STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675617	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eagle Pass Nursing and Rehabilitation	2550 Zacatecas Dr Eagle Pass, TX 78852

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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	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45307 Based on observation, interview, and record review the facility failed to ensure the resident's 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 option he or she preferred, for 1 of 24 residents (Resident #34) reviewed for resident rights. The facility failed to provide Resident #34's Responsible Party with the benefits, risks, and options available after a psychiatrist recommendation to discontinue the Ativan/Benadryl/Haldol Gel on 02/27/2024. This deficient practice could place residents at risk of receiving medications without their responsible party's risk prior knowledge or consent. The findings included: Record review of Resident #34's face sheet, dated 04/17/2024, reflected a [AGE] year-old female was admitted on [DATE] with a primary diagnosis of Other sequelae of cerebral infarction (history of a stroke). The face sheet also reflected Resident #34 had a Responsible Party that was a family member and a Medical POA. Record review of Resident #34's Admission MDS, dated [DATE], reflected Resident #34's cognition was moderately impaired. The MDS also reflected Resident #34 had received antipsychotics, antidepressants, and antianxiety medications. Record review of Resident #34's comprehensive person-centered care plan, dated 04/17/2024, did not reflect any information related to the administration of antipsychotic medications. Record review of Resident #34's physician orders, dated 04/17/2024, reflected an order for: -ABH Gel (Ativan 1mg/Benadryl 25mg/Haldol 1mg) Gel 1mg/25/mg/1mg MG (Lorazepam/Diphenhydramine/Haloperidol) Apply to VOLAR WRIST topically two times a day for Anxiety/Agitation related to VASCULAR DEMENTIA, UNSPECIFIED SEVERITY, WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY (F01.50) HOLD IF RESIDENT BECOMES DROWSY, order date 01/22/2024. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of [Psychiatry Services] Progress Note, dated 02/27/2024, reflected Plan . Mood disorder due to a general medical condition (disorder) . Continue ABH gel [for] 14 days then [discontinue]. Record review of a medication review regimen, dated 02/11/2024, reflected a recommendation for the nursing department, to do an AIMS assessment for ABH gel, to complete a consent for antipsychotics or neuroleptics form, and to consider a more appropriate diagnosis for administering the ABH gel. Observation and interview on 04/15/2024 at 9:23 AM revealed Resident #34 sitting upright in her bed, and confirmed she had no concerns about her care. Resident #34 was observed to stare blankly in the distance at no object with a subtle head bobbing and during an interview with a Spanish interpreter via telephone would continue to stare blankly in the distance occasionally nodding her head. Phone interview on 04/17/2024 at 9:06 AM, Resident #34's family member confirmed he was the primary responsible party for Resident #34. He confirmed he visited the facility several days of every week since Resident #34 had been admitted and was aware of Resident #34 being administered the ABH gel. He stated it was given to Resident #34 because she refused medications. He stated he had not been informed of the psychiatric evaluation on 02/27/2024 that recommended to discontinue the ABH gel after 14 days. Resident #34's family member confirmed he had visited the facility several times in person since 02/27/2024 and had regular communication with the charge nurses. The ADON and the DON however was never informed of the psychiatric assessment. Phone interview on 04/17/2024 at 10:00 AM the MD confirmed he recalled Resident #34 and confirmed as a standard practice he followed the recommendations by other physician's such as psychiatrists and field experts. The MD confirmed he was not aware of the psychiatric evaluation on 02/27/2024 that recommended Resident #34 to discontinue the ABH gel after 14 days and confirmed the risk to Resident #34 could be various. Interview on 04/17/2024 at 10:58 AM, the ADON confirmed she was familiar with Resident #34 having been administered the ABH Gel, and confirmed she was unfamiliar with the recommendation by psychiatric services to discontinue the ABH gel. The ADON confirmed Resident #34's ABH Gel administration and follow-up assessments were handled by the DON primarily so the DON would be the primary point of contact related to contacting the family and physician. Interview on 04/17/2024 at 11:16 AM, the DON confirmed she was familiar with Resident #34 having been administered the ABH Gel, and confirmed she was familiar with the recommendation by psychiatric services to discontinue the ABH gel. The DON stated communication with Resident #34's family and physician was completed by herself and confirmed the family was notified verbally during his on-site visit but did not indicate it in clinical records. The DON confirmed the MD was notified of the psychiatric evaluation however could not recall a precise date or time when the MD was notified and confirmed the MD likely forgot that he was notified of the psychiatric visit. The DON confirmed that the potential risk to Resident #34 was that the family member or MD could have considered not following the recommendation by psychiatric services. A policy specific to notification to family and physician was requested on 04/17/2024 at 11:25 AM to the ADM and not provided upon exit.

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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** 45857 Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident's medical and nursing needs to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 8 residents (Residents #56) reviewed for comprehensive care plans in that: The facility failed to update a plan of care to address Resident #56's current use of oxygen. The care plan did not reflect Resident #56's self administration of his own oxygen. This deficient practice could place residents at risk of not being provided with the necessary care or services and having personalized plans developed to address their specific needs. The findings included: Record review of Resident #56's face sheet dated 4/17/2024 revealed an [AGE] year-old male with an admitted [DATE] with diagnoses which included: pneumonia (An infection of the air sacs in one or both the lungs. Characterized by severe cough with phlegm, fever, chills and difficulty in breathing), diabetes mellitus, anemia (Deficiency of healthy red blood cells in blood. Red blood cells (RBCs) are essential to carry oxygen to all parts of the body. Fatigue, unexplained weaknesses are some of the common symptoms.), acute respiratory failure with hypoxia (inadequate gas exchange by the respiratory system, meaning that the arterial oxygen, carbon dioxide, or both cannot be kept at normal levels. A drop in the oxygen carried in the blood is known as hypoxemia), emphysema (A lung disease which results in shortness of breath due to destruction and dilatation of the alveoli (air sac)), chronic obstructive pulmonary disease (persistent respiratory symptoms like progressive breathlessness and cough), and chronic atrial fibrillation (irregular and often faster heartbeat). Record review of Resident #56's quarterly MDS dated [DATE] revealed a BIMS score of 15 which indicated intact cognition and received oxygen therapy. Record review of Resident #56's physician order summary, dated 4/14/2024, revealed: -a verbal order for oxygen at 2 liters per minute via nasal cannula as needed with a start date of 3/22/2024 and no end date. Record review of Resident #56's Care Plan initiated on 10/19/2023 revealed: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #56 had Oxygen Therapy d/t Dx of Emphysema, initiated on 10/19/2023 and revised on 04/02/2024, give medications as ordered by physician, monitor/document side effects and effectiveness, If the resident is allowed to eat, oxygen still must be given to the resident but in a different manner (e.g., changing from mask to a nasal cannula). Return resident to usual oxygen delivery method after the meal, monitor for s/sx of respiratory distress and report to MD PRN: respirations, pulse oximetry, increased heart rate (tachycardia), restlessness, diaphoresis, headaches, lethargy, confusion, atelectasis, hemoptysis, cough, pleuritic pain, accessory muscle usage, skin color, notify the nurse if the oxygen is off the resident, oxygen at ____lpm per nasal canula, position resident to facilitate ventilation/perfusion matching: use upright, high-fowlers position whenever possible to allow for optimal diaphragm. The care plan did not address the resident self-administration of oxygen, did not address the residents self-use of a pulse oximeter (device used to check oxygen saturation rate and pulse), did not specify the active order for 2 liters per minute rate as needed for oxygen, and did not specify the frequency for vital signs. Record review of Resident #56's MAR, dated 4/17/2024, revealed Oxygen at 2 liter per minute as needed was blank, indicating it had not been administered in the month of April. During an observation on 4/15/2024 at 11:56 a.m. Resident #56 was in his room. The resident had a pulse oximeter on his bedside table and an oxygen concentrator was present next to his bed. Resident #56 stated he used the oxygen at night and checked his own oxygen levels with his pulse oximeter. During a follow up interview on 4/17/2024 at 11:46 a.m. Resident #56 stated he used his oxygen on his own every night and sometimes during the day he will lay down and use it. Resident #56 stated he will check his own oxygen saturation through out the day and if it goes below 90% he knew that was bad and would use his oxygen. Resident #56 stated he did not notify staff if his oxygen saturation was below 90%. Resident #56 stated staff go into his room to check his oxygen saturation twice a day an sometimes an extra time at night. Resident #56 stated they checked his oxygen saturation that morning and it was 97%. During an interview on 4/17/2024 at 11:52 a.m. LVN D stated she had check Resident #56's oxygen saturation that morning when she checked his blood sugar but had not documented it. LVN D stated she remembered his oxygen saturation from that morning and would document it. LVN D stated she checked Resident #56's oxygen saturation everyday but did not document it. She stated the order changed to as needed and her electronic medical record program did not prompt her to document it. LVN D stated the resident liked to check his own oxygen and used his oxygen on his own. During an interview on 4/17/24 at 3:20 p.m. the DON stated nursing staff would document if a resident used oxygen and Resident #56 had a PRN or as needed order for oxygen. The DON stated Resident #56 had a BIMS score of 15 so he could administer his own oxygen and check his own oxygen saturation. The DON stated staff would document if they administered the oxygen to the resident but because he administered it to himself it would not be documented. The DON stated because the resident had a PRN order, they were not expected to check his oxygen saturation like they would for continuous oxygen and oxygen saturation would not be documented daily even if staff were checking it. The DON stated, I can care plan it if you want me to. (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 3:20 p.m. The Regional Compliance Nurse stated Resident #56 had a PRN order for oxygen, so staff only needed to check it weekly. The Regional Compliance Nurse stated staff could check Resident #56's vital signs, including his oxygen saturation but were not expected to document it because they would be going above and beyond. RN E stated they did not know if Resident #56 was administering his own oxygen because he could just be saying he was. Record review of the facility's policy, titled Comprehensive Care Planning, no date, stated The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following, The services that are to be furnished to attain or maintain the resident's highest practicable physical .The resident's preference and potential for future discharge .Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs .The facility will establish, document and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life. Care planning drives the type of care and services that a resident receives [NAME] plans will be person-centered and reflect the resident's goals for admission and desired outcomes .The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented. When developing the comprehensive care plan, facility staff will, at a minimum, use the Minimum Data Set (MOS, to assess the resident's clinical condition, cognitive and functional status, and use of services. if a Care Area Assessment (CAA) is triggered, the facility will further assess the resident to determine whether the resident is at risk of developing, or currently has a weakness or need associated with that CAA, and how the risk, weakness or need affects the resident. Documentation regarding these assessments and the facility's rationale for deciding whether or not to proceed with care planning for each area triggered will be recorded in the medical record.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 5 of 5 residents (Resident #38, #11, #55, #17, and #48) reviewed for indwelling urinary catheter care, in that: 1. Resident #38's indwelling urinary catheter drainage bag was touching the floor. 2. The facility failed to ensure Resident #11 was provided proper catheter care. 3. Resident #55's indwelling urinary catheter drainage bag was touching the floor. 4. Resident #17's indwelling urinary catheter drainage bag and catheter tubing was touching the floor. 5. Resident #48 indwelling urinary catheter drainage bag and catheter tubing was touching the floor. This failure could place residents with indwelling urinary catheter devices at risk for the development of new or worsening urinary tract infections. The findings included: 1. Record review of Resident #38's face sheet, dated 4/14/24 revealed an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] and 2/22/24 with diagnoses that included cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), urinary tract infection, and hypertension (elevated blood pressure). Record review of Resident #38's most recent quarterly MDS assessment, dated 2/26/24 revealed the resident was moderately cognitively impaired for daily decision-making skills and was always incontinent of bowel and bladder. Record review of Resident #38's comprehensive care plan, with revision date 4/10/24 revealed the resident had an indwelling urinary catheter with interventions that included to position the catheter bag and tubing below the level of the bladder, in a privacy bag, and check tubing for kinks and maintain the drainage bag off the floor. Observation on 4/14/24 at 12:57 p.m., revealed Resident #38's indwelling urinary catheter bag was touching the floor while the resident was sitting up in a wheelchair eating lunch in the dining room. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 4/14/24 at 1:21 p.m. revealed Resident #38 continued eating in the dining room and the indwelling urinary catheter bag was touching the floor while the resident was eating lunch. LVN A revealed he observed Resident #38's indwelling urinary catheter bag was touching the floor and it should not have been because the catheter tubing could get kinked or get pulled off causing injury. LVN A further revealed, the indwelling urinary catheter bag touching the floor was considered an infection control issue and could result in Resident #38 developing an infection. 2. Record review of Resident #11's face sheet, dated 4/17/24 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included intellectual disabilities, dementia, type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), rash and other nonspecific skin eruption, seizures, urinary tract infection, hypertension (elevated blood pressure), congenital hydrocephalus (too much fluid builds up in the brain, causing pressure and damage), and acute candidiasis (fungal infection) of vulva and vagina. Record review of Resident #11's most recent quarterly MDS assessment, dated 2/26/24 revealed the resident was moderately cognitively impaired for daily decision-making skills, had a urinary catheter and was always incontinent of bowel. Record review of Resident #11's comprehensive care plan, with revision date 4/02/24 revealed the resident had an indwelling urinary catheter with interventions that included to position the catheter bag and tubing below the level of the bladder, in a privacy bag, check tubing for kinks, and maintain the drainage bag off the floor. Observation on 4/15/24 at 3:15 p.m., revealed CNA L and CNA M provided catheter care to Resident #11. The catheter bag and tubing was hanging from the side of the bed touching the floor. CNA L and CNA M washed their hands and put on gloves and a gown due to the resident being on enhanced barrier precautions. CNA L removed the blankets covering Resident #11. No leg strap was noted on the Resident to hold the catheter tubing in place. CNA L then removed her gloves. CNA M then held the bottle of hand sanitizer with her gloved hands for CNA L to use. CNA M then handed CNA L a new pair of gloves. CNA L then put on the new gloves. CNA L and CNA M both rolled Resident #11 to her side to place a towel under her. CNA M then removed her used gloves, handed the used gloves to CNA L, CNA L grabbed CNA M's used gloves with her gloved hands, and threw them in the trash. CNA L then unfastened Resident #11's used brief and rolled it up and under the resident's vaginal area. CNA L then grabbed the catheter tubing where it exited the urethra meatus (opening where urine exits the body) with her index finger and thumb and wiped the catheter tubing in a direction away from the resident. CNA L then removed her used gloves, sanitized her hands, and continued catheter care. After catheter care was complete the CNAs lowered the bed, and the catheter bag and tubing was touching the floor. During an interview on 04/15/24 at 3:38 p.m. CNA L stated she did not notice that she touched CNA M's used gloves and then touched the catheter tube with the same gloves. CNA L stated she thought she changed her gloves before and stated she should have because they could have been contaminated and could cause an infection. CNA L stated the catheter bag was inside a dignity bag, they washed the dignity bags, so it was ok if it touched the floor, and it was hard to keep the catheter bags from touching the floor because the bed had to be low to the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/15/24 at 5:15 p.m. the DON stated staff did not need to change their gloves after touching another staff s used gloves because the resident had not been cleaned yet and it was okay to touch the catheter tubing since it was not cleaned yet. 3. Record review of Resident #55's face sheet, dated 4/17/24, revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, acute kidney injury, hyperlipidemia (elevated cholesterol), glaucoma (increased pressure within the eyeball causing gradual loss of sight), end stage renal disease (condition in which the kidneys cease functioning on a permanent basis), and atrial fibrillation (irregular, rapid heart rate commonly caused by poor blood flow). Record review of Resident #55's most recent MDS admission assessment, dated 3/30/24, revealed the resident's cognition was intact for daily decision-making skills and had an indwelling catheter. Record review of Resident #55's comprehensive care plan, with revision date 4/12/24 revealed the resident had an indwelling catheter and was at risk for complications with interventions to check tubing for kinks, maintain the drainage bag off the floor, and ensure the tubing was anchored to the resident's leg or linens so that tubing was not pulled. During an observation on 04/14/24 at 12:30 p.m. Resident #55's catheter bag was hanging from the side of her bed in a dignity bag and touching the floor. 4. Record review of Resident #17's face sheet, dated 4/15/24 revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and, eventually, the ability to carry out the simplest tasks), cognitive communication deficit, urinary tract infection, and disorders of bladder. Record review of Resident #17's most recent quarterly MDS assessment, dated 2/16/24 revealed the resident was severely cognitively impaired for daily decision-making skills, was always incontinent of bowel and bladder, and had an indwelling urinary catheter. Record review of Resident #17's comprehensive care plan, with revision date 5/11/23 revealed the resident had an indwelling urinary catheter with interventions that included to position catheter bag and tubing below the level of the bladder and in a privacy bag while in bed or wheelchair. Observation on 4/14/24 at 10:53 a.m. revealed Resident #17 in the bed with the indwelling urinary catheter bag observed in a dignity bag touching the floor. Observation on 4/15/24 at 10:32 a.m. revealed Resident #17 in the bed with the indwelling urinary catheter bag and catheter tubing touching the floor. Observation on 4/15/24 at 2:56 p.m. revealed Resident #17 in the bed with the indwelling urinary catheter bag touching the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 4/15/24 at 3:46 p.m., LVN B observed Resident #17's indwelling urinary catheter touching the floor and stated, I think it (the indwelling urinary catheter bag) needs a bin. LVN B revealed, Resident #17's indwelling urinary catheter bag was in a privacy bag but the indwelling urinary catheter bag itself was not touching the floor. LVN B then stated, Resident #17's indwelling urinary catheter bag was in a privacy bag because it was facility protocol and if the privacy bag were to become soiled or if it leaked, the privacy bag would be replaced. LVN B stated, infection can transfer from the privacy bag to the indwelling urinary catheter bag if soiled and it could be stepped on or dislodged. LVN B revealed if the privacy bag became soiled the resident could develop an infection. LVN B further revealed, if the indwelling urinary catheter tubing was touching the floor, it was considered cross contamination. 5. Record review of Resident #48's face sheet, dated 4/14/24 revealed an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included acute kidney injury, type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), urinary tract infection, and benign prostatic hyperplasia (urine is blocked due to the enlargement of prostate gland). Record review of Resident #48's most recent quarterly MDS assessment, dated 3/19/24 revealed the resident was moderately cognitively impaired for daily decision-making skills. The resident did not have a catheter at the time of the MDS and it was not noted in the MDS. Record review of Resident #48's comprehensive care plan, with revision date 4/09/24 revealed the resident was on enhanced barrier precautions with interventions to wear gloves and gown if any of the following activities are to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity. The catheter was not mentioned anywhere else on the care plan. During an observation on 04/14/24 between 12:52 p.m. and 1:22 p.m. Resident #48 was observed eating in the dining room for lunch. The Resident had his catheter bag hanging from his wheelchair and touching the floor. The dignity bag had a white substance and grass stuck to it. During an observation and interview on 04/14/24 at 1:22 CNA L was observed pushing Resident #48 in his wheelchair back to his room. The catheter bag was clipped on a slanted bar of the wheelchair and was dragging on the floor. CNA L stated they clipped the catheter bag on the wheelchair, but it moved because the resident pulls on it. This state surveyor pointed out that it was clipped on to a slanted bar and the bag would slide down the bar and touch the floor. CNA L stated the catheter bag should not be dragging on the floor or it could get pulled out or dirty. During an interview on 4/15/24 at 5:15 p.m., the DON revealed she considered the indwelling urinary catheter's privacy bag a barrier protecting the actual indwelling urinary catheter bag as it kept it from direct contact with the floor. The DON further stated, I don't think anything can happen like being stepped on. The DON stated, the indwelling urinary catheter tubing should not be touching the floor because the floor was dirty, and infection can happen. The DON revealed, the indwelling urinary catheter tubing touching the floor could result in infection and if the tubing got stuck on the wheelchair it could cause dislodgement. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy and procedure titled, Catheter Care, revision date 2/13/2007 revealed in part, .Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks .Keep tubing off floor and minimize friction or movement at insertion site .Be sure the catheter tubing and drainage bag are kept off the floor . 45857

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observations, interviews and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice for 1 of 2 residents (Resident #55) reviewed for dialysis: The facility did not maintain communication, coordination, and collaboration with the dialysis facility for Resident #55. This deficient practice could affect residents who received dialysis treatments and place them at risk for complications and not receiving proper care and treatment to meet their needs. The findings included: Record review of Resident #55's face sheet, dated 4/17/24, revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, acute kidney injury, hyperlipidemia (elevated cholesterol), glaucoma (increased pressure within the eyeball causing gradual loss of sight), end stage renal disease (condition in which the kidneys cease functioning on a permanent basis), and atrial fibrillation (irregular, rapid heart rate commonly caused by poor blood flow). Record review of Resident #55's most recent MDS admission assessment, dated 3/30/24, revealed the resident's cognition was intact for daily decision-making skills and required dialysis treatments. Record review of Resident #55's comprehensive care plan, with revision date 4/01/24 revealed the resident received dialysis related to renal failure and was at risk for potential complications from dialysis, with interventions that included do not draw blood or take blood pressure in arm with graft, monitor/document peripheral edema, monitor/document/report to MD PRN signs and symptoms of and to report abnormal bleeding, hemorrhage, bacteremia, and septic shock, obtain vital signs and weight per protocol, report significant changes in pulse, respirations, and blood pressure immediately. Record review of Resident #55's Order Summary Report, dated 4/17/24 revealed the following orders: - Dialysis Monday, Wednesday, Friday with a start date of 04/10/2024 and no end date. - Dialysis Monday, Wednesday, Friday discontinued on 04/08/2024 No orders Record review of Resident #55's Dialysis Communications Record revealed the following: -the 3/29/24 record was requested and not provided. - the 4/01/24 record revealed the pre assessment for the nursing facility weight was blank and the dialysis center communication area for vitals was blank. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- the 4/03/24 record revealed the pre assessment for the nursing facility weight was blank and the post assessment for skin condition the nursing facility was blank. - the 4/05/24 record revealed the pre assessment for the nursing facility weight was blank and the post assessment for oxygen saturation and blood sugar was blank. - the 4/08/24 record revealed the pre assessment for the nursing facility skin assessment was blank. - the 4/10/24 record revealed the post assessment for the nursing facility skin assessment was blank. - the 4/12/24 record revealed the pre assessment for the nursing facility nurse's signature was blank. The vitals listed on the morning pre assessment at the nursing facility were also documented the same in the evening on the electronic medical record on 04/12/24 at 8:04 p.m - the 4/15/24 record revealed the dialysis center communication area for vitals was blank and contained no dialysis nurse's signature. -the 4/17/24 record was requested and not provided. During an interview on 4/14/24 at 12:32 p.m., Resident #55 revealed she went to dialysis treatments on Monday, Wednesday, and Friday and had a central port for dialysis. During an interview on 04/17/2024 at 9:45 a.m. the DON stated the facility staff would fill out the pre and post assessment for each dialysis resident. The DON stated the dialysis facility was responsible for filling out the dialysis center communication portion of the form. The DON stated if vitals were missing from the dialysis center portion of the form she would call and get the information from the dialysis center. The DON stated the dialysis center did not fill out the vitals on 04/01/24 and 04/15/24 and were left blank on the form. The DON stated only the information the dialysis facility was responsible for was blank on the forms for Resident #55. Record review of the facility's policy titled Dialysis, dated 11/2013, stated Dialysis is . The facility will establish baseline information from the dialysis center with will monitor changes from the baseline .4. The resident will be referred for a skin/wound assessment by the wound care nurse. Skin assessment will be ongoing .All documentation will be maintained in the resident's clinical record. The physician may obtain a dry weight measure to compare the resident's daily weight results to. Verify with the physician for the weight plan of care . the facility will make every effort to assist the resident in obtaining information and assistance with questions from the dialysis center about his/her treatment .The date and time that the resident leaves the facility will be recorded by the nurse. The facility will monitor departures and returns from the dialysis center. The facility will document the resident's vital signs, general appearance, orientation, and additional baseline data as needed. The resident's clinical record will be documented with this information. The date and time of the resident's return to the facility will be recorded by the nurse. The facility will be observant of any of the following symptoms. If the resident experiences any of these symptoms, the nurse will contact the dialysis center, the attending physician immediately .

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 45307 Based on interviews and record review the facility failed to ensure 3 of 3 Nurses' Aides (NA E, NA F, & NA G) were not working in the facility longer than four months without having completed a competency evaluation program. The facility failed to ensure NA E, NA F, and NA G became certified within four months of hire as full-time staff. This deficient practice place residents at risk for receiving care from an individual whose skill level was not known. The findings included: Record review of the facility staff roster provided upon entrance reflected the following: -Nurse Aide E was listed as a Non-Certified Nurse Aide with a hire date of 09/19/2022. -Nurse Aide F was listed as a Non-Certified Nurse Aide with a hire date of 10/06/2022. -Nurse Aide G was listed as a Non-Certified Nurse Aide with a hire date of 08/09/2023. Record review of employee personnel files reflected the following: -Nurse Aide E had not completed a training and competency evaluation program, or a competency evaluation program approved by the State. -Nurse Aide F had not completed a training and competency evaluation program, or a competency evaluation program approved by the State. -Nurse Aide G had not completed a training and competency evaluation program, or a competency evaluation program approved by the State. (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/17/2024 at 2:00 PM, the HRD confirmed Nurse Aide E did have a start date of employment at the facility on 09/19/2022 and confirmed Nurse Aide E had attempted to complete the competency evaluation program but did not meet the requirements for passing the examination and confirmed Nurse Aide E was a full-time staff member completing ADL assistance with residents. The HRD confirmed she was not aware if Nurse Aide E complete nurse aide tasks independently or shadowed by a CNA. The HRD confirmed Nurse Aide F did have a start date of employment at the facility on 10/06/2022 and confirmed Nurse Aide F had attempted to complete the competency evaluation program but did not meet the requirements for passing the examination and confirmed Nurse Aide F was a full-time staff member completing ADL assistance with residents. The HRD confirmed she was not aware if Nurse Aide F completed nurse aide tasks independently or shadowed by a CNA. The HRD confirmed Nurse Aide G did have a start date of employment at the facility on 08/09/2023 and confirmed Nurse Aide G had attempted to complete the competency evaluation program but did not meet the requirements for passing the examination and confirmed Nurse Aide G was a full-time staff member completing ADL assistance with residents. The HRD confirmed she was not aware if Nurse Aide G completed nurse aide tasks independently or shadowed by a CNA. Interview on 04/17/2024 at 3:04 PM, the DON confirmed she was aware of Nurse Aides E, F, and G having been employed at the facility as full-time nurse aides and that Nurse Aides E, F, and G had not completed a competency evaluation program. The DON confirmed Nurse Aides E, F, G had not worked independently and were shadowed by CNAs. The DON confirmed the expectation for all hired nurse aides was to have them become certified within four months, and that otherwise, residents could potentially be cared for by staff who were insufficiently evaluated for competence. Record review of Nurse Aide job description, undated, reflected: nurse aides were to complete a nursing and competency program and become certified without a precise time stated.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 45307 Based on observations and interviews, the facility failed to ensure all facility dumpsters were equipped with a drain plug. 2 of the 3 facility dumpsters lacked a drain plug. This failure posed a sanitary and safety hazard that could result in water accumulating in the dumpsters and in the attraction of vermin from standing water. The findings included: Observation and interview on 04/15/2024 at 11:18 AM, 3 facility dumpsters were revealed outside of the facility of which 2 were observed to have an exit drain but lacked a drain plug. Of the 2 that lacked a drain plug, one appeared to have a soda bottle lodged in the drain outlet. The DM confirmed the dumpsters were the responsibility of the MS and confirmed she was not aware of the lack of drain plugs in the dumpsters. The DM confirmed she was not aware of the necessity of drain plugs or what their role in garbage maintenance included. Interview on 04/15/2024 at 3:35 PM, the MS, with interpreter assistance provided by the DON, confirmed he was aware of the lack of drain plugs in 2 of the 3 dumpsters and confirmed the drain plugs were removed by the city during a recent inspection for an unknown reason. The MS confirmed he did not have evidence of the city inspection and had no record to support the city removing the drain plugs of those specific dumpsters. The MS confirmed the lack of drain plugs could result in standing water accumulating and attract pests, leading to a pest control concern. Facility policy titled Waste Control and Disposal, undated, reflected Waste Control and Disposal will be taken care of in a sanitary manner . but did not reflect any specific policy related to dumpster maintenance.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observations, interviews and record reviews, the facility failed to maintain medical records on each resident that were accurately documented for 1 of 8 residents (Residents #213) reviewed for accurate medical records in that: The facility accurately documented Resident #213 mobility status on an admission assessment for elopement risk. This deficient practice could affect residents who have medical records and could result in misinformation about professional care provided. The findings included: Record review of Resident #213's face sheet dated 4/17/2024 reflected an [AGE] year-old male was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses left femur fracture, lack of coordination, dementia (conditions that affect the brain's ability to think, remember, and function normally), type 1 diabetes, difficulty in walking, and protein calorie malnutrition. Record review of Resident #213's Admitting MDS, dated [DATE], reflected the Resident was severely cognitively impaired. The MDS reflected Resident #213 had a wheelchair, used supervision or touching assistance to transfer from bed to a chair, used supervision or touching assistance to walk 10 feet, and used supervision or touching assistance to wheel 150 feet. Record review of Resident #213's comprehensive care plan revised date 4/15/2024 reflected: -the Resident had a risk for falls due to assistance with transfers and a history of falls with interventions Ensure that the resident wears appropriate footwear when ambulating or mobilizing in wheelchair and Staff x 2 to assist with transfers. -the Resident had an ADL self-care performance deficit related to dementia with interventions assist with personal hygiene as required: hair, shaving, oral care as needed, bathing requires staff x1 for assistance, bed mobility: required staff x1 for assistance, the resident used a wheelchair, and transferring: required staff x1 for assistance. Record review of an assessment titled Elopement Risk Assessment, dated 3/23/2024, stated 1. Is resident bed bound, in a geriatric, or unable to self-propel wheelchair? Yes. The answer to this question was yes, the assessment was complete. The score was 0 for the elopement risk, indicating no risk for elopement. This assessment showed the resident was non ambulatory and made him not an elopement risk. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an assessment titled Fall Risk Assessment, dated 3/23/2024, stated A. Level of consciousness/ mental status: intermittent confusion B. history of falls (past 3 months): 1-2 falls in the past 3 months C. ambulation/ elimination status: ambulatory/continent .E. Is the Resident able to stand? Yes, balance problem of standing, balance problem while walking, decrease muscular coordination, change in gait pattern when walking through doorway, jerking or unstable and making turns, requires use of assistive devices (cane, wheelchair, walker, furniture) . The resident had a score of 14 which indicated high fall risk. This assessment showed the resident was ambulatory and made him a fall risk. Record review of nursing progress note, dated 4/4/2024, stated resident up during night walking in different halls. Resident refused medication at this time. During an interview on 4/17/2024 at 3:31 p.m. the DON stated Resident #213 can self-propel himself in his wheelchair. The DON stated there were no concerns for wandering or elopement risk for Resident #213. The DON stated on Admission Resident #213 was not able to walk and could only stand. The DON stated ambulatory meant walking. The DON stated the assessments were accurate reflection of the Resident on admission which showed he was unable to self-propel himself and able to ambulate. The DON stated when the resident was admitted he was weak and since then had improved and could self-propel himself in his wheelchair. The DON stated the progress note of the resident walking different halls at night did not make him an elopement risk because he was just walking. The DON stated elopement assessments were done on admission and only if something triggered for a new one to be done. The DON stated walking around does not qualify him for a new assessment and he had no behaviors exhibiting wandering. Record review of the facility's policy titled Documentation, dated 05/2015, stated Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident. It includes observations, investigations, and communications of the resident involving care and treatments. It has legal requirements regarding accuracy and completeness, legibility and timing. Special forms in the clinical record are utilized in nursing documentation, such as assessment, care plan, nursing progress notes, flow sheets, medication sheets, incident reports, and summary sheets (daily, weekly, monthly, discharge). Documentation also occurs in the clinical software . Goal 1. The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets. 2. The facility will ensure that information is comprehensive and timely and properly signed .

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 45307 Based on interviews and record review, the facility failed to follow guidelines for mandatory submission of staffing information based on payroll data in a uniform format for 11 of 91 days in Fiscal Year Quarter 1 of 2024. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. The facility failed to submit staffing information to CMS for 11 of 91 days in Fiscal Year Quarter 1 of 2024. This deficient practice could place residents at risk for personal needs not being identified and met, decreased quality of care, decline in health status, and decreased feelings of well-being within their living environment. The findings included: Record review of CMS Form-671 (Long-Term Care Facility Application for Medicare and Medicaid) dated 04/17/2024 provided by the ADM reflected a total of 56 residents in the facility. Record review of the PBJ Staffing Data Report, Fiscal Year Quarter 1 of 2024 (October 1 - December 31), dated 04/10/2024, reflected the facility had failed to RN staffing hours on the following dates: 11/24, 12/04, 12/05, 12/09, 12/10, 12/16, 12/17, 12/18, 12/21, 12/22, and 12/27. Interview on 04/16/2024 at 4:46 PM, the ADM confirmed the Payroll Based Journal staffing hours were submitted by the corporate office to CMS. The ADM confirmed the facility had an RN during the periods listed within the PBJ staffing data report, however the days were likely staffed by the CCN who, as a salaried staff member, did not complete timesheets and would otherwise not be able to evidence their staffing at the facility. The ADM confirmed the potential harm would be that an RN could not be confirmed to have been at the facility and thus not able to provide RN assistance to the facility. Interview on 04/16/2024 at 5:12 PM, the CCN confirmed she was at the facility during November 2023 and December 2023 when the routine RNs employed at the building were not able to work their shifts. The CCN confirmed that she did not complete time sheets due to her being a salaried staff member and had no ability to enter payroll-based journaling. The CCN confirmed she had no record such as a personal schedule to evidence her having been at the facility during the dates. Record review of the CMS, Electronic Staffing Data Submission Payroll-Based Journal, Long-Term Care Facility Policy Manual, Version 2.6, June 2022, section 1.2 Submission Timeliness and Accuracy, reflected Direct care staffing and census data will be collected quarterly, and is required to be timely and accurate. Further review revealed Report Quarter 1 date range as October 1-December 31. Policy manual reflected, Deadline: Submissions must be received by the end of the 45th calendar day (11:59 PM Eastern Time) after the last day in each fiscal quarter in order to be considered timely.

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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** 39075 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 of 2 Medication Aides and 1 of 1 housekeeper reviewed for infection control, in that: 1. The facility failed to ensure Med Aide C utilized appropriate hand hygiene and infection control principles. Med Aide C did not perform hand hygiene between glove changes, did not sanitize the blood pressure cuff between residents and did not use proper PPE when providing services to residents on contact isolation for Residents #23, Resident #17, and Resident #35. 2. The facility failed to ensure Housekeeper N performed proper hygiene after cleaning Resident #23's and Resident #51's room. This deficient practice could place residents at risk of infection for transmission of communicable diseases and a decline in health. The findings included: 1. a. Record review of Resident #23's face sheet, dated 4/16/24 revealed an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included urinary tract infection, hypertension (increased blood pressure), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), chronic obstructive pulmonary disease (diseases that cause airflow blockage and breathing-related problems), extended spectrum beta lactamase [ESBL] resistance (an enzyme in the body that breaks down commonly used antibiotics making them ineffective), and retention of urine. Record review of Resident #23's Order Summary Report, dated 4/16/24 revealed the following: - CONTACT ISOLATION FOR ESBL TO URINE every shift with order date 4/8/24 and no end date b. Record review of Resident #51's face sheet, dated 4/16/24 revealed an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), hypertension (increased blood pressure), heart disease, chronic obstructive pulmonary disease (diseases that cause airflow blockage and breathing-related problems), chronic kidney disease stage 3 (condition in which the kidneys are damaged and can't filter blood the way they should), extended spectrum beta lactamase [ESBL] resistance (an enzyme in the body that breaks down commonly used antibiotics making them ineffective), and urinary tract infection. Record review of Resident #51's Order Summary Report, dated 4/16/23 revealed the following: - CONTACT ISOLATION FOR ESBL TO URINE every shift, with order date 4/8/24 and no end date (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Record review of Resident #35's face sheet, dated 4/16/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included muscle weakness, abnormalities of gait and mobility, lack of coordination, need for assistance with personal care, dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), and hypertension (elevated blood pressure). Observation on 4/16/24, at 8:04 a.m., revealed Resident #23 and Resident #51, who resided in the same room, had a PPE cart and signage on the outside of the room indicating the residents were on contact isolation. During the medication pass, Med Aide C entered the room to obtain Resident #23's blood pressure and did not wear a gown, or gloves when entering the room. Med Aide C exited the room, prepared the medications for Resident #23, and returned to the bedside to administer the medications without using proper PPE. Med Aide C then exited the room and was approached by the DON who stated, please put on your gown. Med Aide C confirmed she had not put on proper PPE and stated, that's a big no no. Med Aide C returned to the medication cart and put on a gown and a pair of gloves but did not sanitize or wash her hands prior to putting on the gloves. Med Aide C then entered the same room and obtained Resident #51's blood pressure using the same blood pressure cuff used on Resident #23 without sanitizing the blood pressure cuff prior to use. Med Aide C then continued with medication pass and obtained the blood pressure from Resident #35 using the same blood pressure cuff used on Resident #23 and Resident #51 without sanitizing the blood pressure cuff prior to use. During an interview on 4/16/24 at 8:45 a , Med Aide C stated she did not realize the signage and PPE cart outside of Resident #23 and Resident #51's room. Med Aide C revealed she was not sure what type of infection Resident #23 and Resident #51 had and believed they were being treated with antibiotics. Med Aide C revealed she should have been disinfecting the blood pressure cuff between resident use because it could cause a spread of infection and was considered cross contamination. Med Aide C revealed, cross contamination could result in the residents getting sick. 2. During an observation on 04/15/24 at 9:12 a.m. room [ROOM NUMBER], where resident #23 and Resident #51 resided, contained a sign that stated Stop contact precautions everyone must clean hands when entering and leaving room. Doctors and staff must gown and glove at the door and use resident dedicated or disposable equipment clean. A second sign stated Contact Precautions .Remove sign after room is terminally cleaned. Common Conditions (refer to Facility Policy): Highly drug-resistant organisms . Carbapenem resistant Gram-negative rods/ESBL .Equipment and Supplies: equipment and supplies in room, disposable equipment when available. Clean and disinfect reusable equipment including IV pumps, cell phone or pagers if used in room, and other electronics, supplies, and equipment prior to removing from resident's room. Ensure blood pressure cuff and stethoscope are cleaned and disinfected between residents. Linen Management: Bag linen in resident's room. Personal Protective Equipment: .Take OFF & dispose in this order, gown and gloves at the same time, wash or gel hands . Housekeeper N was noted with a cleaning cart outside room [ROOM NUMBER] and cleaned room [ROOM NUMBER]. Housekeeper N exited room [ROOM NUMBER], removed her gown and gloves, did not clean her hands, put on a new pair of gloves, and went into the next room to clean it. (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 04/15/24 at 9:14 a.m. Housekeeper N stated she wore a gown and gloves when cleaning room [ROOM NUMBER]. Housekeeper N stated she cleaned everything in room [ROOM NUMBER] including the bathroom and door handles. Housekeeper N stated she removed the gown and gloves, discarded of them in the trash, put on new gloves, and then started cleaning the next room. Housekeeper N stated she had on clean gloves so she thought it was ok. Housekeeper N stated there was no hand sanitizer available on the PPE cart in front of room [ROOM NUMBER]. This surveyor pointed out a bottle on top of a PPE cart across the hallway and another next to the room on the wall in the hallway. During an interview on 04/15/24 at 5:21 p.m. the DON stated staff was expected to perform hand hygiene before and after care, they could use hand sanitizer to clean their hands, housekeeping gets training for infection control, all staff had access to hand sanitizer, and housekeeper N should have sanitized her hands between rooms to prevent infection. During an interview on 4/16/24 at 5:04 p.m., the DON revealed it was her expectation for the staff to disinfect the blood pressure cuff between resident use to prevent cross contamination, which could cause residents to get an infection. The DON further revealed, for residents on isolation, the staff must use proper PPE to prevent cross contamination. Record review of the facility policy and procedure, titled Infection Control Plan, updated 3/2024 revealed in part, .The Facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection .Preventing Spread of Infection .When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility will isolate the resident .The facility will require staff to wash their hands after each direct contact for which hand washing is indicated by accepted professional practice .The facility will require staff to Donn and Doff PPE before and after contact with resident who needs isolation to prevent the spread of infection to others in the facility .Fundamentals of Infection Control Precautions .Hand Hygiene continues to be the primary means of preventing the transmission of infection .situations that require hand hygiene .Before and after entering isolation precaution settings .Upon and after coming in contact with a resident's intact skin, (e.g., when taking a pulse or blood pressure .) .After removing gloves or aprons .Gloving .Wearing gloves does not replace the need for hand washing because gloves may have small inapparent defects or be torn during use, and hands can become contaminated during removal of gloves .Resident care equipment and articles .Non-invasive resident care equipment is cleaned daily or as need between use by the nursing assistant . 45857

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675617	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eagle Pass Nursing and Rehabilitation	2550 Zacatecas Dr Eagle Pass, TX 78852

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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 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 45307 Based on record review and interview, the facility failed to include as part of its QAPI program, mandatory training that outlined and informed staff of the elements and goals of the facility's QAPI program, for 3 of the 16 staff members (LVN H, LVN I, CNA J) reviewed for mandatory training. Three staff members (LVN H, LVN I, and CNA J) reviewed for mandatory training had not received training regarding the facility's QAA-QAPI program. This deficient practice could place residents at risk of receiving inadequate care from staff who are unfamiliar with the facility's QAPI program. The findings included: Record review of employee files reflected no documented evidence the following employees received training regarding the QAPI program: -LVN H, hired on 07/18/2023 -LVN I, hired on 06/29/2022 -CNA J, hired on 01/17/2024 Interview 04/17/2024 at 2:00 PM, the HRD confirmed she was not aware of LVN H, LVN I, and CNA J not having received QAPI training. The HRD confirmed all staff training was assigned by corporate, and she did not control what staff were assigned. The HRD confirmed LVN H, LVN I, and CNA J were all assigned QAPI training; however, they had not completed the online training via their company contracted training site, Relias. The HRD confirmed her responsibility for training was limited to reminding department heads of late or non-compliant training. Interview on 04/17/2024 at 2:46 PM, the ADM confirmed he was not aware of the facility staff not having been trained on the facility's QAPI plan and protocols. The ADM confirmed the risk could be that staff would be unaware of what the facility's QAPI plan included. The ADM confirmed the QAPI plan was the facility's policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675617	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. 45307 Based on record review and interview, the facility failed to ensure all staff received training in compliance and ethics for 5 of the 16 staff members (the DON, LVN H, LVN I, CNA J, and RN K) reviewed for mandatory training. Five staff members (the DON, LVN H, LVN I, CNA J, and RN K) reviewed for mandatory training had not received training regarding compliance and ethics. This failure could place residents at risk of receiving inadequate care from staff who are uneducated on compliance and ethics. The findings included: Record review of employee files reflected no documented evidence the following employees received training regarding the ethics program: -DON, hired on 12/01/2016 -LVN H, hired on 07/18/2023 -LVN I, hired on 06/29/2022 -CNA J, hired on 01/17/2024 -RN K, hired on 08/09/2023 Interview 04/17/2024 at 2:00 PM, the HRD confirmed she was not aware of the DON, LVN H, LVN I, CNA J, and RN K not having received ethics training. The HRD confirmed all staff training was assigned by corporate, and she did not control what staff were assigned. The HRD confirmed the DON, LVN H, LVN I, CNA J, and RN K were all assigned ethics training; however, they had not completed the online training via their company contracted training site, Relias. The HRD confirmed her responsibility for training was limited to reminding department heads of late or non-compliant training. Interview on 04/17/2024 at 2:46 PM, the ADM confirmed he was not aware of the facility staff not having been trained on corporate compliance and ethics. The ADM confirmed the risk could be that staff would be unaware of corporate compliance and ethics. The ADM confirmed the facility did not have a policy specific to ethics training.