of infection and the spread of infection. Findings included: 1. Record review of Resident #35's face sheet dated 4/15/24 indicated Resident #35 was an [AGE] year-old female and admitted to the facility on [DATE] with diagnoses including dementia (progressive or persistent loss of intellectual functioning with impairment or memory and thinking and often with personality changes), history of UTI (urinary tract infection), and atopic dermatitis-Eczema (itchy inflammation of the skin). (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 #35's quarterly MDS dated [DATE] indicated Resident #35 was understood and understood others. The MDS indicated Resident #35 had a BIMS score of 7 which indicated she had severe cognitive impairment. Resident #35 was always incontinent of bowel and bladder. Record review of Resident #35's undated care plan indicated she had the potential for a UTI related to a history of urinary infection, incontinent of bowel and bladder, and refuses care at times. Resident #35 had interventions including to ensure meticulous personal hygiene, especially after elimination, keep perineal area clean and dry, and use a front to back wiping technique; use principles of infection control and universal/standard precaution. Record review of Resident #35's orders revealed an order to apply nystatin powder (medication used to treat fungal and yeast infections of the skin) to affected area twice daily as needed with a start date of 4/13/21. During an observation on 04/15/24 at 10:30 AM, NA G said came to Resident #35's room to perform incontinent care. NA G told Resident #35 you are going to see me do things, I don't usually do but I want to do things the right way with her (surveyor) watching me. NA G removed everything including Resident #35's two drinking cups from her bedside table and placed them on side table. NA G washed hands and applied gloves, then she covered the bedside table with towel and placed two wash basins on table with soapy water in one and clean water in the other one. NA G said then handed Resident #35 a wet clean washcloth to wash her face with. NA G then used a clean wet soapy washcloth to wash under Resident #35's breasts and underarms and Resident #35 said she has tendency to get yeast and had some raw areas under arms and breast and inner thighs. Observed small, reddened areas under both of Resident #35's breasts and under arms. NA G then cleaned under both breasts and under arms with clean water and patted the areas dry. NA G then applied moisture barrier cream under underarms and breasts then applied powder to the areas. NA G then proceeded without changing her gloves to put a clean gown on Resident #35. NA G then without changing her gloves, cleaned Resident #35's front private area using front to back technique, then assisted Resident #35 to turn on left side by touching bare right hip and leg. NA G then without changing her gloves proceeded to clean Resident #35's buttocks that was soiled with feces. NA G then proceeded to apply moisture barrier cream to Resident #35's buttocks, without changing her gloves. NA G then assisted Resident #35 to turn back over onto her back by placing her same gloves on Resident #35's right hip and leg. NA G then proceeded using same gloves, assisted Resident #35 to roll to right side by placing same gloved hands on her left hip and leg. NA G then removed soiled brief and under pad and placed in a plastic bag. NA G then using same gloves, proceeded to place a clean under pad and brief under and on resident and then positioned resident back onto her back. NA G then without changing her gloves, NA G pulled Resident #35's gown down over brief, used the bed remote to lower the bed, pulled the resident's bedding over her, replaced the resident's 2 drinking cups from side table back onto the bedside table, and pulled the resident up in bed. NA G then removed her gloves and sanitized her hands. NA G performed all of the above using the same gloves throughout and did not change gloves or perform hand hygiene appropriately. During an interview on 4/17/24 at 10:13 AM, LVN E said staff should be changing their gloves when going from dirty to clean areas while performing incontinent care. LVN E said it would not be appropriate for a NA to provide incontinent care, then apply a cream to the resident's bottom, then apply cream to the resident's front private area, and then proceed to touch clean items with same gloves. LVN E said it would be cross contamination and increase the risk of infection for the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/17/24 at 11:00 AM, NA G said she had worked at the facility for a year. NA G said she had completed the CNA program but was waiting to take her certification test. NA G said she told Resident #35 she was doing things different from how she normally cleaned her up because she wanted to make sure she did it right and she just wanted to let the resident know why it was different. NA G said she normally only used one wash basin and did not use two. NA G said she should have changed her gloves when going from front to back during incontinent care and she knew she messed up when she turned the resident back over after performing incontinent care. NA G said she had been told the redness areas under Resident #35's arms and breasts was yeast and the treatment nurse had a special cream she applied to the areas, but she was told to use moisture barrier cream in between when the treatment nurse applied the special cream. NA G said she messed up from top to bottom and cross-contaminated by not changing her gloves after applying cream under Resident's arms and breast, then cleaning resident's front peri area, then feces from buttocks, then applying cream to buttocks, then rolled resident over and applied cream to front peri area, then proceeded to touch bed remote, resident, covers, clothes, and drinking cups. NA G said it was cross-contamination and put the resident at risk for infection. NA G said she had received training on when to change gloves during incontinent care and infection control. NA G said she was so nervous to have the surveyor watching her and knew she had forgot to change her gloves and knew it was wrong. During an interview on 4/17/24 at 2:19 PM, the DON said staff should change gloves when going from a dirty to clean area during incontinent care and wash hands and/or use hand sanitizer with each glove change. The DON said CNA G should have changed her gloves and sanitized her hands after cleaning and applying moisture barrier under Resident #35's arms and breasts, then after cleaning feces from Resident #35's buttocks, then after applying moisture barrier cream to buttocks, then after applying moisture barrier to her front perineal area and inner thighs, and she should have removed her soiled gloves and sanitized her hands prior to handling the resident and items in her room. The DON said there was an increased risk of spreading infection without proper hand sanitation and changing gloves appropriately. During an interview on 4/17/24 at 2:55 PM, the ADM said staff should change their gloves anytime they are going from a dirty area to a clean area and when their gloves become soiled. The ADM said it was unacceptable for CNA G to not change her gloves and sanitize her hands prior to touching Resident #35's clean bare skin, clothing, clean brief, bedding, pillow, drinking cups, bedside table, and bed remote. The ADM said it was an infection control issue. Record review of the facility's Departmental Orientation titled Nursing-CNA, RNA revealed NA G began orientation on 2/09/24 and completed orientation on 2/09/24 and each item was to be checked off as completed . each item was to be fully explained, examples shown, and employee in-serviced on nursing responsibilities regarding . NA G was checked off on bathing (bed, tub, shower, partial, perineal care) . skin care (cleanliness, lotions/powders, massage, positioning) . cleaning procedures . Infection Control . cleaning/sanitizing of all work areas . hygiene (hand sanitizing, gloves) . isolation procedures/universal precautions . check off as completed, the employee must locate or demonstrate each of the following . NA G was checked off on . bathing . perineal care . personal patient hygiene, grooming, and care . proper hand sanitizing . and was signed by NA G on 2/09/24. 44933 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of face sheet printed 04/17/24 indicated Resident #6 was a [AGE] year-old, male and was admitted on [DATE] with diagnoses including colostomy status (is surgery to create an opening for the colon (large intestine) through the belly (abdomen)), Type 2 diabetes (is a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), quadriplegia (is a symptom of paralysis that affects all a person's limbs and body from the neck down), and urinary incontinence (the loss of bladder control). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #6 was understood and understood others. The MDS indicated Resident #6 had a BIMS score of 07 which indicated severe cognitive impairment. The MDS indicated Resident #6 required substantial/maximal assistance for oral hygiene, toileting hygiene, shower/bathe self, dressing, and personal hygiene. The MDS indicated Resident #6 was always incontinent of urine. The MDS indicated Resident #6 had an ostomy (is a surgery that creates an opening in the abdomen, changing the way that waste exits your body). Record review of a care plan dated 03/30/24 indicated Resident #6 was at increased risk for MDRO related to enhanced barrier precautions to be used (pressure ulcer). Interventions included before entering a resident's room with an EBP sign: gather all needed supplies and materials, clean hands correctly, put on a gown and gloves. After care, throw away gown and gloves, clean hands again. Finish all steps before moving on to another resident. Examples of high-contact resident care activities requiring gown and glove use for EBP included: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting. During an observation on 04/15/24 at 12:45 p.m., the WCN asked NA G to change Resident #6 so she could do his wound dressing change. NA G grabbed a bag of items to provide incontinent care, her and CNA J entered Resident #6's room. At Resident #6's door, was a plastic container with gowns and on the door was a Enhanced Barrier Precaution sign. During an observation on 04/15/24 at 12:50 p.m., NA G exited Resident #6's room and noticed the surveyor, WCN, and ADON were wearing gowns to enter another resident with EBP room. NA G stopped and said oops, I did not put that on for Resident #6. NA G went to the linen cart and got an item then reentered Resident #6's room without a gown. During an interview on 04/17/24 at 11:26 a.m., NA G said her, and CNA J did not wear gowns when they provided incontinent care for Resident #6 on 04/15/24. She said Resident #6 was on EBP for his colostomy and wound. She said there was a sign posted on Resident #6's door letting her know she needed to put in on before entering. She said she really did not understand why she had to wear a gown and gloves for EBP resident. She said she did not know the full reason why EBP was being used in the facility, but knew it was important. She said the EBP was done to protect the resident. She said she had been recently in-serviced on EBP. Record review of NA G's Departmental Orientation Nursing- CNA, RNA dated 02/09/24 indicated .check off each item as completed .each item is to be fully explained, examples shown, and employee in-services on nursing responsibilities regarding .check off completed for infection control .isolation procedures/universal precautions . Record review of CNA J's Nurse Aide Checklist dated 03/26/24 did not reveal a checkoff for isolation procedures. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a facility's in-service training topic Enhanced Barrier Precautions by the DON, dated 04/01/24 indicated .enhanced barrier precautions .everyone must: clean their hands, including before entering and when leaving the room .providers and staff must also: wear gloves and gown for the following High-Contact Resident Care Activities .changing briefs or assisting with toileting . NA G and CNA J signatures noted on attendance roster. 3. Record review of a face sheet printed 04/17/24 indicated Resident #7 was an [AGE] year-old, female and was admitted on [DATE] and 12/23/22 with diagnoses including dementia (a group of thinking and social symptoms that interferes with daily functioning), atrial fibrillation (is an irregular and often very rapid heart rhythm), and nutritional deficiency (occurs when the body is not getting enough nutrients such as vitamins and minerals). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #7 was understood and had the ability to understand others. The MDS indicated Resident #7 had a BIMS score of 06 which indicated severe cognitive impairment. The MDS indicated Resident #7 required substantial/maximal assistance for eating, oral hygiene, toileting hygiene, shower/bathe self, dressing, and personal hygiene. The MDS indicated Resident #7 was always incontinent for urine and bowel. Record review of a care plan dated 05/17/18, revised 03/14/24 indicated Resident #7 required substantial/maximal assistance with ADL's related to impaired mobility, impairment in range of motion in all extremities, use of wheelchair for locomotion and transfer by Hoyer lift. Intervention included total assist x1 for bed mobility and toileting. During an observation on 04/15/24 at 1:38 p.m., NA G and CNA A provided Resident #7 incontinent care. NA G held Resident #7 on her side while CNA A wiped Resident #7's bottom with gloves. After CNA A finished cleaning Resident #7, without changing gloves, she assisted NA G with turning Resident #7 on back. CNA A, then lifted Resident #7's leg and straightened the POTUS boot on her left foot with the same gloves. During an observation on 04/17/24 at 11:18 a.m., CNA A said she did not remember not changing her gloves after cleaning Resident #7 then, touching Resident #7 and her POTUS boot. She said when gloves were removed, staff should wash their hands or use hand gel. She said she should have changed her gloves before touching the resident for infection control. Record review of CNA A's Departmental Orientation Nursing- CNA, RNA dated 02/09/24 indicated .check off each item as completed .each item is to be fully explained, examples shown, and employee in-services on nursing responsibilities regarding .check off completed for bathing (.perineal care .) .check off completed for catheters (.indwelling .) .check off completed for Infection control .hygiene (.hand sanitizing, gloves .) . 4. Record review of a face sheet printed 04/17/24 indicated Resident #103 was a [AGE] year-old, male and was admitted on [DATE] with diagnoses including malignant neoplasm of bronchus or lung (is a kind of cancer that starts as a growth of cells in the lungs), secondary malignant neoplasm (cancer) of brain and bone, Crohn's disease (is a chronic (long-lasting) disease that causes inflammation in your digestive tract), and personal history of urinary tract infections (infections that happen when bacteria, often from the skin or rectum, enter the urethra, and infect the urinary tract). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Rose Haven Retreat		STREET ADDRESS, CITY, STATE, ZIP CODE: 200 Live Oak St Atlanta, TX 75551	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a baseline care plan dated 04/11/24 indicated Resident #103 required assistance of bathing and dressing. Intervention included assist with ADLs and assess for restorative. A comprehensive care plan was not completed due to Resident #103 being admitted to the facility less than 21 days ago. Unable to complete a record review of the MDS due to Resident #103 being admitted to the facility less than 21 days ago. No MDS for Resident #103 was completed prior to exit. During an observation on 04/15/24 at 2:34 p.m., CNA B and NA J provided Resident #103 with Foley care. CNA B cleaned Resident #103's groin area and catheter. CNA B asked Resident #103 to turn towards her so NA G could do the back. Resident #103 turned on his right side, CNA B moved Resident #103 covers from around his feet without changing gloves. CNA B with the same gloves, touched the bag her incontinent supplies were in. On 04/17/24 at 11:37 a.m., called CNA B and left message to return phone call. CNA B did not return my phone call before or after exit. Record review of CNA B's Departmental Orientation Nursing- CNA, RNA dated 02/09/24 indicated .check off each item as completed .each item is to be fully explained, examples shown, and employee in-services on nursing responsibilities regarding .check off completed for bathing (.perineal care .) .check off completed for catheters (.indwelling .) .check off completed for Infection control .hygiene (.hand sanitizing, gloves .) . 5. Record review of a face sheet printed 04/17/24 indicated Resident #18 was a [AGE] year-old, male and was admitted on [DATE] and 06/02/23 with diagnoses including chronic obstructive pulmonary disease (is a chronic inflammatory lung disease that causes obstructed airflow from the lungs), urinary tract infection (is an infection in any part of your urinary system: kidneys, bladder, ureters, and urethra), and Type 2 diabetes (is a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #18 was understood and understood others. The MDS indicated Resident #18 had a BIMS score of 12 which indicated moderate cognitive impairment. The MDS indicated Resident #18 required supervision for oral hygiene, toileting hygiene, shower/bathe self, dressing, and personal hygiene. The MDS indicated Resident #18 was always incontinent for urine and bowel. Record review of an acute plan of care for infection dated 01/09/24 indicated Resident #18 had diagnosis of UTI. Intervention included administer meds as per MD orders, monitor and report ill findings to MD as indicated. Record review of a care plan dated 04/01/24 indicated Resident #18 was at increased risk for MDRO related to enhanced barrier precaution to be used for ESBL. Intervention included gloves and gown prior to the high-contact care activity. Record review of a plan of care dated 04/05/24 indicated Resident #18 had UTI. Intervention included administer meds as per MD orders, monitor and report ill findings to MD as indicated. (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 #18's consolidated physician order dated 01/01/24-01/31/24 did not reveal contact isolation order. Record review of Resident #18's consolidated physician order dated 04/01/24-04/17/24 did not reveal contact isolation order. Record review of Resident #18's MAR dated 01/01/24-01/31/24 did not reveal contact isolation order. Record review of Resident #18's MAR dated 04/01/24-04/17/24 did not reveal contact isolation order. Record review of Resident #18's nurse's notes dated 01/10/24-01/16/24 did not reveal Resident #18 had been on contact isolation precaution due to ESBL in his urine. Record review of Resident #18's nurse's notes dated 04/04/24-04/12/24 did not reveal Resident #18 had been on contact isolation precaution due to ESBL in his urine. Record review of the facility's Infection Control Log dated 01/01/24-01/31/24 indicated .Resident #18 . infection related DX: UTI .Organism: Klebsiella Pneumonia .isolated: No . Record review of the facility's Infection Control Log dated 04/01/24 indicated .Resident #18 .Infection DX: UTI .isolated 04/04/24 . Record review of Resident #18's culture results dated 01/08/24 indicated .pathogens detected: High: Klebsiella Pneumonia .antibiotic notes: ESBL (Extended Spectrum Beta-lactamase) detected .antibiotic resistance genes .ESBL 1 . Record review of Resident #18's culture results dated 04/01/24 indicated .pathogens detected: Moderate: Klebsiella Pneumonia .antibiotic notes: ESBL (Extended Spectrum Beta-lactamase) detected .antibiotic resistance genes .ESBL 1 . Record review of Resident #18's 72-hour Antibiotic Time-Out dated 01/12/24 indicated .Resident #18 .UTI . strong odor .change antibiotic .DON . Transmission-based precautions was not selected. Record review of Resident #18's 72-hour Antibiotic Time-Out dated 04/04/24 indicated .Resident #18 .UTI . Transmission-based precautions: Contact .Enhanced Barrier Precaution .DON . During an interview on 04/17/24 at 8:50 a.m., the DON said they suspected Resident #18 was colonized (is the presence of bacteria on a body surface (like on the skin, mouth, intestines, or airway) without causing disease in the person) with ESBL in his urine. She said the doctor had order a urine culture after Resident #18 completed his antibiotics to see if he still tested for ESBL. She said normally if a resident tested positive for ESBL, the resident would be placed on contact isolation until antibiotic were completed then placed on enhanced barrier precautions. She said if a resident was placed on isolation, there should be an order in the resident's chart and the nurses should be documenting the resident being on isolation status in nurses note. During an interview on 04/17/24 at 9:00 a.m., Resident #18 said the only isolation he had been on was when he had COVID-19. He said he had not been on isolation for something growing in his urine. He said he mostly took care of his urine but sometimes staff emptied the urinal for him. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/17/24 at 10:51 a.m., LVN F said if a resident had a MDRO, she followed the physician order after the results were sent to the doctor. She said if the doctor ordered the resident to be on isolation, she would place the resident on isolation. She said isolation was important for resident with MDRO to prevent the transmission of the organism to the other residents. She said not isolating the resident risked spreading the MDRO in the facility. She said gloves should be changed after incontinent care was provided before staff touched the resident or the resident's stuff. She said it was important to change gloves, so germs were not spread. She said if staff touched items with contaminated gloves, then it risked some else touching the same area and spreading it. She said she tried to assist with incontinent care to monitor if the CNAs were providing correct incontinent care. She said gown and gloves were required for residents on EBP. She said residents with Foleys and wounds were placed on EBP. She said EBP was to prevent resident more susceptible to infection for getting an infection. She said no wearing gown and gloves during close care placed the resident at risked for an infection and exposure to germs. She said the resident could then need antibiotics or hospitalization . During an interview on 04/17/24 at 11:37 a.m., the DON said staff should wear gown and gloves for a resident on EBP and who had a MDRO. She said resident with devices such as catheters and wounds with dressing were placed on EBP. She said EBP was important to prevent the spread of infection. She said the DON and CNA coordinator should ensure staff were following the EBP guidelines. She said she tried to do in and out surveillance, but she could not be everywhere. She said the facility also educated the staff of EBP with in-service and video. She said she expected staff the remove their gloves after cleaning a resident then doing some form of hand hygiene. She said it was important to change gloves and perform hang hygiene to be aseptic. She said hand hygiene prevented infection and cross contamination. She said she sometimes observed CNAs perform incontinent care but mostly the CNA coordinator did the monitoring. During an interview on 04/17/24 at 11:56 a.m., CNA coordinator K said he had been in his position for 1-2 weeks. He said he was still working on observing the CNA's skills. He said he expected the CNAs to remove their gloves, perform hand hygiene then place new gloves on before touching the resident. He said it was important for infection control. He said just because something was not visible seen on the glove, did not mean something was not on them to spread. During an interview on 04/17/24 at 12:10 p.m., the ADM said not changing gloves after cleaning a resident then touching the residents and their items was not good infection control practice and had the potential to cause an outbreak in the facility. She said when staff provided direct care to resident on EBP, they were to wear a gown and gloves. She said EBP was important to protect the resident from infection and anything the staff may have on themselves. She said all staff knew to wear gown and gloves during direct contact for resident on EBP. She said the DON had done in-service of the topic. She said a resident with ESBL in their urine, should be placed on isolation. She isolation was important, so the infection did not spread. She said the Infection Control Preventionist was responsible for ensuring infection control was maintained in the facility. She said the DON was the Infection Control Preventionist. (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 the facility's policy titled Handwashing/Hand Hygiene with a revised date of August 2015 revealed . the facility considered hand hygiene the primary means to prevent the spread of infection . all personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections . all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections . wash hands with soap and water for following situations . when hands visibly soiled . use alcohol-based hand rub or soap and water for the following situations . before and after direct contact with residents . before donning sterile gloves . before moving from a contaminated body site to a clean body site during resident care . after contact with objects in the immediate vicinity of the resident . before and after entering isolation precaution settings . the use of gloves does not replace handwashing/hand hygiene . integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections . applying and removing gloves . perform hand hygiene before applying non-sterile gloves . Record review of the facility's policy titled Perineal Care with a revised date of October 2010 revealed . the purpose of the procedure was to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin . wash and dry hands thoroughly . put on gloves . for female resident . wash perineal area, wiping from front to back . wash rectal area thoroughly, wiping from the labia towards and extending over the buttocks . remove gloves and discard . wash and dry hands thoroughly . reposition the bed covers . make resident comfortable . Record review of a CMS Memorandum Enhanced Barrier Precautions in Nursing Homes dated 04/20/24 indicated .EBP recommendations now include use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status .EBP refer to an infection control intervention designed to reduce transmission of MDRO that employs targeted gown and glove use during high contact resident care activities . Record review of a facility's Isolation- Categories of Transmission-Based Precautions policy revised 01/2012 indicated .TBP shall be used when caring for residents who are documented or suspected to have communicable disease or infections that can be transmitted to others .TBP will be used whenever measures more stringent than Standard Precautions are needed to prevent or control the spread of infection .Contact Precautions .for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment .examples of infections requiring contact precautions included, but not limited to . infections with multi-drug resistant organisms .