STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675645	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesa Springs Healthcare Center	7171 Buffalo Gap Rd Abilene, TX 79606

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 Based on interviews, and record review, the facility failed to ensure residents had the right to voice grievances to the facility with respect to care and treatment which had been furnished as well as that which had not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay for 1 of 18 residents (Resident #171) reviewed for grievances. The facility failed to investigate and respond to a grievance made by Resident #171's representative who made a grievance to RN A. This failure could place residents and their representatives at risk of not having their grievances heard and or resolved. The findings included: Record review of Resident #171's electronic face sheet dated 01/15/2025 revealed she was a female admitted to the facility on [DATE] and most recently on 07/14/2023 with diagnoses to include: unspecified dementia, muscle weakness, anxiety disorder, and major depressive disorder. Record review of Resident #171's quarterly MDS dated [DATE] revealed no BIMS score because the resident was rarely or never understood. Further review of the MDS Section E behavior revealed Resident #171 did not have hallucinations, delusions, rejection of care, or wandering. Record review of Resident #171's progress notes dated 12/27/2024 by the SW revealed the SW contacted Resident #171's representative via telephone on 12/24/2024 about her concerns with Resident #171 being not compatible with her roommate that had been reported by another staff member. Further review of the progress note revealed that a tour of available rooms was offered and the representative verbalized understanding. The representative stated they would discuss with other representatives and would follow up with SW if interested in room change on 12/31/2024. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 01/15/2025 at 9:37 a.m., Resident #171's representative stated they had made a verbal grievance around 12/20/2024 to RN A. Resident #171's representative stated the grievance had been written down and placed on the DON's desk by RN A per their request not to give to the grievance coordinator. Resident #171's representative stated she never heard back from the facility about her grievance. Resident #171's representative stated they were upset the facility never responded to the grievance especially since the facility was open 24 hours a day. Resident #171's representative stated they would look through their notes and supply copies of notes. During a record review of notes provided by Resident #171's representative on 01/15/2025 at 5:40 p.m. revealed on 12/21/2024 a grievance regarding Resident #171's roommate had been written and RN A placed the grievance on the DON's desk. Further review of Resident #171's representative notes revealed on 12/24/2024 the grievance coordinator called Resident #171's representative and stated since Resident #171's representative had concern with the roommate then Resident # 171 would need to move if the representative chose to have Resident #171 be moved. A room close to the exit door was offered as available. During a telephone interview on 01/16/2025 at 2:36 p.m., RN A stated she had helped Resident #171's family fill out a grievance form but could not remember exactly what date that had occurred. RN A stated she could not remember exactly what Resident #171's representative had been concerned about. She stated she had placed the grievance on the DON's desk due to it being the weekend and she did not know exactly where to put the grievance form. She stated no-one else but herself had access to the DON's office on the weekends. She stated the grievance coordinator was a different ADMN at the time that no longer worked at the facility. She stated she did not know what happened to the grievance after she left it on the DON's desk. During an interview on 01/16/2025 at 2:49 p.m., the DON stated she had never received a grievance or saw a grievance form on her desk after December 21, 2024, about Resident #171. She stated she had no knowledge of the verbal grievance given to RN A. During an interview on 01/16/2025 at 5:13 p.m., the SW stated she was not aware of a grievance filed by Resident #171's representative later in December. She stated that she had been made aware of concern from Resident #171's representative about a roommate not being compatible with Resident #171. She stated she had called the family on the phone and had written a progress note in the electronic chart about offering room change for Resident #171 due to representative's concerns. She stated she did not remember a formal grievance but would look to see if she had a paper copy of a formal grievance. During an interview on 01/16/2025 at 5:22 p.m., the ADMN stated he was unsure of the grievance process if a family had requested grievance be turned into someone other than the grievance coordinator. The ADMN stated that he was not the administrator over this facility on December 21, 2024. During a follow-up interview on 01/16/2025 at 5:33 p.m., the ADMN stated his expectation would be if a grievance had been reported over the weekend, the SW would have logged the grievance and followed up on the grievance as she was the grievance coordinator. He stated typically if there had been issues with roommate compatibility, the resident or representative who brought up the concerns would be offered a room change. He stated he would look for a policy about roommate compatibility. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 01/16/2025at 5:33 p.m., the SW stated she did remember meeting with the representatives of Resident #171's roommate. She stated she remembered a discussion during an IDT morning meeting after December 21, 2024, but could not remember who [NAME] up the discussion about Resident #171's representative's complaint and that another room was offered but Resident #171's representative decided not to have Resident #171 change rooms. The SW stated she never received a formal grievance about the complaint, and she did not log the complaint on the grievance log due to not a formal grievance. The SW stated Resident #171's representative was offered a room change in regard to complaint and she had documented discussion in Resident #171's medical record under progress notes. She denied any change in outcome of issue and stated she had followed up on it but had not documented it as a grievance. During a follow-up interview on 01/16/2025 at 6:14 p.m., the ADMN stated the grievance log had all the grievances in December of 2024. He stated he had not been able to locate any IDT meeting notes from the facility's morning meetings around December 21, 2024. The ADMN stated he had heard from several staff members the discussion had occurred, but he was not present during those meetings. He stated his expectation would be for all grievances to be logged and the SW was responsible for keeping the grievance log up to date. He stated the outcome would not have changed if the grievance had been logged or the formal form had been present. He stated the ADMN monitored that the SW kept the grievance log and forms up to date. The ADMN stated the ADMN during the time of December 21, 2024, was no longer employed by the company. He stated he could not find any facility policy for grievances filed to someone other than the grievance coordinator per resident or resident representative's request. During a record review of facility's grievance log titled complaint tracking and trending log dated December 2024 revealed no documented grievance from Resident #171 or her representative during the month of December. The last grievance listed on the complaint tacking and trending log was dated December 17, 2024. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of facility's policy titled Grievances revised on 12/2023 revealed: Procedure: 1. The facility's grievance official is responsible for overseeing the grievance process and for receiving and tracking grievances; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decision to the resident, if requested; and coordinating with state and federal agencies, as necessary. Information is made available to the resident and/or representative and posted in designated locations throughout the facility .3. General concerns may be voiced at Resident and/or Family Council meetings. 4. The Grievance Official evaluates and investigates the concern and takes immediate action to resolve the concern and prevent further potential violations of any resident's right while the alleged violation is being investigated. 5. The Grievance Official will immediately report all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property to the Administrator; and as required by State law. 6. The Grievance Official or designee responds to the individual expressing the concern within (3) three working days of the initial concern to acknowledge receipt and describe steps taken toward resolution. 7. The Grievance official/designee completed the Grievance Resolution Forms, takes appropriate corrective action in accordance with State law if the alleged violation of resident's rights is confirmed by the facility or an outside entity having authority or jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency within its area of responsibility. The Grievance Official or designee will contact all parties with the outcome. 8. The grievance log is maintained by the Grievance official and reviewed by the Quality Assessment & Assurance Committee and shall not become part of the medical record. Results of grievance will be maintained no less than 3 years from issuance of the grievance decision.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 48883 Based on interviews and record review, the facility failed to refer residents with newly evident or possible serious mental illness or a related condition for PASSR evaluation for 2 of 18 residents (Resident #27, and Resident #29) reviewed for PASRR. The facility failed to refer Resident #27 & Resident #29 for a PASSR evaluation after diagnoses reflected serious mental disorders. This failure placed residents at risk of not receiving or benefiting from specialized therapy and equipment services they may require. Findings included: Resident #27 Record review of Resident #27's electronic face sheet dated 01/16/2025 revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident #27 had a diagnosis of major depressive disorder with onset date of 03/08/2024. Resident #27 had a diagnosis of post-traumatic stress disorder with onset date on 03/08/2024. Record review of Resident #27's quarterly MDS dated [DATE] revealed Resident #27 had a BIMS score of 15 meaning cognition was intact. Further review revealed active diagnosis of depression and post-traumatic stress disorder. Record review of Resident #27's care plan initiated on date 03/09/2024 revealed Resident #27 had risk for impaired cognitive function with goal to maintain current level of cognitive function and interventions included social services to provide psychosocial support as needed. Record review of Resident #27's medical record revealed no evidence a PASRR evaluation had been performed. Resident #29 Record review of Resident #29's electronic face sheet dated 01/16/2025 revealed a [AGE] year-old female initially admitted to the facility on [DATE] and most recently on 10/12/2024. Resident #29 had a diagnosis of schizoaffective disorder bipolar type with onset date of 09/15/2023. Resident #29 had a diagnosis of bipolar disorder with onset date of 09/15/2023. Resident #29 had a diagnosis of major depressive disorder with onset date of 09/15/2023. Record review of Resident #29's quarterly MDS dated [DATE] revealed Resident #12 had a BIMS score of 00 meaning severe cognitive impairment. Further review revealed active diagnosis of depression, bipolar disorder, and schizophrenia. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #29's care plan initiated on date 09/03/2023 revealed Resident #29 had risk for impaired cognitive function because of diagnoses of bipolar and schizoaffective disorder with goal to maintain current level of cognitive function. Interventions included social services to provide psychosocial support as needed. Record review of Resident #29's medical record revealed no evidence a PASRR evaluation had been performed. During an interview on 01/16/2024 at 4:32 p.m., the SW stated residents who had mental illness diagnoses would not be positive for PASSR services per local mental health authority if a resident had not had law enforcement involvement or an inpatient psych stay in the past two years. During an interview on 01/16/2025 at 8:03 p.m., the MDS coordinator stated post-traumatic stress disorder, major depressive disorder, schizoaffective disorder, and bipolar disorder were all diagnoses that were considered mental illness. She stated if the facility had a suspicion of a mental illness after a resident had been admitted than a PASSR evaluation should have been performed. She stated there was no MDS coordinator on site at the facility at this time and she had been responsible for multiple facilities' resident assessments. She stated she did not know why Resident #27 and Resident #29 had not had a PASSR evaluation performed but could have been because of staff turnover. The MDS coordinator stated the facility had been actively attempting to hire a MDS coordinator for the facility, but she was performing duties until a MDS coordinator was hired. She stated she was responsible for setting up PASSR evaluations after a diagnosis triggered a positive PASSR. She stated both her and the SW monitored that PASSR evaluations were performed. She stated not setting up for local mental health authorities to perform PASSR evaluations could cause residents to be placed in inappropriate living arrangements or not receive services that PASSR positive residents needed. The MDS coordinator stated there were no policies that included what occurred when mental illness was suspected after the resident had been admitted into the facility. Review of the facility policy titled PASRR with no date revealed: It is the policy of this facility to ensure that each resident is properly screened using the PASRR specified by the State .Procedures: 1. A PASRR shall be completed on every resident upon admission. 2. Based upon the assessment, the facility will ensure proper referral to appropriate state agencies for the provision of specialized services to residents with MI/MR.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 Based on observations, interviews, and record review, the facility failed to assistance devises to prevent accidents for 1 of 29 residents (Resident #12) whose records were reviewed for quality of care. The facility failed to ensure that Resident #12's wheelchair was placed at Resident #12's bedside as care planned to prevent falls. This failure could place residents at risk of being injured. Findings included: Review of Resident #12's electronic face sheet revealed a [AGE] year-old male admitted on [DATE] with an original admitted [DATE] with the following diagnosis Alzheimer's disease, history of falls, chronic kidney disease, and lack of coordination. Record review of Resident #12's Quarterly MDS dated [DATE] revealed Section C- Cognitive Patterns a BIMS of 6 (meaning severe cognitive impairment); Section J-Health Conditions revealed that Resident #12 had a history of falls with injury. Record review of Resident #12's Care Plan dated 12/09/2024 revealed an intervention of wheelchair close to resident bed as is his preference to reduce the risk of falls. During an observation on 01/14/2024 at 11:30 AM, Resident #12 had signage on door that stated Droplet Precautions and door was open. Resident #12's family representatives were in room moving things. Resident #12's family member was seen moving the wheelchair from the bathroom. During an interview on 01/15/2024 at 2:49 PM, Resident #12's family representative stated they had visited the facility on 01/14/2025 and was upset because Resident #12's wheelchair was in the bathroom, instead of at Resident#12's bedside. Resident #12's family representative stated they had asked the facility to ensure the wheelchair was at bedside, because he had had two major falls in November. Resident #12's family member stated an aide had told her that she had hid the wheelchair in the restroom because Resident #12 was not supposed to leave the room because he was COVID positive. During an interview on 01/16/25 at 7:05 PM, the DON stated her expectation was Resident #12's wheelchair should have been at bedside and not in the bathroom. The DON stated it was care planned for the wheelchair to be at bedside due to Resident #12's history of falls. The DON stated if the wheel chair was not at bedside it could have led to Resident #12 having a fall. The DON stated staff were responsible to ensure the care plan was followed. The DON and the ADON monitored the care plans being followed by making random checks. The DON stated miscommunication and/or misunderstanding by staff led to failure of the wheelchair not being placed at bedside as care planned. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/16/25 at 08:12 PM, CNA C stated she had put the wheelchair in the restroom because he was weak and had COVID and did not want him to try and get up and fall. CNA C stated she never worked with Resident #12 and did not know the wheelchair was supposed to be at his bedside. Record review of facility policy titled, Fall Prevention dated 05/2007 revealed: It is the policy of this facility to investigate the circumstances surrounding each resident fall and implement actions to reduce the incidence of additional falls and minimize potential for injury .Identify an action plan or approaches to be taken in an attempt to prevent further falls. If there is an existing plan of care in the resident's medical record pertaining to falls it should be updated.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 Based on observations, interviews, and record review, the facility failed to ensure that a resident who needed respiratory care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and/or the residents' goals and preferences, for 1 of 29 (Resident #12) reviewed for respiratory care. The facility failed to ensure that Resident #12's oxygen tubing had been changed weekly per physician order. This failure places residents that use oxygen at risk of respiratory complications and/or possible respiratory infections. Findings included: Review of Resident #12's electronic face sheet revealed a [AGE] year-old male admitted on [DATE] with an original admitted [DATE] with the following diagnosis Alzheimer's disease, history of falls, chronic kidney disease, heart disease, and COVID positive. Record review of Resident #12's Quarterly MDS dated [DATE] revealed Section C- Cognitive Patterns a BIMS of 6 (meaning severe cognitive impairment); Section J-Health Conditions revealed that Resident #12 had a history of falls with injury. Record review of Resident #12's Care Plan revealed an intervention with start date of 08/18/2022 Oxygen therapy: 2-3 LPM via nasal Cannula continuous every shift to maintain oxygen saturation above 92%. Record review of Resident #12's Physician orders revealed a start date of 02/25/2022: Change tubing, clean filter, and change O2 water bottle every night shift every Sun. Observation on 01/14/2025 at 3:30 PM revealed Resident #12 was lying in his bed wearing oxygen. Resident #12's oxygen tubing was dated 01/06 . During an interview on 01/16/25 at 07:05 PM the DON stated her expectation was that oxygen tubing be changed weekly, on Sunday. The DON stated the Sunday night shift nurse was responsible for changing oxygen tubing. The DON stated her and the ADON made random checks to ensure the tubing was changed. The DON stated residents could have been affected by the tubing not being changed, it could have led to infection. The DON stated what led to the failure of oxygen tubing not being changed was oversight. Record review of facility policy titled, Oxygen Equipment dated 05/2007 revealed Tubing should be replaced every week.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48883 Based on observations, interviews, and record review the facility failed to provide pharmaceutical services, including procedures that assure the accurate administering of all drugs and biologicals to meet the needs of the residents for 1 of 1 medication room and 1 of 3 (treatment cart) medication carts reviewed for drugs and biologicals. 1. The facility failed to ensure 1 vancomycin IV bag (antibiotic medication in bag for IV) had been removed from the medication room when it had expired on December 2024. 2. The facility failed to ensure 6 boxes of lancets (needles used to obtain small blood samples) were removed from the medication room when they had expired on or after 08/27/2020. 3. The facility failed to ensure 12 IV start kits (used to start IVs) were removed from the medication room when they had expired on 12/10/2024. 4. The facility failed to ensure 8 packages of lubricating jelly (used for lubrication) were removed from the medication room when they had expired on 12/02/2024. 5. The facility failed to ensure 1 tube of Anasept gel (topical solution that fights bacteria and treats or prevents infections) were removed from the treatment cart when they had expired on 11/01/2024. 6. The facility failed to ensure 1 container of packing iodoform strip (medical dressings made of gauze impregnated with iodoform with antibacterial properties) were removed from the treatment cart when they had expired on 06/2024. These failures could place residents at risk of not receiving the therapeutic benefit of medications and biologicals used for testing and treatment of residents. Findings included: During an observation of the treatment cart on 01/15/2025 at 7:07 a.m. revealed: 1. 1 container of expired Anasept gel (topical solution that fights bacteria and treats or prevents infections) expired on 11/01/2024. 2. 1 container of expired packing iodoform strip (medical dressings made of gauze impregnated with iodoform with antibacterial properties) expired on 06/2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/15/2025 at 7:07 a.m., LVN H stated both the Anasept gel (topical solution that fights bacteria and treats or prevents infections) and packing iodoform strip (medical dressings made of gauze impregnated with iodoform with antibacterial properties) should have been removed from the treatment cart when they expired. She stated she was not aware prior to today that those items were expired because she did not use them to treat any residents at this time. She stated those items not being used during treatments may have led to no one noticing those items needed to be removed. LVN H stated nurses were responsible for removing expired items from treatment cart. During an observation of the medication room on 01/15/2025 at 7:37 a.m. revealed: 1. 1 expired bag of vancomycin IV bag expired on December 2024. 2. 6 boxes of expired lancets expired on or after 08/27/2020. 3. 12 containers of expired IV start kits expired on 12/10/2024. 4. 8 packages of expired lubricating jelly expired on 12/02/2024. During an interview on 01/15/2025 at 8:42 a.m., LVN F stated expired vancomycin (an antibiotic medication) should have been removed from the medication room. She stated using medications after expiration could cause skin or body reaction to the medication. LVN F stated the lancets were used to poke fingers and should be disposed of after they expired. She stated she was unsure of what effect it could cause when using expired lancets but could potentially cause them to become dull. LVN F stated the IV started kits were expired and should have been discarded. She stated she was not sure of the risk to residents if the IV start kits had been used but residents should not be exposed to expired goods. LVN F stated that the lubricating jelly was expired and should have been disposed of. She was unsure of any risk using expired lubricating jelly could have on residents. During an interview on 01/16/2025 at 9:20 a.m., MA E stated she checked the medication room daily and did not know how an expired vancomycin IV bag was found in the medication room. She stated she was responsible for making sure that medications including OTC medications were stocked and not expired. She stated expired IV start kits, lubricating jelly, and lancets should have been discarded. She stated she had been responsible for the medication room for approximately five months and did not know she should look for expired supplies in the medication room. She stated not disposing of medication and supplies could hurt the residents if nurses did not notice the items were expired and used them on residents. During an interview on 01/15/2025 at 9:04 a.m., the ADON stated her expectation would be that expired goods be destroyed and not stored in medication room or on medication carts. She stated MA E was responsible for items stored in medication room and nurses were responsible for treatment carts. She stated she did not know why expired goods were found in the medication room and on treatment cart. (continued on next page)

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Mesa Springs Healthcare Center	7171 Buffalo Gap Rd Abilene, TX 79606

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/16/2025 at 12:16 p.m., the DON stated her expectation would be that expired medications and supplies were removed from the treatment cart and medication room. She stated the lead MA was responsible for checking the medication room weekly and nurses and MAs should check the carts daily for expired products. The DON stated the effect of using expired medications or biologicals would be symptoms not being managed or treated by products not being as effective. The DON stated both herself and the ADON performed random audits in the medication room and medication carts and the failure occurred due to oversite. Record review of the facility's policy titled Disposal of Drugs and Supplies with no date revealed: Disposal and or disposition of medications and other drugs is defined as any process by which a substance leaves or is removed from the facility, except for the authorized administration to a patient .Procedures: Ointments, creams, and similar substances are placed in trash receptacles in the medication room. Tablets, capsules, and liquids are washed down the toilet or hopper sink or disposed of in another acceptable manner. The consultant pharmacist is contacted if the facility is unsure of proper disposal methods for a medication. Record review of the facility's policy titled Storage of Medications with no date revealed: Medication and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48883 Based on observation, interview and record review, the facility failed to store all drugs and biologicals in locked compartments and to permit only authorized personnel to have access to 1 (treatment cart) of 5 medication carts reviewed for security. The facility failed to ensure treatment cart with prescription medications and biologicals were not left unlocked, unsecured, and unattended. These failures could place residents at risk of misappropriation of medications, drug diversions, or accidental ingestion. The findings included: During an observation on 01/16/2025 at 12:10 p.m. the treatment cart was sitting at the nurses' station with no nursing staff present ; residents were observed in area of the treatment cart. Items in treatment cart included: Insulin pens (insulin filled containers in pen form), Insulin needles (needles to give insulin), lancets (device used to obtain blood sample for finger stick blood sugar), albuterol (medication in inhaler used for shortness of breath), Breztri (medication in inhaler used for shortness of breath), Trelegy (medication in inhaler used for shortness of breath), DuoNeb (liquid medication stored in bullets for opening up airways when inhaled using nebulizer), Scissors, Nystatin (prescription anti-yeast powder), Clobetasol ointment (medication used to treat skin conditions including rashes), Skin Prep swabs (individual swabs with medication infused to help adhesive stick to skin and reduce irritation), IV start Kits (kits with needle, tourniquet, catheter, tape, and adhesive dressing) , Saline syringes (syringes filled with saline solution for IV medication administration), Milk of Magnesia (liquid medication used to treat constipation), Maalox (liquid medication used to treat heart burn), and disinfectant wipes. During an observation and interview on 01/16/2025 at 12:13 p.m., MA E observed walking by the treatment cart and locked the treatment cart as she walked by it. MA E stated she was not responsible for monitoring medication carts were locked. MA E stated she saw the treatment cart was unlocked so she locked it. She stated the treatment cart that was unlocked was RN G's responsibility. MA E stated RN G was in the dining room at 12:13 p.m. During an observation and interview on 01/16/2025 at 12:21 p.m., RN G stated she was responsible for the treatment cart being left unlocked and unattended at the nurse's station. She stated the treatment cart should have been locked when she was not using the treatment cart. RN G stated she had been in a hurry to get to the dining room and must have forgotten to lock the treatment cart. She stated not locking the treatment cart could give residents access to the items in the cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/16/2025 at 12:16 p.m., the DON stated her expectation would be for medication and treatment carts to be always locked when not in use. She stated the effect on residents from an unlocked treatment cart would be items could be taken out or put inside without use of a key. The DON stated the assigned nurse was responsible for locking treatment carts. She stated both her and the ADON do educations as necessary and perform random cart checks. She stated carelessness led to the failure of locking the treatment cart. Record review of facility's policy titled, Medication Access and Storage, E kit access with no date revealed: Only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medications (e.g. , medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. 48883 Based on observations, interviews, and record review the facility failed to ensure the quality of laboratory services in the facility for 1 of 1 medication room reviewed for drugs and biologicals. The facility failed to ensure 2 boxes of COVID testing kits (used for COVID testing) were removed from the medication room when they had expired on 12/15/2023. The facility failed to ensure 1 box and 4 packages of influenza A & B Tests (used for Flu testing) were removed from the medication room when they had expired on 11/30/2024. These failures could place residents at risk of inaccurate testing results. Findings included: During an observation of the medication room on 01/15/2025 at 7:37 a.m. revealed: 1. 2 boxes of expired COVID testing kits expired on 12/15/2023. 2. 1 box and 4 packages of expired influenza A & B testing kits expired on 11/30/2024. During an interview on 01/15/2025 at 8:42 a.m., LVN F stated COVID and influenza tests should be disposed of after they were expired. She stated she did not know why expired test kits were in the medication room. LVN F stated COVID and influenza tests that were expired could cause results to not be accurate. During an interview on 01/16/2025 at 9:20 a.m., MA E stated expired COVID tests and influenza tests should have been discarded. She stated she had been responsible for the medication room for approximately five months and did not know she should look for expired supplies in the medication room. She stated not disposing of supplies could hurt the residents if nurses did not notice the items were expired and used them on residents. During an interview on 01/15/2025 at 9:04 a.m., the ADON stated her expectation would be that expired goods be destroyed and not stored in medication room or on medication carts. She stated MA E was responsible for items stored in medication room. She stated she did not know why expired goods were found in the medication room During an interview on 01/16/2025 at 12:16 p.m., the DON stated her expectation would be that expired supplies were removed from the medication room. She stated the lead MA was responsible for checking the medication room weekly. The DON stated the effect of using expired medications or biologicals would be symptoms not being managed or treated by products not being as effective. The DON stated both herself and the ADON performed random audits in the medication carts and the failure occurred due to oversite. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled Storage of Medications with no date revealed: Medication and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44728 Based on observations, interviews, and record reviews the facility failed to properly store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitization. The facility failed to ensure foods in Refrigerator #1, Refrigerator #2, and the freezer were not sealed and/or labeled properly. The facility failed to ensure food that left the kitchen was covered. This failure could place residents that eat out of the kitchen at risk for contamination and food borne illnesses. Findings included: During an observation on [DATE] at 10:15 AM of facility kitchen revealed the following: Refrigerator #1: 1 bin of Celery was unlabeled and with no in date and was open to air, and 1 box of Muffins was unsealed and open to air. Refrigerator #2: 1 box of sausage was unsealed and open to air, in refrigerator. Freezer: 1 box of Cannoli was unsealed and open to air. During an observation and interview on [DATE] at 9:07 AM with the DM observed in the refrigerators the open to air product (cannoli's, celery and muffins), as well as the open box and open to air box of sausage. The DM stated the open to air products should be in placed in sealed containers or packages. She stated the possible negative impact for residents could have been cross contamination with residents becoming sick. She stated her expectations were for all products, once received, to have an in date, as well as labeled if needed. The DM stated that she had continuous trainings with her staff on this subject. During observation on [DATE] at 12:24 PM, the hall carts which contained resident trays was observed being transported from the kitchen to the hallways with the cakes being uncovered. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 12:44 AM the DM stated the desert should have been covered prior to being transported to the hallways. She stated the possibility of cross contamination could have been possible. She stated she monitored the proper transporting of food prior to leaving the kitchen to resident's room. The DM stated her expectations were that all food be covered prior to leaving the kitchen. She stated the failure was with the Dietary staff being in a hurry, as well and thinking since the whole cart was covered, they were in compliance. The DM stated it should have never happened and should have been covered. During an interview on [DATE] at 5:12 PM the Interim ADMN stated the staff should have followed the policies and procedures for dating and labeling all food product where needed. He stated there was a possibility of a negative impact to residents with the potential of getting and consuming expired food which could have been a potential for contamination. The Interim ADMN stated the failure likely occurred from the time of food being delivered and stored. He stated the DM monitored all food coming into the facility. During an interview on [DATE] at 5:30 PM the SW stated, all but 1 resident ate from the kitchen. Record Review of facility's Dietary Services, Food Storage, undated revealed; Policy: It is the policy of this facility that food storage areas shall be maintained in a clean, safe, and sanitary manner. Procedures:.10. Food products must be labeled and dated. Review of FDA Food Code 2022: Full Document accessed on [DATE] in annex 7 page 37, 38 revealed: Applicable Code Sections: ,d+[DATE].16(A)(2) and (B) Time/Temperature Control for Safety Food, Hot and Cold Holding (P) 23. Proper date marking and disposition FDA Food Code 2022 Annex 7: Model Forms, Guides, and Other Aids Annex 7 -38 IN/OUT This item should be marked IN or OUT of compliance. This item would be IN compliance when there is a system in place for date marking all foods that are required to be date marked and is verified through observation. If date marking applies to the establishment, the PIC should be asked to describe the methods used to identify product shelf-life or consume-by dating. The regulatory authority must be aware of food products that are listed as exempt from date marking. For disposition, mark IN when foods are all within date marked time limits or food is observed being discarded within date marked time limits or OUT of compliance, such as when date marked food exceeds the time limit or date-marking is not done.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883 Based on observation, interview, and record review, the facility failed implement its policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption for 3 (Resident #23, Resident #36, and Resident #65) of 18 residents reviewed for food and nutrition services. 1. The facility failed to ensure that Resident #36's personal refrigerator did not have expired goods stored and failed to log refrigerator's temperature after [DATE]. 2. The facility failed to ensure that Resident #65's personal refrigerator did not have expired goods stored and failed to have a thermometer inside to check temperature. 3. The facility failed to ensure that Resident #23's personal refrigerator had a thermometer inside to check temperature and failed to keep temperature log during the month of [DATE]. These failures could place residents at risk for foodborne illnesses. The findings were: 1.During an observation and interview on [DATE] at 10:21 a.m., Resident # 36 personal refrigerator had temperature log outside of the door. Temperature 42 written on [DATE] a.m. with initials WR. No other temperatures logged during [DATE]. Observed container of whip cream inside of the refrigerator with best when used by 07 [DATE] written on container. Observed container of Ranch dressing inside of the refrigerator with best if used by date which read 14 JUN 24 written on the label. Resident #36 stated she was unaware the items had used by dates that had been exceeded. She stated it was hard for her to read small numbers on food labels and asked that the food items be disposed of in the restroom trash receptacle. 2.During an observation and interview on [DATE] at 11:15 a.m., Resident #65 was lying in her bed and a visitor brought in supplemental drinks to place in refrigerator. The outside of the refrigerator had a log with no date or year on it. It was filled in with 14 different numbers with initials MS by each number. There was no thermometer inside of the refrigerator. The refrigerator had cultured buttermilk with a best by date of 09 [DATE] on the container. Resident #65 stated she was unaware of the cultured buttermilk's date and stated she was not able to get items out of the refrigerator without assistance of staff or visitors. She did not know how often the refrigerator was checked. Resident #65's visitor stated she would remove expired buttermilk so that Resident #65 would not accidentally drink it. 3.During an observation and interview on [DATE] at 10:35 a.m., Resident #23 was sitting in her wheelchair inside of her room and was sipping on a soda that she had removed from her personal refrigerator. The refrigerator did not have any temperatures logged during the month of [DATE]. Inside the refrigerator, observed drinks and some food that appeared to be cake stored in Styrofoam container. There was no thermometer inside of the refrigerator. She stated she did not know how often the facility looked at the refrigerator or items inside of it. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 9:40 a.m., CNA C stated she did not know who was responsible for checking the resident's personal refrigerators. She stated she had gone and checked some of the refrigerators on [DATE] when the residents would let her. She verified that Resident # 36 did not have temperatures on her refrigerator since [DATE]. She verified that Resident # 65 did not have a thermometer in her personal refrigerator. She stated the refrigerators should have thermometers and should be checked to help prevent sickness. During an interview on [DATE] at 9:44 a.m. LVN D stated housekeeping was responsible for monitoring the refrigerators in resident's rooms. She stated nursing staff were responsible for monitoring refrigerators in nutrition and medication room. During an interview on [DATE] at 9:48 a.m., HK B stated housekeeping was responsible for monitoring residents' personal refrigerators including temperatures. He stated temperatures should be taken weekly and then written on logs. He stated if the logs were not filled in then the temperature was not taken. HK B stated the HK supervisor had gone home sick on [DATE] and that may have led to the failure of not checking refrigerators. He stated he used to carry a thermometer that he would use to obtain temperatures in refrigerators that did not have one inside of them but that had been recently broken. During an interview and observation on [DATE] at 11:56 a.m., the Director of Maintenance had personal refrigerators in sealed packages at the nurses' station. He stated that he had gone to several local stores and purchased the thermometers that morning. He stated he had taken over the HK supervisor role 2 weeks ago and was not aware that personal refrigerator thermometers were needed and were part of his role to provide. During a follow up interview on [DATE] at 8:47 p.m., the Director of Maintenance stated HK was responsible for cleaning out the residents' personal refrigerators and that included removing expired foods. He stated not removing expired foods could cause residents to become sick if they ate those items. Record review of the facility policy titled Resident Personal Food Storage revised on ,d+[DATE] revealed Food or beverage brought in from outside sources for storage in facility pantries, refrigeration units, or persona/resident room refrigeration units will be monitored by designated facility staff for food safety .Facility staff will assist resident with accessing and consuming food if resident is not able to do so on his/her own. All refrigeration units will have internal thermometers to monitor for safe food storage temperatures. Units must maintain safe internal temperatures in accordance with state and federal standards for safe food storage temperatures. Staff will monitor and document unit refrigerator temperatures. Resident and individuals bringing food in from outside sources will be educated on safe food handling and storage techniques by designated facility staff as needed. Record review of the facility policy titled Food Storage not dated revealed Cold foods shall be maintained at temperatures of 40 F or below.

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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. 48883 Based on 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 to help prevent the development and transmission of communicable diseases and infections for 2 (CMA J and CMA K) of 6 staff observed for infection control practices. The facility failed to ensure CMA J wore the required PPE in a Resident #17's room while providing medication and eye drops for Resident #17. The facility failed to ensure CMA K sanitized face shield per infection control protocols and procedures. These failures place residents at risk for cross contamination and spreading of infections while in facility. Finding included: Record review of facility provided document for Covid testing of residents revealed: Resident #12 tested positive for COVID on 1/11/2025; Resident #17 tested positive for COVID on 01/10/2025; and Resident #41 tested positive of Covid on 1/11/2025. During an observation on 1/14/2025 between 10:30 AM and 10:40 AM Resident #17 and Resident # 12's had signs on door that stated, STOP Airborne Precautions Everyone must: Put on a fit-tested N-95 or higher-level respirator before room entry. There were only surgical masks available at both doors, no N-95 masks were available with the PPE. During an observation on 1/14/2025 at 11:20 PM staff were observed taking the surgical mask out of the PPE bins and placing N-95 masks in its place. During an observation and interview on 1/14/2025 at 12:15 PM CMA K left Resident #47's room with face shield and walked down hallway to shower room to clean shield with bleach wipes and then walked back down hall to place shield in bin PPE bin outside of Resident #47's room. CMA K stated she had been trained on PPE, but there were no wipes on the hall at the Resident room, so she had to go to shower room to get wipes to clean the shield. She stated she was told that the wipes were not left on the hall because they were afraid residents would get the wipes. CMA K stated she did not think it made sense to go down the hall to get wipes to clean the shield and stated the wipes should have been at the door. CMA stated she should not have carried the shield down the hall. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 01/15/2025 at 10:00 AM CMA J had set a tray covered in a clear bag with medications, gloves and tissues to take into Resident #17's room. CMA J had put on a gown, gloves, and a N95 mask. CMA J failed to put on a face shield before she entered Resident # 17's room. After CMA J entered Resident #17's room she stated she forgot to put on the face shield, CMA J failed to stop and put on a face shield. CMA J continued to place eye drops in Resident #17' s eyes. CMA J gave the last eye drop and dropped a clean glove on the floor, CMA J stated, I never drop gloves and I did not bring, extra gloves. CMA J continued to hand Resident # 17 her medication with gloved hand and assisted Resident # 17 drinking water with her ungloved hand. Before exiting the room CMA J discarded supplies off the tray but did not take the bag off the tray and laid the tray wrapped in the contaminated bag on her mediation cart in hallway. CMA J stated she should have stopped and put on a shield, and she should have gotten another glove. During an interview on 01/16/2025 at 12:16 PM the DON stated staff have been trained on how to provide care for COVID positive residents and the requirements of wearing PPE. The DON stated staff should be wearing all the PPE listed on the door which was a gown, gloves, N95 mask and face shield. The face shield should have not been carried down the hall to be cleaned, it should have been cleaned or disposed of prior to exiting the room. The DON stated the residents could have been affected by exposing residents to COVID. The DON stated what led to failure was staff not following policy or their training. Record review of facility policy titled, COVID Related Processes not dated revealed The facility will follow recommendations made by local health department related to masking, testing and other COVID related precautions. Donning a PPE (healthcare professionals and visitors); Mandatory when working with COVID positive resistant (mask, eye protection and gloves). Review of the CDC https://www.cdc.gov/infection-control/media/pdfs/Toolkits-PPE-Sequence-P.pdf revealed: The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE. GOWN o Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back o Fasten in back of neck and waist 2. MASK OR RESPIRATOR o Secure ties or elastic bands at middle of head and neck o Fit flexible band to nose bridge o Fit snug to face and below chin o Fit-check respirator 3. GOGGLES OR FACE SHIELD o Place over face and eyes and adjust to fit 4. GLOVES o Extend to cover wrist of isolation gown.