STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675611	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Dallas	550 E Ann Arbor Ave Dallas, TX 75216

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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 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** 47743 Based on observations, interviews, and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for two (Resident #6 and Resident #7) of ten residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #6 and Resident #7's rooms were in a position that was accessible to the residents. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. Findings included: Resident #6 Review of Resident #6's Face Sheet, dated 09//25/2024, reflected that the resident was an [AGE] year-old female admitted on [DATE]. Resident #6 was diagnosed with muscle wasting, muscle weakness, and unsteadiness on feet. Review of Resident #6's Comprehensive MDS Assessment, dated 07/06/2024, reflected that Resident #6 had a moderate impairment in cognition with a BIMS score of 11. Resident #6 required substantial assistance for personal hygiene, toileting, and shower. Review of Resident #6's Comprehensive Care Plan, dated 07/27/2024, reflected Resident #6 was at risk for falls related to Alzheimer's disease and one of the interventions was to be sure the resident's call light was within reach. Observation and interview on 09/24/2024 at 9:44 AM revealed Resident #6 was in her bed, awake. It was observed that the resident's head of the bed was raised and the cord of her call light was dangling below the head of the bed. The resident's call light was observed pressed between the upper right corner of the mattress and the frame of the bed. She said she was looking for her call light earlier but could not find it. She said she cannot even find the cord of her call light. She said she did not know how her call light ended between the mattress and the bed. She said she would just holler if she needed anything. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with CNA C on 09/24/2024 at 9:58 AM, CNA C stated the call lights should be with the residents at all times because the residents used the call lights to let the staff know that they needed something. She said the call lights were the residents' lifeline. CNA C went inside Resident #6's room and saw the call light was not with the resident. CNA C pulled the cord of the call light and said she cannot pull it. she followed the cord and saw the call light was pressed between the mattress and the frame of the bed. She pulled the call light and put it where Resident #6 could reach it. She said she was not able to check the call lights during her initial round because she was running late. She said she would do her round and check if the call lights were with the residents. Resident #7 Review of Resident #7's Face Sheet, dated 09/25/2024, reflected that the resident was a [AGE] year-old male admitted on [DATE]. Resident #7 was diagnosed with muscle weakness, unsteadiness on feet, and blindness to both eyes. Review of Resident #7's Comprehensive MDS Assessment, dated 08/09/2024, reflected that Resident #7 had a severe cognitive impairment with a BIMS score of 05. Resident #7 required substantial assistance in toileting, shower, and dressing. Review of Resident #7's Comprehensive Care Plan, dated 09/02/2024, reflected that Resident #7 was at risk for falls related to blind to both eyes and one of the interventions was to be sure the resident's call light was within reach. Observation and interview with Resident #7 on 09/24/2024 at 11:16 AM revealed Resident #7 was in his bed, awake. It was observed that the resident's call light was hanging on the wall near the privacy curtain. The resident only shrugged his shoulder and smiled when asked where his call light was. Observation and interview on 09/24/2024 at 11:53 AM revealed the DOR went inside Resident #7's room and saw the resident's call light was hanging on the wall. The DOR took the call light from the wall and gave it to Resident #7. She said call lights were important for the resident because the residents use the call lights to call the staff if they needed something. Without the call light the staff would not know the residents needed something. In an interview with the DON on 09/25/2024 at 8:43 AM, the DON stated call lights were important for the residents and they should be placed where the residents could access them without difficulty. The DON said the call lights were the residents' mode of communication so they could tell the staff they needed something. She said, without the call lights, the residents' needs would not be addressed. She said all the staff were responsible in ensuring that the call lights were within reach. The DON said the expectation was for the staff to be mindful that the call light was in reach every time they left the residents' room. The DON said she would conduct an in-service about call lights. In an interview with the Administrator on 09/25/2024 at 9:11 AM, the Administrator stated the call lights should be with the residents always. The Administrator said the staff should be make sure the call lights were within reach. The Administrator said he would coordinate with the DON regarding call lights. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the ADON on 09/25/2024 at 10:37 AM, the ADON stated the call lights should be accessible to the residents at all times because the residents needed them to call the staff. The ADON said if the call lights were not within reach, the residents would not be able to call the staff and their needs would not be met. The ADON said the residents might be having an emergency and staff would not know. The ADON said the expectation was for all the staff to make sure the call lights were within the reach of the residents. The ADON said they would do an in-service about call lights being accessible to the residents. Record review of facility's policy Call Light/Bell Policy/Procedure - Nursing Clinical revised 05/2007 revealed Policy: It is the policy of this facility to provide the resident a means of communication with nursing staff . Procedures: . 5 . Place the call device within resident's reach before leaving the room.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observations, interviews, and record review the facility failed to provide a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for 6 (room [ROOM NUMBER], #2, #3, #4, #5, and #6) of 10 resident rooms reviewed for cleanliness and sanitization. The facility failed to ensure that Resident Rooms #1, #2, #3, #4, #5, and #6 were thoroughly cleaned and sanitized. This deficient practice could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life. Findings included: An observation on 09/24/24 at 12:57 PM of Resident room [ROOM NUMBER] reflected the bathroom floor had built up dirt particles along the walls. The base that the toilet sat on, had thick brownish stains along the front and sides. The air condition unit in the resident's room had dirt stains along the top of the unit and thick black dirt between the vents. The mini fridge in the room had a thick orange stain along the inside bottom. An observation on 09/24/24 at 12:59 PM of Resident room [ROOM NUMBER] reflected the base that the toilet sat on, had thick brownish stains along the front and sides. The air condition unit in the resident's room had dirt stains along the top of the unit and thick black dirt between the vents. The mini fridge in the room had a thick white dust along the top. An observation on 09/24/24 at 01:01 PM of Resident room [ROOM NUMBER] reflected the bathroom floor had built up dirt particles along the walls. The base that the toilet sat on, had thick brownish stains along the front and sides. The air condition unit in the resident's room had dirt stains along the top of the unit and thick black dirt between the vents. An observation on 09/24/24 at 01:03 PM of Resident room [ROOM NUMBER] reflected the bathroom floor had built up dirt particles along the walls. The base that the toilet sat on, had thick brownish stains along the front and sides. The air condition unit in the resident's room had dirt stains along the top of the unit and thick black dirt between the vents. An observation on 09/24/24 at 01:05 PM of Resident room [ROOM NUMBER] reflected the air condition unit had dirt stains along the top of the unit and thick black dirt between the vents. An observation on 09/24/24 at 01:07 PM of Resident room [ROOM NUMBER] reflected the air condition unit had dirt stains along the top of the unit and thick black dirt between the vents. The mini fridge in the room had a brownish stain along the inside bottom. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/25/24 at 09:41 AM, Housekeeping S stated she had been at the facility for 3 years. She stated they are supposed to clean all parts of the room, including the bathrooms and the air condition unit. She stated they are also supposed to dust, mop, and empty trash. She was shown pictures of the concerns observed in the resident rooms and she stated they were supposed to clean the air condition units, but she stated they did not have a good brush to clean the vents. She stated she tried cleaning the base of the toilets, but it was rust. She stated the risk to the residents was that the concerns observed was a hazard and could cause breathing issues. In an interview on 09/25/24 at 10:22 AM, the Housekeeping Supervisor stated she had been at the facility for [AGE] years and in her current position for 4 years. She stated housekeeping staff was supposed to clean bathrooms, floor, windowsills, air condition units. She stated the filter was cleaned once a week at the beginning of the month. She stated housekeeping did not clean out the mini fridges in the resident rooms unless they are very dirty. She stated the family member, or the CNAs clean the mini fridges out. She was shown pictures of the concerns observed in the resident rooms and she stated that there was no excuse and she had completed in services on 09/18/24 about properly deep cleaning the rooms. She stated the resident rooms are scheduled to be deep cleaned once a week. She stated the concerns observed could cause health problems for the resident. In an interview on 09/25/24 at 10:35 AM, the Administrator stated he had spoken with the housekeeping supervisor about the concerns observed in the resident rooms. He was also shown pictures of the concerns observed. He stated housekeeping was to clean all the areas of concern, including cleaning the inside of the resident's mini fridge. He stated the housekeeping supervisor takes her role very seriously and she will ensure that the concerns were corrected. He stated the concerns observed in the resident rooms could cause health problems for the resident. Review of the facility's policy on Cleaning and Disinfection of Environmental Surfaces (08/2019) reflected Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSHA Bloodborne Pathogens Standard. Review of the facility's policy on Environmental Services (November 2021) revealed To provide a clean, attractive, and safe environment for residents, visitors, and staff. High Dust Wall Articles: Damp Dust the Doors and Wall the tops of items along the resident's room and restroom walls (door frames, picture frames, clocks, over bed lighting, door closures, etc.) that are at or above your shoulder height. Clean and Disinfect the Room Furnishings: A. Clean all furnishings in the resident's room including the bed rails, IV poles, doorknobs, wheelchairs, walkers, and all other high contact surfaces.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 41211 Based on interview and record review, the facility failed to ensure residents in facility received adequate supervision and assistance devices to prevent accidents 1 of 5 residents (Resident #10) reviewed for accidents and supervision. The facility staff member failed to follow the facility's No Lift policy, which indicated the total mechanical lift will be used for individuals who can bear weight on their legs and can only offer minimal assistance with their transfers/lifts. The facility failed to provide assistive devices (mechanical lift) during transfers as required per their No Lift policy and after requested by Resident #10 and her POA on 04/04/24. After the inappropriate transfer, Resident #10 had uncontrolled pain (even after administration of opioid analgesic), was sent to the hospital via 911 and was diagnosed with a fracture. The facility failed to obtain accurate transfer status information from the referring facility prior to admission. On 4/04/24 Resident #10 was inappropriately transferred resulting in a right distal tibial spiral fracture. An Immediate Jeopardy (IJ) was identified and presented to the Administrator on 10/01/2024 at 1:36 PM. The IJ was lifted at 10/02/2024 at 7:00 PM. the facility remained out of compliance at a severity level of actual harm and scope of isolated, due to the facility's continued monitoring of the effectiveness of their plan of removal. This failure could place residents at risk of serious injury resulting from improper transfer technique. Findings Included: Record Review of Resident #10's Face Sheet dated 03/29/2024 revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included osteoarthritis, hemiplegia and hemiparesis affecting her left side resulting from a stroke (unknown date, but not recent). She had a surgical history of knee replacement to her right knee [AGE] years prior. Record review of referral information from previous facility indicated that resident #10 was a moderate assist of 1 or 2 persons and that she was only able to provide minimal assistance due to left sided hemiplegia (weakness to left side). No incident report was completed by the facility staff for this incident per the DON due to the resident's transfer to the hospital for evaluation, and no incident report was completed after the incident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #10's Admission Minimum Data Set (MDS) dated [DATE] revealed her cognition was intact with a Brief Interview of Mental Status (BIMS) score of 15. She was impaired of upper and lower extremities on one side. She was dependent for total assistance for sit to stand and transfer from chair/bed transfers to bed. She was wheelchair bound and required total assistance with shower/bathing and personal hygiene. Resident #10 was always continent of bladder and bowel. Record review of Resident #10's Care Plan Review, dated 04/03/2024, revealed she had limited mobility, hemiplegia, musculoskeletal impairment, impaired balance, pain, limited range of motion, stroke, she was at risk for falls related to gait balance problems, she had acute/chronic pain related to arthritis, and persistent right knee pain with a history of total knee arthroplasty (a surgical procedure that replaces a damaged knee joint with prosthetic components.) which was over twenty years ago. Physical examination by the facility medical director 0on 04/04/24 noted that she may have been experiencing excessive wear of hardware, and possible loosening of hardware. It was recommended she follows up with orthopedic provider a to formally evaluate right knee with imaging and full evaluation. Other recommendations included Patient will continue Norco (hydrocodone) regimen per facility attending (physician). Record review of Resident #10's Progress Note by LVN F, dated 04/03/2024 at 6:13 PM, revealed: Resident transferred via WC with attendant from a transport service. with belongings. Vitals at this time is T-98.3, P-78, R-17, BP-145/76. O2 @ 96% on room air. Meds verified with the AP (Attending Physician) to see resident tomorrow. no complaints of pain at this time, head to toe done skin intact, clean, and dry, resident is incontinent of bowl [sic] and bladder. alert and oriented x 2. resident oriented to facility at this time. bed in lowest possible call light within reach. Record review of Resident #10's Progress Note by LVN F, dated 04/04/2024 at 9:26 PM, revealed: Change in Condition: Symptoms or signs noted of Condition change: Pain (uncontrolled) Vital Signs: BP 151/66 - 4/4/2024 11:23 Position: Lying r/arm, P 79 - 4/4/2024 11:23 Pulse Type: Regular, R 17.0 - 4/3/2024 18:43, T 98.3 - 4/3/2024 18:43 Route: Forehead (non-contact), O2 96.0 % - 4/3/2024 18:43 Method: Room Air Notifications: Reported to primary care clinician: Physician's Assistant (PA), Date and time of clinician notification: 04/04/2024 4:09 PM, Name of family member or resident representative notified: Power of Attorney (POA) (at bedside), Date and time family or representative notified: 04/04/2024 4:00 PM. Record review of Resident #10's Progress Note by LVN F, dated 04/05/2024 at 11:19 AM, revealed the resident was hospitalized . Review of Resident #10's clinical records from 09/30//24 to 10/02/24 revealed there was no assessment completed PT/OT to determine her weight bearing status during her stay at the facility nor prior to her discharge to the hospital . Record Review of page 1 of the Discharge Summary Brief Overview from the hospital dated 04/16/24, revealed the resident was admitted on [DATE] and discharged on [DATE]. Primary Discharge Diagnosis was Fracture of right tibia. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record Review of page 14 of the Discharge Summary Brief Overview from the hospital dated 04/16/24, revealed the report from Radiology: X-ray Ankle 3+, Result Date: 4/6/26 IMPRESSION: 1. Spiral fracture of the distal shaft of the tibia Finalized by MD on 04/06/2024 4:03 X-ray Tibia Fibula 2 View Right, Right, Result Date: 4/6/2024, Result Date: 4/6/2024, IMPRESSION: 1. Spiral fracture of the distal shaft of the tibia. Record review of Details of Hospital Stay dated 04/16/24 revealed Resident #10 had an elevated risk for surgery due to Cardiac disease. As a result of her cardiac risk, the orthopedic specialist opted to pursue nonoperative management of her fracture and placed a brace on her right leg and ordered non-weight bearing status for 6- 8 weeks. In an interview on 09/27/24 at 3:08 PM with Resident #10's Family Member, she stated on 04/04/24, Resident #10 was complaining about the mattress on her bed. Then a short, dark skinned African guy brought in another mattress, and he began to try to pick her up by lifting her up under her arms. She stated when she saw how he was going to try to get her up, she told him that he could not do it like that, because it was not safe, and he needed to get someone to help him or get a lift and the resident agreed with her. She stated he said, I'll do it, I can do it. She stated he continued to get her up by lifting her under her arms and when he got her up, he almost dropped her. She stated he hurried up and twisted her around to get her in the chair and he basically dropped her into the chair. She stated right then, she hollered out and said she felt something pop and she was screaming and crying really bad. She stated it made her cry. She stated a middle-aged woman was present in the room and she was attending to another resident who was in the room. She stated a little white or Hispanic man was standing in the doorway. She stated once he got her in the chair, he left the room. She stated he did not try to see about Resident #10, he just walked out of the room. She stated neither the female staff nor the guy in the doorway came to see about Resident #10. She stated a little bit later, the man who was in the doorway came back with a pain pill and gave it to the resident. She stated he then went and called 9-1-1 and the paramedics came to take the resident to the hospital. She stated she arrived at the facility to visit Resident #10 around 2:30 PM. She stated the transfer happened close to 4:00 PM. In a follow-up interview on 09/27/24 at 3:45 PM with Resident #10's Family Member, she stated she called the next day and spoke to a lady, but she did not remember the name or title. She stated she told the lady that Resident #10 was in the hospital and the lady told her that someone would call her back the next day, but no one ever did, and she did not try to call the facility back. In an interview on 09/30/24 at 1:50 PM with Resident #10, she stated she did not know why the guy was bringing another mattress to her. She stated she just knew that it was a dark, heavy-set guy. She stated he was a big guy. She stated he was tall to her. She stated he came in with a mattress and he said she would have to get out of the bed, so he could change out the mattresses. She stated he then started pulling her up with his hands. She stated he was pulling her up by holding her under her arms. She stated he was moving too fast, and she was telling him that he needed to get a slip for her and use the lift. She stated her family member also told him the same thing. She stated he did not listen to her either. She stated she kept telling him not to bend her leg, but he did it anyway and that was when she felt the pop. She stated she could not remember what time of day it was. She stated after thinking about it, she believed it happened during the middle of the day, around 2:00 PM. She stated she knew for sure that she was lying in bed and her family member was sitting near the bed. She stated she was not in pain prior to man getting her out of bed. She stated she and her family member were just sitting there talking prior to the guy coming in the room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 09/30/24 at 9:38 AM with the Central Supply Clerk, she stated if a resident needed something like a mattress switched out, it would go through her. She stated the nurse would verbally communicate that request to her and then she would locate another mattress and bring it to the floor and change it out. She stated if the mattress was somewhere further away from the room which it needed to go to, then one of the maintenance staff would assist by retrieving the mattress and bringing it to the floor of the room and then she would be the one to take it to the room and change it out. She stated only herself would be the one to change the mattresses. She stated that was her sole responsibility. She stated there have been times when she has instructed the maintenance staff to meet her at the room and then they might bring the mattress into the room, and she would still be the one to remove the current mattress and then replace it with the one which was brought to the room. Then they would take the old mattress out and store it. She stated she remembered Resident #10 and she stated the maintenance staff, who did not match the description of the person who transferred Resident #10, did bring it to the room and she was the one who placed it on the bed frame. She stated when she entered the room, the resident was sitting in a wheelchair and so she went ahead and took the air mattress off the bed frame and when the replacement mattress was brought in, she was the one who put it on the bed frame. She stated she removed the air mattress from the room. An interview with the Administrator on 09/25/24 at 12:05 PM, he stated when they have a new admission, the care information was obtained by the nurses. He stated they are responsible for communicating with the previous facility or hospital from which the resident was coming from. He stated information was shared with the aides. He stated they have been doing it this way for a very long time and there had not been any incidents. He stated the information was placed where any of the staff could access it and know how to care for the new resident. He stated the Progress Notes which they received from the previous facility stated the resident was moderate assist x1, which meant the resident only needed one person. He stated C.N.A. G had never had an incident while transferring residents. He stated they go by what was done at the previous facility or hospital, until facility staff can complete their own assessments. Then that information was entered into the system and shared with other staff. He stated they did not have a policy for this process, because there has not been a need to have one for this issue. He stated based on the information which they received from the previous facility, he believed C.N.A. G did what he was supposed to do. An interview with the DON on 09/25/2024 at 12:09 PM, she stated she was not familiar with Resident #10, and she needed to see the resident's records. She stated LVN F was the floor nurse who entered the assessments for the resident. She stated LVN F was no longer at this facility but was working at a sister facility. She stated he did not report anything to her about the resident's injury. She stated had the resident been injured, it would have been documented in Progress Notes and it would have been reported to Health and Human Services Commission (HHSC). She stated the records from the hospital or facility, which the resident transferred from, would have gone to the nursing department. She stated the Social Workers (SW) would have done initial assessments with the resident, upon admission. She stated when a resident comes from a hospital or another facility, they would refer to those records for indications on the resident's care, until they could complete their own assessments. She stated transfer needs would be included in what they would reference from the hospital or former facility's records. She stated that the resident's transfer information would be in LVN F's notes and/or could probably be obtained from the Director of Rehabilitation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the SW on 09/25/2024 at 12:33 PM, she stated she did not remember the resident. She stated she would have to look at her notes. She then stated the SW would conduct an initial assessment by speaking with the resident or their representative. She stated the assessment is a collection of information which they get during that interview. She stated those notes are taken and translated into a Social Services Progress Note. She stated any transfer needs would be provided by the Director of Rehabilitation. An interview with the PA on 09/25/2025 at 3:55 PM, She stated she did not remember the incident. She stated by looking at the Progress Notes, she was notified, but she did not remember it. She stated she was not familiar with Resident #10 because she never got the chance to see her. She reviewed the resident's chart and stated given her being hemiplegic and her size, and the fact that she had not ambulated for a number of years, she would imagine that the resident would require adequate assistance for transfers and mobility. She stated staff should have referred to the transfer notes from the resident's previous facility. She looked through the notes from the previous facility and could not find anything referencing transfers. She stated staff should have at least listened to the resident, given that her cognition was intact, and she was able to communicate to the staff who was assisting her, that he should have help with assisting her with her transfer to the wheelchair. She stated, especially since there was no documented reference as to how to transfer her, CNA G should have listened to the resident. She stated with Resident #10 being overweight, paralyzed on the left side and the right knee was problematic and the notes under Functional Performance, dated 04/03/2024 revealed, the resident was non-weight bearing on her right leg, she should have at least had a two-person assist with transfers. In a follow-up interview on 09/26/2024 at 11:12 AM with the DON, she stated the floor nurse was supposed to ask for specifics, such as ADL care, including transfers when considering new admissions. She stated if they have someone new come in, they should 1.) use information from where the new admit came from, and 2.) use clinical decision making. She stated depending on the resident's cognition level, the resident could also tell them how they have received care previously. She stated if staff do not use informed methods to transfer a resident, injury could occur. (continued on next page)

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	675611	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Dallas	550 E Ann Arbor Ave Dallas, TX 75216

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 09/26/24 at 12:32 PM with the ADON, he stated when a new resident is coming in, they take a verbal report from the facility that they are coming from. He stated they have a temporary report sheet which they write the information on. He stated this template was only used for their initial assessment and getting information that they need to know about the in-coming patient. He stated it includes everything about the patient, including when they had their bowel movement, are they mobile, do they used some type of device, or do they ambulate independently. He stated whatever they need to relate to the Certified Nurse Aides (C.N.A.) and the rest of the staff, was then shared from that report sheet. He stated the report was usually done prior to the resident coming to the facility. He stated once the resident comes to the facility, they also use that report sheet to do their head-to-toe assessment. He stated the assessment includes if they can stand, ambulate, how far can they ambulate, and do they require a device to ambulate. He stated if he does not know anything about the person, when he walks into the room, and if that person cannot tell him how they need to be transferred, he is going to assume they are a two-person assist or a two-person lift. He stated a two-person lift means they are going to use a mechanical lift. He stated if he saw a sling underneath the resident, that would tell him that the resident requires a two-person lift and he would go get the mechanical lift and call for a co-worker. He stated if he did not see a sling under the resident, he would assume they are a one-person assist and could stand or give some type of assistance with pivoting. He stated when he went to the room to introduce himself, Resident #10's family member was present. He stated he thought she had an immobilizer on her right leg; however, he could not be sure. He stated the resident's family member told him that even though she had an immobilizer on her right leg (unsure if it was right or left leg) the resident could stand a little bit and bear weight. He stated the family member told him that she was having some pain and that the previous facility had had an X-ray on the resident's right knee done just a few prior to her coming to this facility. He stated the resident's family member told him that the resident could stand a little bit, by standing on her right side, but not for long. He stated he was assuming that maybe that was what CNA. G used, to determine how to transfer Resident #10, however, he was not sure if that was true. He stated when he met Resident #10, he did not see CNA G. He stated LVN F may have relayed that information from the resident's family member to CNA G. He stated when he met her, she was not complaining of pain to him. He stated he knew she was taking was taking Norco and was taking it routine and prn. He stated if nursing staff did not have the information on the resident prior to them arriving to the facility, or if no one told him how to transfer a newly admitted resident, and they had not received the report from the previous facility, he stated he would go by what the resident told him. He stated he would ask if the resident was able to stand and/or walk, if the resident was alert and oriented, he would ask them. He stated the questions staff could ask a new resident are, Can you stand? Will you be able to help me, get you over there or to the wheelchair? He stated if the resident were to say, No, then staff would need to ask the resident to wait and then the staff should go get a co-worker to assist. He stated if Resident #10's family member did tell C.N.A. G that the resident could help him transfer her and he was unsure, he could have asked the resident some clarification on her abilities and requirements before trying to transfer her alone. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 09/26/24 at 2:02 PM with the Attending Physician, he stated he referred to the Progress Notes from the previous nursing facility and stated the notes read that Resident #10 was mod assist x1 with functional transfers. He also stated that the notes read that Resident #10's legs would swell when she tries to stand, so they (facility) knew that she could put weight on her legs. He stated Resident #10 told him that she could not walk, which made sense, but as far as transfers are concerned. He stated she complained of right knee pain and the notes spoke of multiple negative X-rays of the right knee; however, the X-rays were only of the knee. There were also notes from the doctor, which read that she needed to be seen by an Orthopedist for possible hardware loosening. He stated when he saw her, she did not say anything about that, as bothering her, in particular. He stated she was pleasant and interactive. He stated she had chronic pains, but she did not focus on that leg during their interview. He stated she did tell him about her shoulder and knee pains and that she could not push on a wheelchair. She stated her shoulder limited her from self-propelling in a wheelchair. He stated she did not say anything about how she usually transfers. He stated he specifically asked her when the last time was that she walked, (because that tells him a lot about how functional a person was going to be. He stated it told him whether they will be wheelchair dependent.) He stated she told him that she had not ambulated, meaning walking, in years. He stated he did not see an immobilizer on her leg when he talked to her. He stated she was sitting in a couch-like chair, watching tv. He stated if there was no other information to go by, it was reasonable to believe that a one-person transfer was feasible. He stated the notes reflected that she was standing at the other facility, and she was moderate assist x1. He stated he did not see why she could not transfer her with one person. He stated there was no trauma reported, meaning just because there was a fracture, it did not mean it came from being plopped down into a chair. He stated given that only the knee was X-ray at the previous facility, while she had been complaining about knee and leg pain, who is to say that the fracture did not happen at the previous facility. He stated, it's the chicken vs the egg kind of thing because he did not know if the fracture was already there or not. He stated given the location of the fracture (distal tibia); it would not have been seen on a knee X-ray. He stated they (facility) did not get very clear information from the previous nursing facility, about activity in terms of whether she needed assistance, or whether she needed a Hoyer. He stated what was provided revealed she was doing standing with therapy, because the notes indicated that her legs got swollen while she was standing. He stated also, the notes stated she was moderate assist x1; which tells us that she was able to bear weight on both her legs. He stated if the resident was able to bear weight and was transferred incorrectly it could have prompted a new fracture, a refracture, or exacerbated an existing fracture that anyone was even aware of. He stated she was not at the facility long enough (facility) to decipher what was going on with her. He stated there are multiple dependent to factors when a new patient was admitted to the facility. He stated what does the paperwork say, was the patient oriented, can they tell what was necessary and what is not. He stated days before Resident #10 arrived at the facility, the notes provided from Occupational Therapy (OT) stated she was moderate assist x1 with transfers. He stated in worst case scenario, you do not know if there was hesitancy for anything then yes, wait until therapy can evaluate. He stated he has had patients who can just get up and go with a walker, but they are obviously demented. He stated there are a lot of factors that come into play when you are making a decision. He stated he could not be more help because he only saw her once. He stated if she had been there longer, who is to say that while she was at the facility, they would not have X-rayed her leg. He stated he did not know why the former facility did not X-ray more than just the knee. He stated you can have radiating pain. He stated you can have hip pain radiating to the knee, you can have ankle pain radiating to the knee. He stated he did not know why they only focused on the knee and not anywhere else, especially since the pain was persistent. He stated the notes indicated that the resident's activity had decreased. He stated the physician made note that he had referred her to an Orthopedist, but she never got to go because she left the facility. He stated the Orthopedist probably would have X-rayed her leg. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 09/26/24 at 2:59 PM with C.N.A. G, he stated he started his shift at 2:00 PM. He stated about 2:30 PM, a female C.N.A. was standing at the door of Resident #10's room and called for him to come help her. He stated when he came to the room, the female aide left to get something, but he was not sure what. He stated the family member told him the resident could help him get her into bed. He stated Resident #10 then said she could stand a little and could help him. He stated when he entered the room, Resident #10 was sitting in the wheelchair and it was near the bed, but not right next to the bed. He stated her family member was standing next to her, kind of between the chair and the bed. He stated the family member told him that the resident wanted to get back in bed because she was in pain. He stated she was not crying, but she was whining and grunting. He stated her family member was rubbing her side and back and telling her it was ok and that she was about to be put back in bed. He stated he moved the wheelchair next to the bed and then he used a gait belt to help lift her from the chair and then he helped her into bed. He stated the resident had already started to try to push herself up on one side and he told her to wait for him to help her. He stated the resident was holding on to his arms and the gait belt was still behind her and he held it to help him steady her. He stated she took about two steps and then she was turned to where her back was to the bed, and she was against the bed. He stated she had to step to the left to get to the bed. He stated the bed was low, so she was able to just sit on the bed without having to have to scoot back onto it. He stated when he came in the room, she was already whining, and her family member said she was in pain. He stated when he finished transferring her into bed, he went and told the nurse that she was complaining of pain. Then he went to answer another call light. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 09/27/24 at 11:15 AM with LVN F, he stated he did not have many interactions with Resident #10. He stated he was the admitting nurse. He stated she was quiet when she arrived. He stated he remembered having to call her previous nursing facility several times to get report on her because they were not returning his calls. He stated he finally received report on her after she was admitted . He stated one person brought the resident into the facility and she was in a wheelchair. He stated he and an aide transferred the resident to the bed. He stated he could not recall what the paperwork stated as far as how many people were required, but he used two people just to be safe. He stated Resident #10 told him that she was uncomfortable in the wheelchair after a while, and that's when he and an aide transferred her onto the bed. He stated his shift ended at 10:00 PM on 04/03/24. He stated she was still in bed when he got off shift. He stated on 04/04/24, his shift started at 2:00 PM. He stated the off-going nurse reported to him that Resident #10 was out of bed and in her wheelchair. He stated the nurse told him that the resident had been uncomfortable on and off but not to the point of excruciating pain. He stated when he went to see her for the first time that day, the resident told him that she wanted to get back in bed. He stated she did not ask for any medications at that time. He stated there were two aides on shift, and he called for them to transfer her back into bed. The female came first, but then he told C.N.A. G to do it. He stated he was ok with C.N.A. G transferring her alone, because he himself had had time to review her admission paperwork and it said that she was a x1 person assist. He stated when C.N.A. G finished transferring her, he (C.N.A. G) came to him and told him that the resident was in pain from being uncomfortable in the chair. He stated he went to assess the resident and she told him that she was in pain, so he went to get the medication for her. He stated the way she was expressing her pain; he could see that it was more intense than the day before. He stated he checked her orders and then administered pain medication first, then he contacted the PA. He stated the PA told him to send her to the hospital. He stated the admission process was that the nurse would receive a report from the facility or hospital that the new resident was coming from. He stated they verify the transportation method, which the resident would be arriving in. He stated the ADONs enter the care information in the Kardex. He stated some stations enter it in a binder, while others enter it into the system. He stated the C.N.A.s and other nurses receive report from the admitting nurse or the ADON. He stated the kitchen was notified of the new resident's dietary needs. He stated medications are ordered. He stated housekeeping was notified, so they can make sure the room is ready. He stated when the new resident arrived, the admitting nurse will greet them and take them to their room. Then the residents are interviewed, and vitals and weight are taken. Then they see if the resident wants to remain in their wheelchair or get in bed. He stated once the resident was made comfortable, then the nurse was to document the information which they received from the resident during that initial interview. Then the nurse will begin assessments on the resident. Record review of the sign-in schedule for all shifts from 04/03/24 and 04/04/24, revealed six of nine staff who were responsible for the resident, no longer worked at the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 09/27/24 at 12:48 PM with CMA I, she stated she was on shift when Resident #10 was admitted on [DATE]. She stated she thought it was around lunch time when Resident #10 arrived at the facility, she introduced herself to the resident to make her feel welcome. She stated a lady from the transport service brought the resident into the facility. She stated she was sitting in a wheelchair. She stated the transport driver was talking to LVN F for a little while. She stated staff brought the rest of the resident's belongings in and LVN F took her to her room. She stated the resident was calm and was not complaining of pain at that time. She stated LVN F returned to the nurses' station and entered her information in the system. She stated a little later on, the resident asked for a pain pill, and she checked the system and saw that it was time for another pain pill, so she administered the medication to her. She stated the resident had been getting that pain medication twice a day at the other facility. She stated the aides had put her in bed and she was asleep, by the time she got off shift at 8:00 PM. She stated to her knowledge, the resident had not complained of pain the rest of the night. She stated when she came to work the next day, the resident had already been sent to the hospital. On 09/27/24 at 1:20 PM a call was made to LVN J, there was no answer. A voice message was left. In a follow-up interview on 09/27/24 at 5:00 PM with C.N.A. G, he stated he was in the hall and was called to the room by the older female aide. He stated the female aide started talking to the roommate when Resident #10 and her family member told him that Resident #10 could stand a little bit and could help him transfer her from the [TRUNCATED]

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50444 Based on observations, interviews, and record review, the facility failed to ensure that all drugs and biologicals were accurately dispensed and administered to meet the needs of each resident when 1 (Resident #8) of 3 residents were reviewed for pharmaceutical services. Resident #8 had 1 oblong white pill in a medicine cup on the nightstand that Resident #8 had not taken. This failure could place residents at risk of not receiving their medications as ordered by their physician. Review of Resident #8's Face Sheet, dated 09/24/24, reflected that Resident #8 admitted [DATE] with chronic venous insufficiency (veins in legs are damaged and cannot pump blood back to the heart properly), chronic osteomyelitis (bone infection) in tibia and fibula (bones in lower leg) of left leg, and localized swelling, mass and lump, of left lower leg. Review of Resident #8's physician's order, dated 03/30/23, reflected an order for HYDROcodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth two times a day for chronic pain. Review of Resident #8's Quarterly MDS (Minimum Data Set: assessment of functional capabilities and health needs) Assessment, dated 08/30/24, reflected that Resident #8 was cognitively intact with a BIMS (Brief Interview for Mental Status: tool used to track cognitive decline or improvement) score of 15. Resident #8 received a scheduled pain medication regimen. Review of Resident #8's Care Plan, dated 07/29/24, reflected that Resident #8 was currently prescribed an Opioid for Pain. Resident at risk for potential for adverse outcomes from opioid use. Interventions for this focus was to Administer opioid as prescribed and the Expected benefit of opioid use is to reduce acute/chronic pain conditions. An observation and interview on 09/24/24 at 09:43 AM revealed a medicine cup, with a white oblong pill in it, on Resident #8's nightstand. Resident #8 stated that a nurse brought the pain pill about 8:00 PM the evening before. Resident #8 stated that she told the nurse to leave the pain pill and that she would take it later. Resident #8 stated that she was tired and forgot to take it. Resident #8 stated that a night shift CNA came into the room about 4:00 AM that morning and found the pill lying on Resident #8's chest. Resident #8 stated that the CNA put the pill in the medicine cup and placed it on the nightstand. Resident #8 stated that she knew she would get a pain pill with her morning medicine and did not want to double up. Resident #8 stated that a wound on the left leg bothered her at times, but that she did not have pain because of the missed dose. LVN A was in the hall at the time, passing medication, and was notified about the pill left in Resident #8's room. LVN A stated that the medication should not have been left in the room and LVN A immediately went to Resident #8's room and got the pill. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview 09/25/24 at 9:05 LVN A stated that the pill left in Resident #8's room was hydrocodone-acetaminophen 5-325 mg (a narcotic pain medication). LVN stated that she had put the pill in the sharp's container and reported the incident to the ADON. LVN A stated that that resident received this medication twice a day, once in the morning and once in the evening. LVN A stated that the Resident #8 could have experienced pain because of the missed dose. LVN A stated that a confused resident could have wandered in the room, thought it was candy, and took it. LVN A stated that it was important to stay in the room and be sure a resident did not choke while swallowing their medication. During an interview the DON at 09/25/25 at 09:25, she stated that the night nurse should have watched the resident take the medication before leaving the room. The DON stated that this incident was reported to her, and that she had already in-serviced the nurses about this. During an interview on 09/25/24 at 02:10 PM, CNA B stated that if she found medication in a resident's room, she would immediately take it to the nurse. Review of the facility policy, revised July 2020, and titled Nursing Services: Administration of Drugs, stated that Medications are administered within prescribed time frames.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based observations, interviews, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for five (Resident #1, Resident #3, Resident #4, Resident #5, and Resident #9) of eleven residents observed for Infection Control. 1. The facility failed to ensure that CNA B changed her gloves and performed hand hygiene while providing incontinent care to Resident #1. 2. The facility failed to ensure that LVN A would not bring a plastic container containing push button lancets (small, sharp needle used to prick the skin and draw blood), a container of test strips, and alcohol wipes inside Resident #3, Resident #4, and Resident #5's room when she checked the residents' blood sugar. 3. The facility failed to ensure that CNA D and CNA E changed gloves and performed hand hygiene while providing incontinent care to Resident #9. These failures could place the residents at risk of cross-contamination and development of infections. Findings included: 1. Review of Resident #1's Face Sheet, dated 09/25/2024, reflected that the resident was an [AGE] year-old male admitted on [DATE]. Resident #1 was diagnosed with cystitis (inflammation of the urinary bladder) and acute kidney failure. Review of Resident #1's Quarterly MDS Assessment, dated 06/11/2024, reflected that Resident #1 had a severe impairment in cognition a BIMS score of 04. Resident #1's Quarterly MDS Assessment indicated that the resident was incontinent for bowel. Review of Resident #1's Comprehensive Care Plan, dated 08/28/2024, reflected that Resident #1 has bowel/bladder incontinence related to benign prostatic hyperplasia (enlarged prostate) and one of the interventions was check as required for incontinence. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with CNA B on 09/24/2024 at 1:26 PM revealed CNA B was about to do Resident #1's incontinent care. She put on her gloves, opened a brief, and put it on the other bed. She also put some wipes beside the brief. CNA B raised the bed, lowered the head of the bed, and pulled the resident's blanket towards the feet of the resident. She did not wash her hands before putting on her gloves. She unfastened the tape of the brief on both sides and tucked the front part of the brief in between the resident's legs. CNA B pulled some wipes and started to clean the front part of the resident. After cleaning the front part of the resident, she rolled the resident towards the right and the cleaned the resident's bottom. After cleaning the resident's bottom, CNA B rolled the soiled brief and the bed padding altogether towards the middle of the bed. After rolling the soiled brief and padding, CNA B rolled back the resident and instructed the resident to roll to the other side. After rolling the resident to the other side, CNA B pulled the soiled brief and padding and threw them in the trash can. CNA B took the new brief and put it at the bottom of the resident and fixed it. CNA B did not change her gloves nor sanitize her hands before touching the new brief. CNA B rolled the resident back and said she would clean the resident's front part again. At this point, she pulled the trash can near her, pulled some wipes, and cleaned the resident's front part again. She did not change her gloves nor sanitize her hands after touching the trash can. After cleaning the front part of the resident again, she threw the soiled wipes, fixed the new brief, and taped the brief on both sides. She did not change her gloves nor sanitize her hands after cleaning the resident again and before touching the new brief. She then pulled the resident's blanket towards the resident's chest, tied the plastic bag that was in the trash can into a knot, and went out of the room. She did not wash her hands before going out of the room. CNA B stated hands should be washed or sanitized before and after doing incontinent care. She said the hands should also be sanitized before putting on clean gloves. CNA B said hand hygiene was important to prevent the spread of germs. She said she should have done hand hygiene and changed her gloves after touching the soiled brief, after cleaning the resident's bottom, after touching the trash can, and before touching the new brief. She said not doing hand hygiene and not changing her gloves after touching soiled items could cause cross contamination and infection. She said she had in-services about hand hygiene almost every month. 2. Review of Resident #3's Face Sheet, dated 09/25/2024, reflected that the resident was a [AGE] year-old male admitted on [DATE]. Resident #3 was diagnosed with type 2 diabetes mellitus (body has higher sugar level). Review of Resident #3's Comprehensive MDS Assessment, dated 09/20/2024, reflected Resident #3 was cognitively intact with a BIMS score of 14. The Quarterly MDS Assessment indicated diabetes mellitus as one of Resident #3's active diagnosis. Review of Resident #3's Comprehensive Care Plan, dated 09/2/2024, reflected Resident #3 had diabetes mellitus and one of the interventions was to give diabetes medications as ordered. Review of Resident #3's Physician's Order, dated 07/08/2023, reflected Insulin Regular Human Injection Solution (Insulin Regular (Human). Inject subcutaneously (administer under the skin) with meals for diabetes check FSBS before meals, inject insulin only if actively eating meal; give HS snack. (continued on next page)

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	675611	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Dallas	550 E Ann Arbor Ave Dallas, TX 75216

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 09/24/2024 at 11:21 AM revealed LVN A was preparing to check for the blood sugars of the residents on her hall. She said she would do Resident #3's blood sugar first. She went to Resident #3's room, sanitized her hands and the glucometer. LVN A had a square plastic container which contained blood glucose test strips, lancet push buttons, and alcohol wipes. She also put the glucometer on the plastic container. She went inside Resident #3's room, brought with her the plastic container, and placed it on top of the resident's bed. She wiped the resident's right pointing finger, pricked it with a lancet push button, and scooped the blood with the test strip. After pricking the resident's finger, she threw the lancet push button on the plastic container. She said the resident's blood sugar was 255. She went back to her cart and put the plastic container on top of her cart. She logged on to her computer and said the resident would receive 4 units of insulin. She opened the right drawer of her cart and took the resident's insulin. She cleaned the top of the vial, took a syringe for insulin, and drew 4 units of insulin. After getting 4 units of insulin, she returned the vial of insulin back to the drawer. She went inside the room and injected the insulin on the left upper arm of the resident. She was not wearing any gloves when she injected the insulin. Review of Resident #4's Face Sheet, dated 09/25/2024, reflected that the resident was a [AGE] year-old male admitted on [DATE]. Resident #4 was diagnosed type 2 diabetes mellitus. Review of Resident #4's Comprehensive MDS Assessment, dated 08/05/2024, reflected Resident #4 had a moderate impairment in cognition with a BIMS score of 09. The Quarterly MDS Assessment indicated diabetes mellitus as one of Resident #4's active diagnosis. Review of Resident #4's Comprehensive Care Plan, dated 08/05/2024, reflected Resident #4 had diabetes mellitus and one of the interventions was to give diabetes medications as ordered. Review of Resident #4's Physician's Order, dated 01/24/2024, reflected Insulin Aspart Flex Pen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart) Inject subcutaneously with meals for Hyperglycemia (too much sugar in the blood) related to TYPE 1 DIABETES MELLITUS WITH UNSPECIFIED COMPLICATIONS. Observation on 09/24/2024 at 11:32 AM revealed LVN A went to Resident #4's room. She sanitized her hands and the glucometer. LVN A took the plastic container from the top of her cart. The plastic container contained blood glucose test strips, lancets, and alcohol wipes. She also put the glucometer on the plastic container. She went inside Resident #4's room, brought with her the plastic container, and placed it on top of the resident's overbed table. She wiped the resident's right pointing finger, pricked it with lancet push button, and scooped the blood with the test strip. She said the resident's blood sugar was 352. She went back to her cart and put the plastic container to the top of her cart. She logged on to her computer and said the resident would receive 8 units of insulin. She opened the right drawer of her cart and took the resident's insulin. She cleaned the top of the vial, took a syringe for insulin, and drew 8 units of insulin. After getting 8 units of insulin, she returned the vial of insulin back to the drawer. She went inside the room and injected the insulin on the right upper arm of the resident. She was not wearing any gloves when she injected the insulin. Review of Resident #5's Face Sheet, dated 09/25/2024, reflected that the resident was a [AGE] year-old male admitted on [DATE]. Resident #5 was diagnosed with type 2 diabetes mellitus. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #5's Comprehensive MDS Assessment, dated 07/24/2024, reflected Resident #5 had a moderate impairment in cognition with a BIMS score of 10. The Quarterly MDS Assessment indicated diabetes mellitus as one of Resident #5's active diagnosis. Review of Resident #5's Comprehensive Care Plan, dated 08/23/2024, reflected Resident #5 had diabetes mellitus and one of the interventions was to give diabetes medications as ordered. Review of Resident #5's Physician's Order, dated 03/20/2024, reflected Fiasp FlexTouch Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart (with Niacinamide). Inject subcutaneously before meals related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS. Observation and interview on 09/24/2024 at 11:42 AM revealed LVN A went to Resident #5's room. She sanitized her hands and the glucometer. LVN A took the plastic container from the top of her cart. The plastic container contained blood glucose test strips, lancets, and alcohol wipes. She also put the glucometer on the plastic container. She went inside Resident #5's room, brought with her the plastic container, and placed it on top of the resident's overbed table. She wiped the resident's right pointing finger, pricked it with lancet push button, and scooped the blood with the test strip. After she pricked the resident's finger, she threw the used lancet in the plastic container. The glucometer displayed error. LVN A placed another strip on the glucometer, took another lancet push button, and prick the resident's finger again. After pricking the resident's finger again, she threw the used lancet on the container again. She said the resident's blood sugar was 207. She went back to her cart and put the plastic container to the top of her cart. She logged on to her computer and said the resident would receive 4 units of insulin. She opened the right drawer of her cart and took the resident's insulin. She cleaned the top of the vial, took a syringe for insulin, and drew 4 units of insulin. After getting 4 units of insulin, she returned the vial of insulin back to the drawer. She went inside the room and injected the insulin on the abdomen of the resident. She was not wearing any gloves when she injected the insulin. She stated she sanitized the glucometer before using it for Residents #3, #4, and #5. She said she brought the whole container with her inside the residents' room in case she needed another test strip or another lancet. She said she did not have to go back to her cart just to get another test strip or another lancet. She said she should have left the plastic container on top of the cart because the test strip and the lancet push button were for all the residents that needed their blood sugar checked. She said bringing the plastic container inside the resident's room, putting it on the resident's table and bed, and then putting it on the cart using it could result to cross contamination. She also said the used lancet should be returned to the plastic container because it was already in contact with resident's skin or blood. She said gloves should also be worn when administering the resident's insulin to minimize the risk of transmission of germs from the staff to the resident or vice versa. In an interview with LVN A on 09/25/2024 at 8:24 AM, LVN A stated hand hygiene was the basic component in the prevention of cross contamination and development of infection. LVN said hand hygiene should be a part of the staff's routine, especially those that were providing direct care. She said staff should do hand hygiene before and after any care, should sanitize their hands in between changing of gloves, should change their gloves after touching anything that was dirty or soiled and before touching the clean items. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON on 09/25/2024 at 8:43 AM, the DON stated all the staff should know that hand hygiene was the most effective way to prevent cross contamination and infection. She said hands should be washed before and after doing incontinent. She said gloves should be changed after touching any soiled items like the soiled brief or the trash can. She said the gloves should also be changed after cleaning the resident's bottom. She said hand hygiene should be done after taking off the gloves. She said the container containing the test strips, lancets and alcohol wipes should stay in the cart. She said staff should only bring what was needed for blood sugar. She said staff could bring with them the glucometer, a couple of test strips, and a couple of lancets in case the first try would result to error. She said bringing the plastic container inside, placing it on the residents' table and bed, and then putting it back on the cart could cause cross contamination. She said any germs from the resident's overbed table and resident's bed could transfer to the plastic container. She also said the used lancets were not supposed to be mixed with the unused lancets because it was already contaminated with blood. She said the expectation was for the staff to do hand hygiene before and after any care, to change their gloves from dirty to clean, to do hand hygiene in between changing of gloves, and not to bring any item used by other residents inside a resident's room. She said she will do an in-service about infection control. In an interview with the Administrator on 09/25/2024 at 9:11 AM, the Administrator stated staff should always wash their hands when they were with the residents. he said the gloves should be changed when appropriate to prevent spread of germs. He said the expectation was for the staff to follow the policy and procedures pertaining to infection control. He said he would collaborate with the clinicians to in-service the staff about infection control. In an interview with the ADON on 09/25/2024 at 10:37 AM, the ADON stated hand hygiene was included in all the procedures of any care and should be done before and after every care. He said gloves should be changed after touching the soiled brief, the soiled padding, and the trash can. He said the hands should be washed or sanitized before putting on a new pair of gloves. He also said the plastic container should stay in the cart and the staff should have just brought a couple of strips and lancets in case there was an error in checking the blood sugar. He said the test strips and lancets brought inside the resident's room should be discarded if not used. He said there might be no specific policy about bringing the plastic container inside the room, but the best practice was not to bring it inside the room. He said used and unused lancet should not be mixed. He said all the issues discussed were causes of cross contaminations and probable development of infections. He said the expectation was for the staff to do hand hygiene before and after every care and before putting on a new pair of gloves, to change their gloves when transitioning from dirty to clean area, not bringing any item inside the resident's room if used for other residents. The ADON said he would coordinate with the DON on how to go forward. 3. Review of Resident #9's Face Sheet, dated 09/25/24, reflected that Resident #9 admitted [DATE]. Resident #9 was diagnosed with dementia (abnormal brain changes), cerebral infarction (also called a stroke: occurs when blood flow cannot reach a part of the brain), cognitive communication deficit, and a need for assistance with personal care. Review of Resident #9's Comprehensive MDS, dated [DATE], reflected in the Care Area Summary that Resident #9 had a BIMS score of 02. This score indicated severe cognitive impairment. Resident #9 was incontinent of bowel and bladder and dependent on staff for personal and toileting hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #9's Care Plan, dated 08/13/24, reflected that Resident #9 had bowel and bladder incontinence related to dementia and impaired mobility. One intervention was to change Resident #9 every two hours and as needed. Another intervention was to wash, rinse, and dry perineum, and change clothing as needed after incontinence episodes. An observation 09/25/24 at 10:56 AM revealed that CNA D and CNA E provided incontinence care for Resident #9. Resident #9's family member was also inside the room. CNA D and CNA E washed their hands and put on clean gloves. The front and back of Resident #9's pants was wet. CNA D assisted CNA E to take off Resident #9's pants. The tabs on the brief were secured at the waist but Resident #9's brief was loose on the sides and Resident #9's bottom was visible. Resident #9 held on to CNA D's and CNA E's arms while being changed. CNA E removed the wet brief and then changed gloves, without performing handwashing or using hand sanitizer. CNA E cleaned the resident's peri area and then changed her gloves, without handwashing or using hand sanitizer. CNA E turned Resident #9 to her right side. CNA D wiped Resident #9's bottom. CNA D did not remove her soiled gloves and continue to provide care. CNA D placed a clean brief under Resident #9 and secured the tabs at the front of the brief. CNA E assisted CNA D to put clean pants on Resident #9. CNA D and CNA E removed their gloves and washed their hands in the Resident #9's bathroom before leaving the room. In an interview with CNA D on 09/25/24 at 11:15 AM, CNA D stated she should have washed her hands or used hand sanitizer after taking off the dirty gloves. She stated this was an infection control issue and it was important to prevent spreading bacteria. In an interview with CNA E on 09/25/24 at 11:18 AM, CNA E stated she should have washed her hands after taking off the dirty gloves. She said this was important to prevent contamination and infection. CNA E stated the staff has in-services regularly about providing incontinence care. In an interview on 09/25/24 at 11:40 AM, the ADON stated that CNA D and CNA E should have performed hand hygiene after removing their soiled gloves. The ADON stated proper hand hygiene was important to contamination and the spread of infection. The ADON the facility staff has skills checks annually and provide in-service training to staff on incontinence care. The ADON stated that the new CNAs are observed performing skills and get checked off. During an interview with the DON on 09/25/24 at 11:45 AM, stated the facility has a male and female mannequin, and that staff was required to demonstrate providing incontinence care. The DON stated if a staff member does not pass the skills check off, they are required to repeat it, and demonstrated that they can provide incontinence care correctly. The DON stated this was important to prevent the spread of infection. The DON stated if she sees a pattern of infection, an in-service was done to ensure staff were providing incontinence care correctly. Review of facility policy, Infection Control Infection Prevention and Control Program revised 10.2022 revealed Goal: Decrease the risk of infection to residents and personnel . Recognize infection control practices while providing care . 3. The facility personnel . provide care in a way that minimizes the spread of infection . b. Facility personnel will wash their hands after each direct resident contact 4. Facility personnel will handle, store, process, and transport . to prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy, Hand Hygiene Infection Control revised 10.2022, revealed Purpose: Hand hygiene is one of the most effective measures to prevent the spread of infection . Procedures: b. Before and after direct contact with residents . h. Before moving from a contaminated body site to a clean body site during resident care . m. After removing gloves.