STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675649	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Health Rehab	11127 Circle Dr Austin, TX 78736

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50872 Based on observations, interviews, and record review, the facility failed to ensure the residents' right to privacy during personal care for 1 of 2 residents (Resident #5) reviewed for privacy. The facility failed to ensure RN G provided and continued to provide privacy during wound care for Resident #5, by ensuring the door and privacy curtain remained closed throughout the procedure. This failure could place residents at risk of having their bodies exposed to the public, resulting in low self-esteem and diminished quality of life. The finding included: Record review of Resident #5's admission record, dated 2/14/2025, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Urinary tract infection, cystitis (inflammation of the bladder), pleural effusion (a collection of fluids around the lungs), chronic heart failure (the heart is unable to pump blood to meet the demands of the body), right above the knee amputation, hypertension (high blood pressure), and anxiety disorder. Record review of Resident #5's admission MDS, dated [DATE], revealed a BIMS score of 15, which indication no cognitive impairment. Further review of the MDS revealed Resident #5 had one unhealed pressure ulcer. Record review of Resident #5's care plan, dated 12/13/2024, revealed the resident had an impairment to skin integrity of the left buttock/coccyx (tailbone) area. The relevant intervention was monitor/document location, size, and treatment of skin injury. Report abnormalities, failure to heal, sign and symptoms of infection, maceration (skin breakdown due to moisture at the cellular level) to the MD. During an observation on 02/13/2025 at 02:03 PM revealed RN G provided wound care to Resident #5. During the wound care, RN G left Resident #5 with exposed buttocks toward the door and opened the privacy curtain to retrieve supplies. While the RN was retrieving the supplies another resident (unknown) opened the room door leaving Resident #5 with exposed buttocks to the hallway. RN left the door and privacy curtain open while she finished the remainder of the wound care. If anybody passed by the hallway to Resident #5's rooms, they would see Resident #5 exposed buttocks. (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/13/2025 at 03:04 PM Resident #5 stated she didn't notice that the curtain and the door were opened. She stated it could be embarrassing if someone had seen her exposed backside. During an interview on 02/13/2025 at 02:30 PM RN G stated, she had been trained on resident rights. She stated some rights are residents had the right to privacy, right to refuse care, and right to be informed about care. She stated by not closing the door and the curtain when it was opened, the privacy and dignity of Resident #5 were compromised as anyone passing by the room could have seen Resident #5's exposed body. She stated she was nervous and didn't realize at the time. During an interview on 02/14/2025 at 04:18 PM the DON stated that the staff providing wound care were responsible for ensuring the resident's privacy was maintained. She stated not ensuring the resident's privacy could affect the resident emotionally. The DON stated that she and the ADON monitored the staff to ensure they provided privacy for the residents with daily observations. During an interview on 02/14/2025 at 04:40 PM the ADM stated the residents have the right to privacy. She stated she expected staff to close the door and use the privacy curtains when providing care for the residents. She stated if a door and/or privacy curtain were opened during patient care it could make the resident feel exposed. Record review of undated blank Treatment Nurse Competency Check off revealed step #9. Closed door and pulled privacy curtain and step #20 Maintain resident's dignity during treatment. Record review of policy titled Resident Rights, dated 2001 and revised December 2016, revealed: Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: t. privacy and confidentiality.

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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 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** 50872 Based on interview and record review, the facility failed to ensure that the residents who needed respiratory care were provided such care, consistent with professional standards of practice, for 1 of 4 (Resident #22) reviewed for quality of care. The facility failed to ensure Resident #22 received adequate physical assessment, including vital signs and lung sounds, prior to and after she received medications through a nebulizer and while on antibiotics for an upper respiratory infection. The failure could place resident at an increased risk for an adverse reaction to medication. Findings include: Record review of Resident #22's admission record, dated 2/14/2025, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included cerebrovascular disease (a condition that affect blood flow to the brain), vascular dementia (a condition affecting thought processes caused by impaired blood flow to the brain), muscle weakness, hypertension (high blood pressure), retention of urine (unable to urinate naturally), and hyperlipidemia (high cholesterol). Record review of Resident #22's quarterly MDS, dated [DATE], revealed a BIMS score of 14 which indicated no cognitive impairment. Record review of Resident #22's Medication Administration Record, dated January 2025, revealed Resident #22 received Azithromycin (an antibiotic) on January 10-14, 2025, for infection. Resident #22's Nursing Medication Administration Record revealed Resident #22 received Ipratropium-Albuterol Inhalation Solution on 01/02/2025, 01/10/2025, 01/12/2025, 01/13/2025, 01/14/2025, 01/15/2025, 01/16/2025, and 01/19/2025. Record review of Resident #22's progress note written by NP L, dated 01/10/2025, revealed Patient is seen in her room. She still has a cough, over 1 week in, has been flu negative, no fever but cough is productive, difficult sleeping. Will treat as URI and start x park[sp?] and prednisone. Assessment and plan 1. Cough: for over a week, productive, taking cough medicine, will treat with zpak and short course of Prednisone. Diagnoses Acute upper respiratory infection, unspecified. Record review of Resident #22's care plan on 02/14/2025 revealed no care plan related to respiratory. Record review of Resident #22's vital signs dated 02/14/2025 revealed no heart rate/pulse, oxygen saturation, respiratory rate, and temperature were documented on 01/02/2025, 01/10/2025, 01/12/2025, 01/13/2025, 01/14/2025, 01/15/2025, 01/16/2025, and 01/19/2025. Record review of Resident #22's nursing progress notes revealed no documented vital signs or lung sounds on 01/02/2025, 01/10/2025, 01/12/2025, 01/13/2025, 01/14/2025, 01/15/2025, 01/16/2025, and 01/19/2025. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 02/13/2025 at 01:11 PM, the DON stated nebulizer treatments did not require documentation of lung sounds, heart rate, oxygen saturation or respiratory rate. She stated after reviewing Resident #22's chart, there were not any vital signs documented on 01/02/2025, 01/10/2025, 01/12/2025, 01/13/2025, 01/14/2025, 01/15/2025, 01/16/2025, and 01/19/2025. The DON stated vital signs should be assessed and documented when residents were taking antibiotics. She didn't have an answer for how it might affect a resident if an assessment is not performed and documented while a resident is on antibiotics. During an interview on 02/14/2025 at 03:24 PM, LVN C stated the policy for assessment prior to administering a nebulizer treatment included assessing pulse, respiratory rate, oxygen saturation and lung sounds. She stated the nurse administering the medication is responsible for performing the assessment and documentation. LVN C stated residents on antibiotics for a respiratory infection should have temperature and oxygen saturations monitored and documented. She stated the nurse responsible for the resident during that shift is responsible for monitoring these vital signs. She stated she wasn't sure who was responsible for monitoring for completion of assessments. During an interview on 02/14/2025 at 3:48 PM, LVN A stated prior to administering nebulizer treatments they are responsible for raising the head of the bed, checking oxygen saturation and heart rate, and documenting it on a pop-up screen. He stated when a resident is taking antibiotics for a respiratory infection, they should be monitored for side effects and the resident's temperature and oxygen saturation. Record review of undated handheld nebulizer competency provided by the facility revealed Step #8 Performs patient assessment (pulse, breath sounds, respiratory rate, pulse ox), Step # 15 Encourage patient to cough and observe sputum characteristics if cough is productive. Assess breath sounds, RR, and HR, and Step #21 Correctly document all appropriate information into patient's medical records. Record review of facility policy titled Charting and Documentation, dated 2001 and revised July 2017, revealed Policy statement All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation 2. The following information is to be documented in the resident medical record: a. Objective observations; b. Medications administered; c. Treatments or services performed; d. Changes in the resident's condition; e. Events, incidents or accidents involving the resident; and f. Progress toward or changes in the care plan goals and objectives. 7. Documentation of procedures and treatments will include care-specific details, including a. The date and time the procedure/treatment was provided; b. The name and title of the individual(s) who provided care; c. The assessment data and/or any unusual findings obtained during the procedure/treatment; d. How the resident tolerated the procedure/treatment; e. Whether the resident refused the procedure/treatment; f. Notification of family, physician or other staff, if indicated; and g. The signature and title of the individual documenting.

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50872 Based on observation, interview and record review, the facility failed to ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 5 (Resident #195) residents reviewed for pain. The facility failed to provide scheduled Morphine and Tramadol for Resident #195 from 02/07/2025-02/09/2025 which resulted in mental anguish and untreated pain. An IJ was identified on 02/11/2025. The IJ template was provided to the facility on [DATE] at 04:56 PM. While the IJ was removed on 02/14/2025, the facility remained out of compliance at a scope of isolated and a severity level of 1 because all nursing staff had not been trained on pain assessments and the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk for prolonged and unnecessary pain and suffering and a decreased quality of life. Findings included: Record review of Resident #195's admission record, dated 02/14/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included pneumonia (an infection in lungs), dementia (a condition that affects thought processes), insomnia (difficulty sleeping), chronic pain syndrome, hypertension (high blood pressure), osteoarthritis (a condition that affects the cartilage that cushions the ends of the bones), scoliosis (a sideways curvature of the spine), and spinal stenosis (narrowing of the spinal canal in the low back). Record review of Resident #195's care plan, dated 02/12/2025, revealed Resident #195 had pain with relevant interventions that included administer analgesia and evaluate effectiveness of pain interventions. Record review of Resident #195's hospital discharge physician orders dated 02/07/2025 revealed the following order: Morphine SR 30mg oral three times a day last administered at 02/07/2025 at 08:19 AM. The physician progress note reflected, chronic backache continue home regime. Record review of Resident #195's physician's orders, dated 02/10/2024, revealed: Morphine Sulfate Oral Tablet 30mg Give 1 tablet three times a day for pain with a start date of 02/07/2025 07:00PM Tylenol Tablet 325mg Give 2 tablet by mouth every 4 hours as needed for mild pain with a start date of 02/08/2025 12:30AM Tramadol 100mg Give 1 tablet by mouth every 8 hours as needed for pain. Give medication until he gets Morphine Sulfate 30mg TID with a start date of 02/09/2025 02:00AM and an end date of 02/09/2025 02:10AM (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Tylenol Extra strength 500mg Give 2 tablet by mouth every 8 hours for pain with a start date 02/09/2025 07:00AM and an end date of 02/09/2025 03:42PM Tramadol 100mg Give 1 tablet by mouth every 8 hours for pain to be given until Morphine is available with a start date of 02/09/2025 07:00AM and end date of 02/09/2025 03:41PM. Record review of Resident #195's medication administration record for 02/07/2025-02/10/2025 revealed: Morphine Sulfate Oral Tablet 30mg Give 1 tablet by mouth three times a day for pain with start date of 02/07/2025. Missed doses with documented awaiting arrival from pharmacy noted were: 02/07/2025 07:00 PM 02/08/2025 07:00 AM 02/08/2025 01:00PM 02/08/2025 07:00PM 02/09/2025 07:00 AM 02/09/2025 01:00PM First dose of medication documented for 02/09/2025 at 08:54 PM. Tylenol 325mg Give 2 tablet by mouth every 4 hours as needed for mild pain. Medication documented as given: 02/08/2025 12:40 AM 02/08/2025 03:25 PM 02/10/2025 01:48 AM Tramadol oral tablet 100mg Give 1 tablet by mouth every 8 hours as needed for pain start date 02/09/2025 02:00 AM and end date 02/09/2025 02:10AM. No signature noted on medication administration record for this medication. Tramadol oral tablet 100mg Give 1 tablet by mouth every 8 hours for pain start date 02/09/2025 07:00 AM and stop date 02/09/2025 03:41 PM. Medication documented as not given 02/09/2025 07:00AM with notation waiting for the pharmacy to deliver, the nurse was notified. Medication documented as not given 02/09/2025 03:00 PM with notation Hold medication per nurse's request. Tylenol Extra strength 500 mg Give 2 tablet by mouth every 8 hours for pain start date 02/09/2025 07:00 AM and stop date 02/09/2025 03:42 PM. Medication documented as not given 02/09/2025 03:00 PM with notation Hold medication per nurse's request. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #195's progress note, dated 02/08/2025 at 10:09 PM and documented by LVN A, revealed the following: Resident has not received his Morphine 30 mg po tablet. He is really frustrated over this issue. Faxed another triplicate to [MD] and awaiting delivery. Tylenol 650mg and not enough. Record review of Resident #195's progress note, dated 02/09/2025 at 02:44 AM and documented by LVN A, revealed the following: Resident continue to call for his Morphine 30mg. Called on call NP for [MD] temporarily orders Tramadol 100mg q 8 hrs to be given together with Tylenol ES 1000 mg po q 8 until Morphine comes. First dose already given. Discussed about the Morphine with resident and stated that he has the medication at home. Encouraged resident to communicate with his [family member] to bring the medication today. Record review of Resident #195's progress note, dated 02/09/2025 at 02:58 AM and documented by LVN A, revealed the following: No pain noted or expressed. Pain level is currently at 10. Record review of Resident #195's progress note, dated 02/09/2025 at 08:54 PM and documented by LVN A, revealed the following: Received 10 tablets of Morphine 30mg and given to resident. Tramadol and Tylenol d/c as Morphine received. Record review of Resident #195's progress note, dated 02/09/2025 at 08:56 PM and documented by LVN A, revealed the following: Resident verbalizes or expresses presence of pain. Pain level is currently at 10. Resident demonstrates non-verbal signs of pain. Record review of Resident #195's progress note, dated 02/10/2025 at 01:44 AM and documented by LVN A, revealed the following: Resident awake and alert in bed. Called several times asking for his Morphine medication. Explained to him that the medication is to be given 3 x a day at 7am, 1pm, and 7pm .Tylenol 650 mg po given prn at 1:40am. During an interview and observation on 02/10/2025 at 10:06 AM, Resident #195 revealed he had concerns about his morphine not being administered since he was admitted . The resident stated he had been taking Morphine three times a day for a long time. He stated his primary care physician had him set up on the medication to control his pain and it had worked in the past. Resident #195 stated he hadn't been below a level 7 of 10 pain(Scale 0=no pain and 10=the worst possible pain), and he hurt in his lungs and lower back. When asked to describe the pain he rated at 10, the resident stated hell and sharp. The resident exhibited facial grimacing and appeared in pain during the interview. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 02/10/2025 at 03:01 PM, LVN D stated she was the nurse on duty when Resident #195 was admitted to the facility on [DATE] around 03:30 PM. She stated she faxed a request for a triplicate (specialized prescription for controlled medications) for the Morphine to the MD per protocol, but she wasn't sure what time. The Morphine didn't come in before she left her shift on 02/08/2025 at 06:00 AM. She stated she passed it on in report and documented it on the 24-hour report. She stated there had been some communication errors with the pharmacy getting prescriptions. She stated they needed to continue to attempt to obtain the medication needed. LVN D stated not getting pain medication that was ordered could cause discomfort for the resident. During a telephone interview on 02/10/2025 at 03:23 PM, LVN E stated he worked the next morning after Resident #195 was admitted . He stated he was not aware that Resident #195 was missing his Morphine on that day. LVN E stated if he had been aware of the need for pain medication, he would have contacted the on-call NP to get an order for something stronger than Tylenol until the Morphine arrived and the DON to expedite getting the medication. During a telephone interview on 02/10/2025 at 04:11 PM, NP L stated if a resident needed a triplicate, then the nurse needed to fax a completed request form to the MD. She stated the MD received the faxes on the weekend too and addressed the requests as they were received. She stated Tylenol 650mg is not a comparable pain medication to Morphine Sulfate 30mg. During a telephone interview on 02/10/2025 at 04:17 PM, the MD stated he received the request for a triplicate prescription for Resident #195 on 02/07/2025. He stated he sent the prescription to the wrong pharmacy. The MD stated he wasn't sure how the lack of pain medication could affect the resident since he had not assessed the resident yet. During an interview on 02/11/2025 at 10:42 AM, the DON stated the facility preferred to get the orders prior to the residents' admission to ensure a triplicate could be requested prior to the resident's arrival. She stated the policy was for the nurse to fax a request form to the MD. The MD then would send the prescription to the pharmacy, and the facility should have received the medication on the next delivery. The DON stated if there were issues with obtaining the medication then that medication needed to be put on hold and an order should have been obtained for a substitute that could have been pulled from the E-kit or the nurse should have administered Tylenol from the standing orders. She stated she did not consider Morphine and Tylenol to be equivalent. The DON stated Resident #195 arrived at the facility around 3:30PM on 02/07/2025. She stated the nurse requested a triplicate when the resident arrived. The DON stated Resident #195's Morphine wasn't received on 02/07/2025 or 02/08/2025. She stated Morphine should have been placed on hold after the first delivery without it. She stated the nurse and medication aide just documented the medication was unavailable. The DON stated the nurse that worked 02/09/2025 at 02:20AM pulled the Tramadol from the emergency kit and administered it. She stated Resident #195 received Tylenol an additional 3 times prior to his Morphine arriving on 02/09/2025 around 09:00 PM. She stated that uncontrolled pain might affect each resident differently. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on 02/11/2025 at 11:54 AM, LVN A stated he worked with the resident the nights of 02/09/2025 and 02/10/2025. He stated he called the pharmacy on 02/09/2025 to locate the Morphine. They had not received a triplicate. He stated the only orders Resident #195 had for pain was Tylenol 650mg, so he contacted the NP and received an order for Tramadol and Tylenol together. He stated the NP was going to follow up with the MD for the triplicate for Morphine. LVN A stated he then pulled the Tramadol from the E-kit and gave the initial dose. He stated the resident was rating the pain a 10 before the Tramadol and between a 6 and 8 after the Tramadol. During a phone interview on 02/11/2025 at 01:16 PM, MA N stated she worked with Resident #195 on 02/08/2025 and 02/09/2025. She stated she notified the nurses that were working that the Morphine was unavailable. MA N stated, I was told to just document it as unavailable by them[the nurses]. She stated [Resident #195] was in a lot of pain and stuff. During an interview on 02/11/2025 at 01:26 PM, CNA I stated he worked with the Resident #195 on 02/08/2025 and 02/09/2025. He stated Resident #195 complained of pain on those days. CNA I stated he gave Resident #195 a bed bath on 02/09/2025 because Resident #195 was in too much pain to get up. He stated he notified LVN M about Resident #195's pain. During an interview on 02/11/2025 at 01:40 PM, the FM stated Resident #195 had been taking Morphine Sulfate 30mg three times a day for more than a decade. The FM stated during a visit on 02/08/2025, Resident #195 had facial grimacing worse than ever before. During an interview on 02/11/2025 at 02:36 PM, the DON stated she didn't have an answer for why the nurse didn't pull the second dose of Tramadol from the E-Kit. She stated there was Tramadol in the E-kit at that time and the nurse should have pulled the medication to administer it to the Resident #195. Record review of facility policy titled Pain-Clinical Protocol, dated 2001 and revised October 2022, revealed: Assessment and Recognition 1. The physician and staff will identify individuals who have pain or who are at risk for having pain . 2. The nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. . Monitoring 1. The staff will assess the individual's pain and related consequences at regular interval, at least each shift for acute pain or significant changes in levels of chronic pain. Record review of facility policy titled Admission Assessment and Follow Up: Role of the Nurse, dated 2001 and revised in September 2012, revealed (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Purpose-The purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan and completing required assessment instruments, including the MDS. . Steps in the Procedure . 7. Conduct an admission assessment (history and physical), including: . d. Current medications and treatments . 11. Reconcile the list of medications from the medication history, admitting orders, the previous MAR (if available), and the discharge summary from the previous institution, according to established procedures. 12. Contact the Attending Physician to communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders that are based on these findings. Record review of undated facility policy titled Delivery, Receipt and storage of medication revealed: 6.1 Delivery schedules .Orders requiring more urgent delivery will be communicated by the facility to the pharmacy either by fax or verbally. The pharmacy will expedite delivery of those medications within a 4-hour window. The ADM and DON were notified on 02/11/2025 at 04:56 PM that an IJ had been identified and an IJ template was provided. The following POR was approved on 02/12/2025 at 03:29 PM and included: On 02/10/25 an abbreviated survey was initiated at [facility name]. On 02/11/2025 the surveyor provided an Immediate Threat (IT) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to resident health and safety. The notification of the alleged immediate jeopardy states as follows: The facility failed to provide effective pain interventions for Resident #195 for 2 days. (continued on next page)

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	675649	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Health Rehab	11127 Circle Dr Austin, TX 78736

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action: Upon learning of the deficient practice, the Director of Nursing and Nursing Admin began a review of resident's charts for pain assessment orders, reviewed current PRN pain medication usage for all residents, and reviewed all residents who are flagging for increased pain to assure effective pain management regimens. A total of 12 residents were identified. The 12 identified residents have received an evaluation by the provider (NP or Hospice RN) to evaluate the effectiveness of the current pain regimens. All new orders have been transcribed and confirmed. Monitoring: This will be monitored for completion through the morning clinical meeting process. The DON or designee will oversee this until this is completed. This task has been completed and does not require further oversight due to completion. Responsible: Director of Nursing and Nursing Administration Start Date: 02/11/2025 Completion Date: 02/12/2025 Action: Regional Director of Clinical Services contacted Pharmacy to aid in a MAR to Cart Medication Audit to assure all ordered medications are available. The results from the MAR to Cart Medication Audit are available in a report sent by the consultant pharmacist. Monitoring: DON/Designee to complete MAR to Cart Audit on all narcotic pain medications once monthly for three months to ensure compliance. The Administrator will provide oversight of the monitoring. Responsible: Regional Director of Clinical Services Start Date: 02/11/2025 Completion Date: 02/11/2025 Action: Regional Director of Clinical Services provided in-service education to Director of Nursing and Nursing Administration regarding pain assessments for all resident each shift to include acute pain or significant changes in levels of chronic pain and when to notify the physician regarding pain not being managed by regimen in place, how to conduct a pain assessment properly and proper action when ordered pain medication is not available. ADON and Nursing Administration provided verbal summary of educational material to ensure comprehension. Responsible: Regional Director of Clinical Services Start Date: 02/11/2025 Completion Date: 02/11/2025 (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action: DON began in-service education for all nurses currently on shift regarding pain assessments for all resident each shift to include acute pain or significant changes in levels of chronic pain and when to notify the physician regarding pain not being managed by regimen in place, how to conduct a pain assessment properly and proper action when ordered pain medication is not available. Nursing Administration will complete a second pain assessment on 5 residents twice weekly for 3 months to ensure proper assessment of resident pain and level of nurse proficiency. Comprehension was verified through return demonstration and verbal summary. Monitoring: Ongoing education will be provided to all new hires, PRN, leave of absence prior to first shift worked. Responsible: Director of Nursing or Designee Start Date: 02/11/2025 Completion Date: Ongoing Action: Regional Director of Clinical Services initiated and completed an audit of pain evaluation assessments on 100% of residents on 02/11/25. No residents were identified as having a pain rating score of greater than 5. The pain evaluation assessment is available for review in the resident's individual chart. Responsible Party: Regional Director of Clinical Services Start Date: 02/11/2025 Completion Date: 02/11/2025 Action: All CNAs and MAs will be educated on how to enter a pain alert in PCC (the electronic health record) and to verbally notify charge nurse of resident complaints of pain. All CNAs and MAs currently working have been educated on the process. Comprehension was verified through return demonstration and verbal summary. PRN and/or new staff will be educated prior the start of their next shift. Comprehension will be verified through return demonstration and verbal summary. Facility does not currently utilize agency staff. Monitoring: Alerts will be reviewed in morning and afternoon meeting process to ensure they have been addressed. Responsible Party: DON/ADON or Designee Start Date: 02/11/2025 Completion Date: Ongoing (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action: All licensed nursing staff will be provided with in-service education regarding pain assessments for all resident each shift to include acute pain or significant changes in levels of chronic pain and when to notify the physician regarding pain not being managed by current regimen and proper action when medication is not available prior to next shift worked, including new hires, PRN, Vacation, and Leave of Absence staff. Validation of triplicate receipt will be completed by the assigned nurse upon admission. If a resident is admitted with a new controlled medication that a triplicate has not been received for, they will immediately contact the primary care physician. Comprehension was verified through return demonstration and verbal summary. Responsible Party: DON/ADON or Designee Start Date: 02/11/2025 Completion Date: Ongoing Action: Confirm that pain assessment order was placed on the resident chart for all new admissions, readmissions during clinical morning meeting process to ensure compliance with plan. Monitoring: The DON/ADON or designee will follow the morning meeting process to ensure compliance. This will be documented on the morning clinical follow-up sheet. During weekend hours, the on-call nurse will verify that a pain assessment order has been entered for all admissions and/or readmissions. Responsible Party: DON/ADON or Designee Start Date: 02/11/2025 Completion Date: Ongoing Action: Confirm Pain medications are available for all new Admissions, Readmissions, or newly received orders for pain medication during clinical morning and afternoon meeting process to ensure pain medication availability. If the medication is unavailable, the medication will be removed from the Med Bank. During weekend hours the on-call nurse system will be utilized if a medication is unavailable. Monitoring: Follow the morning meeting process to ensure compliance Responsible Party: DON/ADON or Designee Start Date: 02/11/2025 Completion Date: Ongoing Action: Review all residents currently identified for increased or change in pain weekly during WE CARE clinical meeting to confirm ongoing interventions and physician notification. Monitoring: Follow WE CARE meeting process to ensure compliance. This will be documented on the We Care form. The Administrator will provide oversight for the ongoing monitoring. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Responsible Party: DON/ADON or Designee Start Date: 02/11/2025 Completion Date: Ongoing Action: AD HOC (as needed) QAPI meeting conducted to discuss plan of removal for compliance Monitoring: Review any compliance issues in QAPI meeting for 3 months. Responsible Party: Administrator Start Date: 02/11/2025 Completion Date: 02/11/2025 Action: Medical Director notified of alleged deficient practice. Monitoring: Will update Medical Director of any compliance issues during QAPI meeting for 3 months. Responsible Party: Administrator Start Date: 02/11/2025 Completion Date: 02/11/2025 The Surveyor monitored the POR on 02/13/2025 and 02/14/2025 as followed: During interviews and observations on 02/13/2024 from 11:40 AM - 12:04 PM and 02/14/2025 at 12:31 PM, CNA K, CNA Q, and MA R, from different shifts, stated they were in-serviced on pain management before working their shift. The CNA K and CNA Q stated any time a resident verbalized pain they were to notify the nurse immediately and put an alert in the EHR. CNA K, CNA Q and MA R stated if a resident could not verbalize pain, then they monitored for non-verbal signs of pain including facial grimacing or behaviors out of the ordinary. If they were to notice any of the non-verbal signs of pain, then they were to notify the nurse immediately and put it in the EHR. All staff then demonstrated how to enter the alert in the EHR. During an interview on 02/14/2025 at 10:44 AM with the RDCS, revealed that she did in-service the DON and the ADM regarding pain assessments, acute pain, change in level of pain and who to notify. During interviews on 02/14/2025 from 01:18 PM - 01:41 PM, LVN S, LVN T, and LVN U from different shifts stated they had been in-serviced on pain management before their shifts. All three LVNs verbalized how to assess for pain in residents, which included non-verbal pain indicators. All stated for new residents with orders for pain medication that required a triplicate, they needed to contact the pharmacy and physician to ensure a triplicate was received. All staff stated they would follow up to ensure the triplicate was received by the pharmacy. The nurses stated they would give the pain medication and follow up a short time later to ensure the medication was effective. If the medication was ineffective, then the provider would be contacted for something else. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation of 4 medication carts 02/13/2025 at 11:23am revealed that pain medications were available for all residents on the list of residents that had orders for pain medication provided by the pharmacy. Record review of Pain Assessments for 16 of 16 residents reviewed revealed they all had a Pain Assessment done on 2/11/2025. Record Review revealed that the RDCS used a Census Sheet to verify all pain assessments were completed on 02/11/2025. She also wrote a statement of completion. Record review of 11 of 11 residents' charts revealed pain level was entered for every shift. Record review revealed the pharmacy conducted a medication/nursing cart audit on 02/11/2025. Record review revealed in-service training with the DON and Nursing Administration was completed on 2/11/2025 related to pain assessments, acute pain, change in level of pain and who to notify. Record Review revealed 37 of 45 nursing staff were in-serviced for pain management from 02/11/2025-02/14/2024. Record review of morning clinical follow-up sheets revealed they were filled out for follow up items on 2/12/2025, 2/13/2025 and 2/14/2025. Record review revealed that the facility had already scheduled a We Care Meeting for 2/17/2025 to 2/20/2025. Record Review of QAPI held on 2/11/2025 over Plan of Removal revealed that all required members attended the meeting and signed off, including the MD. The ADM and DON were notified on 02/14/225 at 03:08 PM that the IJ had been removed. While the IJ was removed on 02/14/2025, the facility remained out of compliance at a scope of isolated and a severity level of 1 because all nursing staff had not been trained on pain assessments and the facility's need to evaluate the effectiveness of the corrective systems.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 50872 Based on observations, interviews, and record review, the facility failed to ensure drugs and biologicals were stored and labeled in accordance with currently accepted professional principles for 1 of 1 medication storage room and 2 of 3 medication carts. A) The facility failed to ensure expired supplies and medications were removed from the medication storage room. B) The facility failed to ensure expired supplies and medications were removed from the nurses' medication cart for 400 hall. C) The facility failed to ensure that the nurses medication cart for 100 hall was secured by a lock when it was left unattended by LVN A. These failures could place residents at risk of contamination causing illness, decreased effectiveness of medication, and risk of injury to other residents if medication left unsecured were consumed. Findings included: A. During an observation on 02/12/2025 at 02:24 PM of the medication storage room with the ADON revealed one bottle of Senna S that expired 01/2025, 16 alcohol wipes that expired 12/2024, 1 safety blood collection set that expired 11/2017, 57 hypodermic needles that expired 05/30/2023 and 34 blunt fill needles with filter that expired 2/27/2024. B. During an observation on 02/12/2025 at 02:48 PM of the 400 hall nurse's medication cart with LVN B revealed 2-10ml syringes of Ativan-Benadryl-Haldol compound syringes for Resident #36 that expired 02/08/2025, 2-10ml syringes of Ativan-Benadryl-Haldol syringes for Resident #39 that expired 02/08/2025, 1 tube of Dimethacone body shield 5% that expired 04/2023, 1 tube of Skintegrity Eco Hydrogel that expired 09/10/2024, 1 tube of Phytoplex Antifungal Ointment that expired 10/2024, 2 bottles of PVP Povidone Iodine 10% that expired 12/2024, and 1 honey coated absorbent dressing that expired 6/2023. C. During an observation on 02/12/2025 from 04:40 PM- 04:52 PM revealed the 100-hall nurse's medication cart was left unlocked and unattended against the wall near the nurse's station. During the observation the ADON walked past the cart 4 times; the Administrator walked past the cart 3 times; and LVN A walked past the cart 2 times. At 04:52 PM as the DON and ADON approached the nurses' station it was noted the nurses' medication cart was unlocked and the DON secured the cart by locking it. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/12/2025 at 02:33 PM, the ADON stated she checked the medication room on 02/11/2025 for expired medications but didn't know about the supplies in the cabinets. She stated there was not one specific person that was responsible for checking for expirations dates and that it was a group effort between the nurses, and she wasn't sure how often it was done. The ADON stated using the supplies past the expiration dates could lead to contamination or defective supplies. She stated taking the medication past the expirations date could lead to decreased effectiveness or ad verse effects including sickness. During an interview on 02/12/2025 at 02:51 PM, LVN B stated all of the nurses were responsible for checking for expiration dates on the medications and supplies in the medication carts. He stated using the expired medications and supplies could lead to the medications and topical treatments not being as effective. During an interview on 02/13/2025 at 05:00 PM with LVN A revealed he was responsible for the nurse's medication cart that was left unlocked. He stated he was expected to lock the nurse's medication cart when he walked away from it. He stated if it was left unlocked then a resident could open a drawer and take anything that was not for them. He stated he had left the cart unlocked because he was busy with assisting with dinner meal trays. During an interview on 02/14/2025 at 04:18 PM with the DON revealed numerous staff, including her and the ADON, were responsible for ensuring expired medications were pulled from the medication room and carts. She stated the contract pharmacist checked the medication room and carts once a month to ensure all expired and discontinued medications were removed. The DON stated her expectation of staff when they walk away from the medication cart was to lock it. She stated she had provided in-services to the staff, and she visually monitored daily. Record review of undated facility policy Delivery, Receipt and Storage of Medication revealed 6.3 Storage of Medication The facility should ensure that only authorized facility staff should have access to the medications storage areas. Authorized facility staff should include nursing staff and those authorized to administer medications. Scheduled medications should be stored in a separate locked area within the medication carts or medication room. Record review of in-service, dated 10/17/2024, titled Med cart compliance revealed Remove D/C meds, meds from res. who discharged or expired, expired meds timely *Includes ointments, nebs prn meds, narcs . must keep cart locked @ all times if away from cart.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 51289 Based on observation, interview, and record review the facility failed to prepare foods by methods that conserve nutritive value, flavor, and appearance in the facility's only kitchen. The DM prepared food 2 1/2 hours prior to meal service. The DM held food in a convection steamer and/or on a hot food table for more than 2 1/2 hours prior to meal service. Food service started 150 minutes after food was placed on the steam table. Food item not being pureed with adequate and appropriate liquids. Pureed foods were prepared with water. Liquids for pureed foods were not measured. Thickener for pureed foods was not measured. Pureed and mechanical soft foods did not follow policy/procedures of determining number of servings needed to determine the portion size method. Condiments and seasonings used on regular textured foods was not used on puree and mechanical soft foods. DM prepared foods without proper equipment: scale, measuring cups, and measuring spoons. Pureed test tray rendered a bland flavor. These failures could compromise and destroy nutritive value of food and prevent residents who ate food from the kitchen at risk of recovery from illness or injury. Finding included: Observation on 02/10/2025 at 09:25 a.m. during the initial brief tour of the kitchen revealed the following: o Mealtime schedule posted in the entrance of the dining room noted lunch is served at 12 p.m. o The pureed diet food and mechanical soft diet food, which included beef steak with mushrooms and onions, buttered cabbage, and blackeye peas was prepared and was being held in the convection steamer until meal service. o The regular diet meal, which included beef steak with mushrooms and onions, buttered cabbage, and blackeye peas was prepared and being held on the hot food table until meal service. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o The 5 pureed diets, 10 mechanical soft diets, and 26 regular diets were prepared without measuring tools, without a count or consideration of portion amounts and sizes to align with dietary needs. Observation on 02/11/2025 at 9:29 a.m., revealed the following: o The veggie cream of tomato soup was prepared and sitting on the heating table and then moved to the convection steamer. o Country gravy was prepared and placed in the convection steamer. o Cubed fully cooked chicken breast pieces were removed from the freezer to begin preparing for lunch. o 96 ounces of canned carrots were prepared for the pureed vegetable item. The puree process did not contain thickener measurements and placed on in the convection steamer. o Regular diet instant mashed potatoes were prepared with milk, butter, and seasonings. Puree instant mashed potatoes were prepared with water and butter. Both foods were prepared without measurements and without portion counts and were placed on the hot food table. o Fully cooked breaded chicken patties were placed in the fryer for immediate cooking and transferred to the convection steamer. o Unmeasured amount of cubed fully cooked unseasoned chicken breast pieces was placed in the oven for 10 minutes to heat up to make soft prior to puree process. o Unmeasured amount of cubed fully cooked unseasoned chicken breast pieces for mechanical soft diet was placed in a deep pan and placed in the convection steamer to heat up. o The cubed fully cooked unseasoned chicken breast pieces were placed in the puree machine, with unmeasured hot water, and unmeasured thickener. Once pureed it was placed in the convection steamer. Observation on 02/112025 at 12:33 p.m. of the survey test tray revealed the following: o Puree carrots temperature reading was 149 degrees, was creamy and bland in flavor. o Puree bread temperature reading was 80 degrees and was sweet in flavor. o Puree mashed potatoes with gravy temperature reading was 150 degrees, flavorful, no lumps, no grit, no peels, creamy, and the right consistency. o Puree chicken temperature was 165 degrees, creamy, pureed well, bland flavor, tasted like chicken soup. During an interview on 02/10/2025 at 11:29 a.m., the DM stated he checks the food temperatures 30 minutes before meal service. He stated the pureed consistency is like pancake batter, smooth and for flavor he will add more butter, cream cheese, or sour cream. If the consistency is too thin, he uses Thickener powder and if too thick uses milk or butter to thin. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/11/2025 at 9:29 a.m., the DM stated he cooked the instant mashed potatoes for puree and regular diet differently, to avoid residents choking on seasoning flakes. He stated all puree consistency should be pancake batter like. And when pureeing you can use water, butter, and sour cream, to gain the consistency you need. During an interview on 02/12/2025 at 2:25 p.m., the DM stated the RD visits two times a month. He stated the RD spends one full day, 9 a.m. - 5 p.m. with kitchen staff and one full day for clinicals to go over resident needs and diets. He stated quality assurance of the kitchen was conducted monthly by the RD. When she visits with him, she provides a consult on puree consistency, reviews, and signs off on menu substitute logs, consults on food storage practices, hand hygiene and hygienic practices, emergency food supply, proper storage practices, rotation of produce, preparing regular, mechanical soft, and puree foods, preparing puree foods and maintaining nutritional value, and food holding times. He stated she provided him with in-service topics monthly, the training materials, sign-in sheets, and training assessments to provide to the dietary staff to confirm their understanding of the different kitchen topics. He stated he will conduct the trainings in English and Spanish for the dietary staff and have them complete the assessment for understanding, which are reviewed by the RD. He also stated his Food Manager Certification program trained him to use the FDA Handbook as a guide. During an interview on 02/12/2025 at 03:21 p.m., the DM stated he had been employed at the facility since 2020. He stated he normally begins preparing meals two hours prior to meal service. He stated he places foods in the convection steamer and hot food table when completing food temp checks 10 - 15 minutes prior to meal service. The DM stated the RD provided him and his staff training on pureeing foods while maintaining nutritional value, to use milk, butter, and sour cream when pureeing, to use water for pureeing bread (later made correction), preparing, and cooking foods according to the menu. He stated the menus and guides were located centrally in the kitchen for all staff. He stated if dietary staff do not adhere to portions, measurements, ingredients listed on the recipe, correct liquids for pureeing could result in poor quality and negatively impact the residents in weight loss concerns. He stated the RD stressed the importance of using milk or other approved liquid for pureeing to maintain flavor and nutritional value. He stated despite his training he will use other ingredients at times for flavor and pureeing foods. He stated he trained his cooks to puree foods with milk or juice. He prepared food early and placed in the convection steamer or hot food table to keep on schedule understanding it could result in poor quality. He stated, measuring and portioning foods ensured residents' diet was followed. He stated he would be conducting in-services with all dietary staff immediately and will get better. During an interview on 02/13/2025 at 01:25 p.m., the ADM stated she has been employed at the facility for a year. She stated dietary staff were trained to use and follow measurements, portions, ingredients, recipes, menus approved by the RD, use appropriate liquids for pureeing, to check food temperatures, to place food in the steam table or on the hot food table no more than 30 minutes prior to meal service, and clean equipment according sanitation standards. The ADM stated on numerous occasions, I feel your questions are noting specific concerns in the kitchen and perhaps speaking to the RD would be helpful. She also stated, I don't feel comfortable answering your questions without reviewing the facility's policies on dietary expectations as I don't want to be giving the wrong answer. She stated the current DM worked closely with the RD, he reported directly to her, and they reviewed monitoring reports, audits, and training topics. She stated that when dietary staff do not follow kitchen practices it could cause concerns for the residents. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/14/2025 at 01:03 p.m., the RD P, Account Manager and Clinical Supervisor of Nutrition Lifestyle stated she was stepping in for the RD that consults and monitors the facility. She stated she just concluded an hour in-service with the DM and dietary staff. She stated the in-service addressed hand hygiene, hair nets, beard guards, following menus, proper puree, food holding, thermometer cleaning, and proper usage for temping foods. She stated several staff were primary Spanish speakers, but used Google translate or had DM to help translate so all receive the same information. She stated the ADM asked her to go over any potential concerns in the kitchen. She stated dietary staff have received training and expected to follow the menus, recipes, prepare meals with measurements, and portion practices, use approved liquids for pureeing. She stated all dietary and non-dietary staff are expected to follow hand hygiene practices and hand washing, gloves, and wear hairnets. She stated that when dietary staff do not follow kitchen practices it can cause concerns for residents and cause illnesses that can be severe. Review of facility's document provided titled QA I Monitor Report dated 02/06/2025 reflected: Dietary staff underwent a monitoring and evaluation of kitchen practices conducted by the RD in general sanitation and cleanliness, dishwashing, tableware sanitation and storage, staff sanitation, food storage, meal service observation, and tray cards. Results of the monitoring were reviewed with the ADM, DM, and dietary staff. Dietary staff were redirected during the evaluation to improve quality and safety ensuring facility practices are achieved. Monitoring areas which staff met expectations: practices appropriate hand washing when cooking and serving food; washes hands or changes gloves when moving from one operation to another; Non-dietary staff are prohibited from entering the kitchen; all dietary staff have a current food handler's certificate; cook can demonstrate knowledge of final cooking temperature and use of a thermometer; foods cooked in a manner to conserve nutritive value, flavor, appearance, and texture; consistencies prepared correctly; portion sizes agree with menus; food service started within 30 minutes after food was placed on the steam table; Menu prepared as written; Recipes followed Monitoring areas that staff did not meet facility expectations and RD recommended for further training and follow-up: i. Hair nets and beard guards not in use, which was corrected during the monitoring. Review of facility's document provided titled QA I Monitor Report dated 01/10/2025 reflected: Dietary staff underwent a monitoring and evaluation conducted by the RD which addressed kitchen practices in general sanitation and cleanliness, dishwashing, tableware sanitation and storage, staff sanitation, food storage, meal service observation, and tray cards. Results of the monitoring were reviewed with the ADM, DM, and dietary staff. Dietary staff were redirected during the evaluation to improve quality and safety ensuring facility practices are achieved. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Health Rehab	11127 Circle Dr Austin, TX 78736

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Monitoring areas which staff met expectations: staff practices appropriate hand washing when cooking and serving food; staff washes hands or changes gloves when moving from one operation to another; hair nets and beard guards in use; non-dietary staff are prohibited from entering the kitchen; all dietary staff have a current food handler's certificate; cook can demonstrate knowledge of final cooking temperature and use of a thermometer; foods cooked in a manner to conserve nutritive value, flavor, appearance, and texture; consistencies prepared correctly; portion sizes agree with menus; and food service started within 30 minutes after food was placed on the steam table; Monitoring areas that staff did not meet facility expectations and RD recommended for further training and follow-up: ii. Menu not prepared as written and recipes not followed. i. No sanitation buckets in use. ii. Dietary staff cooking with long acrylic nails - not using gloves when handling food per policy. iii. Recommend current DM educate kitchen staff on taking temperatures on the line (RD demonstrated but language barrier was difficult). iv. Reviewing menu extensions with cooks to prepare all necessary items like breads for puree and gravies and sauces for mechanical soft & puree. Review of facility's document provided titled Quality Assurance Monitor II Tray Line and Test Tray Audit dated 01/10/2025 reflected: Dietary staff underwent an audit conducted by the RD which addressed kitchen practices in meal preparation, tray line preparation, tray line service, meal service, steam table temperatures, and test tray. Audit results were reviewed with the DM and dietary staff and presented to the ADM. Dietary staff were redirected during the audit to improve quality and safety ensuring facility practices are achieved. Audit areas which staff met expectations: standardized menus available and used: menus and extensions available and used: consistencies prepared correctly: recipes in use for mechanically altered food items: food prepared in scheduled time frames items batch cooked when appropriate: food placed on steam table no sooner than 30 minutes prior to service: portion sizes agree with menus: test tray was eye appealing, recipe followed, portion size correct, and item served per menu. Audit areas that staff did not meet facility expectations and RD recommended for further training and follow-up: i. Menu not prepared as written. ii. All items on main menu were not available and not on the steam table. iii. Alternative/therapeutic/fortified menu items were not available and not on the steam table. iv. Puree prepared water. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	v. Test tray point of service temperature not adequate and test tray flavor was unacceptable. vi. Puree was missing hush puppies, alternative not provided for puree for fish allergy, no lemon butter sauce prepared per menu extension. vii. Staff needing further education on puree preparation. viii. Mac n Cheese was without significant flavor. This places older adults at risk for malnutrition r/t lack of palatability. Please ensure cheese is cheesy and add additional herbs and seasonings to food to enhance flavor. Review of facility's document provided titled Quality Assurance Monitor I Kitchen/Food Service Observation dated 12/10/2024 reflected: Dietary staff underwent a monitoring and evaluation conducted by the RD which addressed kitchen practices in general sanitation and cleanliness, dishwashing, tableware sanitation and storage, staff sanitation, food storage, meal service observation, and tray cards. Results of the monitoring were reviewed with the DM and dietary staff and presented to the ADM. Dietary staff were redirected during the evaluation to improve quality and safety ensuring facility practices are achieved. Monitoring areas which staff met expectations: staff practices appropriate hand washing when cooking and serving food: staff washes hands or changes gloves when moving from one operation to another: hair nets and beard guards in use: non-dietary staff are prohibited from entering the kitchen: all dietary staff have a current food handler's certificate: cook can demonstrate knowledge of final cooking temperature and use of a thermometer: foods cooked in a manner to conserve nutritive value, flavor, appearance, and texture: consistencies prepared correctly: portion sizes agree with menu: food service started within 30 minutes after food was placed on the steam table: menu prepared as written: recipes followed. Monitoring areas that staff did not meet facility expectations and RD recommended for further training and follow-up: None. Review of facility's document provided titled Quality Assurance Monitor VI Cost Control Audit dated 12/10/2024 reflected: Dietary staff underwent an audit conducted by the RD which addressed kitchen practices in inventory, purchases, and food preparation, and meal service. Audit results did not note if reviewed by facility staff, no deficiency's noted by the RD. Audit areas which staff met expectations: approved menus followed daily: standardized recipes followed for each meal: staff provided with a count of all therapeutic and mechanically altered diets to use during meal preparation; correct portion sizes served. Review of facility's document provided titled Food and Nutrition Service Fortified Food in-service dated 12/23/2024 reflected: Foods addressing nutrient deficiencies and wound healing. What are fortified foods. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When to use fortified foods. Why fortified foods. When considering fortified foods. Review of facility's Policy titled Fall/Winter 2023-24 Dining Service Menu Guide Revised 2020 reflected: The community RD should review and sign the menu and menu components prior to implementation to ensure state regulations as well as community policies and procedures are met. The following guidelines were used to ensure nutritional adequacy when planning menus. Explanation of Diets General Guidelines i. For safety puree with adequate and appropriate liquid. ii. Importance of following the recipe. iii. Use appropriate measuring and weighing equipment when preparing foods. iv. Never use water to puree a food item. v. Weigh foods required for the standardized recipe. vi. Measure when adding commercial thickener as directed in the recipe.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51289 Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen. The cook was not wearing hair restraints while in the kitchen. The cook did not practice appropriate hand washing prior to preparing and cooking food. The cook did not wash hands or wear gloves when moving from one operation to another. The DA did not wash hands or wear gloves when moving from one operation to another. Non-dietary staff, CNA entered the kitchen without hair restraint. Non-dietary staff did not wash hands. The DM improperly cleaned the thermometer while checking holding temperatures of foods prior to meal service. The DM did not have knowledge of cleaning and sanitization of the thermometer. These failures could place residents who ate food from the kitchen at risk of foodborne illness. Finding included: Observation on 02/11/2025 at 9:29 a.m. revealed the following: The DA in the kitchen was preparing liquids by covering with plastic wrap prior to meal service. The DA was not wearing gloves. At one point the DA left out the back door of the kitchen, returned a few minutes later, she put on gloves without washing her hands and returned to her task. Observation on 02/11/2025 at 11:43 a.m. revealed the DM was monitoring food temperatures with used thermometer sanitizer wipes. When he realized he was cleaning the thermometer with the used wipes he proceeded to dip the thermometer directly into the red sanitation bucket that was in use with murky gray water, sanitizing solution, and cleaning clothes located on shelf below hot food table and stated, I use this when I run out of wipes. He then inserted the thermometer with dripping liquid into the pan with tomato soup to check the temperature. He performed this same step a 2nd time and inserted the thermometer into the soft vegetables pan and checked the temperature. He stated the red sanitation bucket contained water and sanitizing solution for towels used to clean kitchen surfaces. He stated this was the process he used to sanitize and clean the thermometer when he ran out of wipes. Observation on 02/11/2025 at 11:50 a.m. revealed CNA O entered the kitchen to check meal tickets and he did not wash hands or wear hair restraints. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 02/12/2025 at 2:50 p.m. revealed [NAME] rushed into the kitchen from the backdoor. He did not wash his hands; he did not put on a hair net or beard guard; and he did not put on gloves, and he went immediately to the stove and began mixing food that was cooking in a large pot. Observation on 02/12/2025 at 3:04 p.m. revealed [NAME] exited the kitchen to the dining room, handled his personal cell phone, returned a few minutes later and he did not wash his hands; he did not put on a hair net or beard guard; and he did not put on gloves, and returned to the oven and removed a pan of meat. During an interview on 02/12/2025 at 2:25 p.m., the DM stated the Licensed RD visited two times a month. He stated the RD spends one full day, 9 a.m. - 5 p.m. with kitchen staff and one full day for clinicals to go over resident needs and diets. He stated quality assurance of the kitchen is conducted monthly by the RD. When she visits with him, she provides a consult on puree consistency, reviews, and signs off on menu substitute logs, consults on food storage practices, hand hygiene and hygienic practices, emergency food supply, proper storage practices, rotation of produce, preparing regular, mechanical soft, and puree foods, preparing puree foods and maintaining nutritional value, and food holding times. He stated she, provides him with in-service topics monthly, the training materials, sign-in sheets, and training assessments to provide to the dietary staff to confirm their understanding of the different kitchen topics. He stated he will conduct the trainings in English and Spanish for the dietary staff and have them complete the assessment for understanding, which are reviewed by the RD. He also stated his Food Manager Certification program trained him to use the FDA Handbook as a guide. During an interview on 02/12/2025 at 2:56 p.m., the [NAME] stated he has been employed four years with the facility. He spoke primarily Spanish and used his phone to translate a few words. He stated he has received training in infections, wearing hairnets and contamination. He stated you should always wash hands and wear gloves when cooking to avoid contamination. He stated that he understood that he was not wearing a hairnet or beard guard and was not wearing gloves while he was cooking because he was rushing onto shift late and was moving too quickly. He stated he knows this was not an excuse, but it was what happened. During an interview on 02/12/2025 at 03:10 p.m., DA stated she has been employed five months with the facility. She was primarily a Spanish speaker and used her phone to translate using Google. She stated she has received training on preparing food, cleaning the kitchen, washing hands, wearing hair nets to avoid contamination. She stated she received training monthly. She stated it was important to wash hands and put on a hair net every time she leaves the kitchen and returns. She stated staff should not enter the kitchen without their hair net or washing their hands as they could contaminate food or equipment, and this can be harmful to the residents and make them sick. During an interview on 02/12/2025 at 03:21 p.m., the DM stated he had been employed at the facility since 2025. The DM stated the RD provides him and his staff training and monitoring of sanitation buckets cleaning schedule and routine cleaning of equipment, staff washing hands, using hair nets, and wearing gloves when handling food. The DM stated staff not practicing appropriate hand hygiene, glove use during food preparation, not employing hygienic practices, and not wearing hair restraints can lead to foodborne illnesses and cross contamination. He stated he would be conducting in-services with all dietary staff immediately and will get better. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 02/13/2025 at 01:25 p.m., the ADM stated she has been employed at the facility for about a year. The ADM stated on numerous occasions, I feel your questions are noting specific concerns in the kitchen and perhaps speaking to the RD would be helpful. She also stated, I don't feel comfortable answering your questions without reviewing the facility's policies on dietary expectations as I don't want to be giving the wrong answer. She stated the DM is on site and works closely with the RD that is consulting for the facility. She stated she is the direct report staff for the DM. She stated dietary staff are expected to practice appropriate hand hygiene, glove use when necessary, during food preparation activities, and wearing hair restraints to prevent cross-contamination. She stated all staff entering the kitchen area should be washing their hands with soap and water and using hair restraints to prevent cross contamination. She stated the facility practice for checking food temperatures and cleaning thermometers between checks is expected to happen before serving foods to residents. She stated the consultant RD visit summaries also note the training the dietary staff is receiving on these specific concerns. During an interview on 02/14/2025 at 01:03 p.m., the RD, Account Manager and Clinical Supervisor of Nutrition Lifestyle stated she is stepping in for the RD that consults and oversees the facility. She stated she just concluded an hour in-service with the DM and kitchen staff. She stated the in-service with kitchen staff addressed hand hygiene, hair nets, beard guards, following menus, proper puree, food holding, thermometer, and proper usage for temping foods. She stated several dietary staff were in attendance. She stated several dietary staff members are primary Spanish speakers, but the usual consultant finds ways to provide training that is understood. She stated she was contacted by the ADM to go over any potential concerns in the kitchen. All kitchen staff are expected to follow hand hygiene practices and hand washing, use gloves, and wear hairnets. She stated she was not aware that staff could not use a sanitization bucket with used cleaning towels to clean a thermometer during temperature checks. She stated that when kitchen staff do not follow kitchen practices, they have received training in can cause concerns for patients and cause illnesses that can be severe. Review of facility's document provided titled QA I Monitor Report dated 02/06/2025 reflected: Dietary staff underwent a monitoring and evaluation of kitchen practices conducted by the RD in general sanitation and cleanliness, dishwashing, tableware sanitation and storage, staff sanitation, food storage, meal service observation, and tray cards. Results of the monitoring were reviewed with the ADM, DM, and dietary staff. Dietary staff were redirected during the evaluation to improve quality and safety ensuring facility practices are achieved. Monitoring areas which staff met expectations: practices appropriate hand washing when cooking and serving food; washes hands or changes gloves when moving from one operation to another; Non-dietary staff are prohibited from entering the kitchen; all dietary staff have a current food handler's certificate; cook can demonstrate knowledge of final cooking temperature and use of a thermometer; foods cooked in a manner to conserve nutritive value, flavor, appearance, and texture; consistencies prepared correctly; portion sizes agree with menus; food service started within 30 minutes after food was placed on the steam table; Menu prepared as written; Recipes followed Monitoring areas that staff did not meet facility expectations and RD recommended for further training and follow-up: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	i. Hair nets and beard guards not in use, which was corrected during the monitoring. Review of facility's document provided titled QA I Monitor Report dated 01/10/2025 reflected: Dietary staff underwent a monitoring and evaluation conducted by the RD which addressed kitchen practices in general sanitation and cleanliness, dishwashing, tableware sanitation and storage, staff sanitation, food storage, meal service observation, and tray cards. Results of the monitoring were reviewed with the ADM, DM, and dietary staff. Dietary staff were redirected during the evaluation to improve quality and safety ensuring facility practices are achieved. Monitoring areas which staff met expectations: staff practices appropriate hand washing when cooking and serving food; staff washes hands or changes gloves when moving from one operation to another; hair nets and beard guards in use; non-dietary staff are prohibited from entering the kitchen; all dietary staff have a current food handler's certificate; cook can demonstrate knowledge of final cooking temperature and use of a thermometer. Monitoring areas that staff did not meet facility expectations and RD recommended for further training and follow-up: i. No sanitation buckets in use. ii. Dietary staff cooking with long acrylic nails - not using gloves when handling food per policy. iii. Recommend current DM educate kitchen staff on taking temperatures on the line (RD demonstrated but language barrier was difficult). Review of facility's document provided titled Quality Assurance Monitor II Tray Line and Test Tray Audit dated 01/10/2025 reflected: Dietary staff underwent an audit conducted by the RD which addressed kitchen practices in meal preparation, tray line preparation, tray line service, meal service, steam table temperatures, and test tray. Audit results were reviewed with the DM and dietary staff and presented to the ADM. Dietary staff were redirected during the audit to improve quality and safety ensuring facility practices are achieved. Audit areas which staff met expectations: thermometer sanitized between each food item: staff utilizes hygienic practices. No bare hand contact with food. Using tongs when needed: Audit areas that staff did not meet facility expectations and RD recommended for further training and follow-up: i. Staff struggled to take temps, RD educated staff on tray line temps and reheating. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of facility's document provided titled Quality Assurance Monitor I Kitchen/Food Service Observation dated 12/10/2024 reflected: Dietary staff underwent a monitoring and evaluation conducted by the RD which addressed kitchen practices in general sanitation and cleanliness, dishwashing, tableware sanitation and storage, staff sanitation, food storage, meal service observation, and tray cards. Results of the monitoring were reviewed with the DM and dietary staff and presented to the ADM. Dietary staff were redirected during the evaluation to improve quality and safety ensuring facility practices are achieved. Monitoring areas which staff met expectations: staff practices appropriate hand washing when cooking and serving food: staff washes hands or changes gloves when moving from one operation to another: hair nets and beard guards in use: non-dietary staff are prohibited from entering the kitchen: all dietary staff have a current food handler's certificate: cook can demonstrate knowledge of final cooking temperature and use of a thermometer: i. Monitoring areas that staff did not meet facility expectations and RD recommended for further training and follow-up: None noted. Review of facility's document provided titled 2022 Food Code U.S. Food and Drug Administration, undated reflected: Microorganisms may be transmitted from a food to other foods by utensils, cutting boards, thermometers, or other food-contact surfaces. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301. 12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. Food-contact surfaces and equipment used for time/temperature control for safety foods should be cleaned as needed throughout the day but must be cleaned no less than every 4 hours to prevent the growth of microorganisms on those surfaces. Alcohol swabs or other suitable equipment for sanitizing probe thermometers.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50872 Based on observations, interviews, and record reviews the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 5 residents (Resident #5) reviewed for infection control. 1. The facility failed to ensure RN G and CNA H followed enhanced barrier precautions when they provided wound care for Resident #5 on 02/13/2025. 2. The facility failed to ensure RN G followed infection control precautions when she performed wound care on Resident #5. These failures could place residents at risk for cross contamination and infection. Findings included: Record review of Resident #5's admission record, dated 2/14/2025, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Urinary tract infection, cystitis (inflammation of the bladder), pleural effusion (a collection of fluids around the lungs), chronic heart failure (the heart is unable to pump blood to meet the demands of the body), right above the knee amputation, hypertension (high blood pressure), and anxiety disorder. Record review of Resident #5's admission MDS, dated [DATE], revealed a BIMS score of 15, which indication no cognitive impairment. Further review of the MDS revealed Resident #5 had one unhealed pressure ulcer. Record review of Resident #5's care plan, dated 12/13/2024, revealed the resident had an impairment to skin integrity of the left buttock/coccyx area. The relevant interventions were follow facility protocols for treatment of injury and monitor/document location, size, and treatment of skin injury. Report abnormalities, failure to heal, sign and symptoms of infection, maceration (skin breakdown due to moisture at the cellular level) to the MD. There was no mention of enhanced barrier precautions in the care plan. Record review of Resident #5's physician's orders, dated 02/14/2025, revealed Stage III pressure wound to L buttock: cleanse with NS, pat dry, apply collagen, skin prep peri wound, apply dry dressing T-Th-Sat and prn until resolved and enhanced barrier precautions (gown and glove) for high contact direct care every shift. During an observation on 02/13/2025 at 02:03PM of wound care for Resident #5 revealed CNA H assisted RN G with positioning the resident in bed. CNA H washed hands and applied gloves prior to assisting resident but did not wear a gown. RN G washed hands and put on gown but did not secure it with the waist tie when donning (to apply) it. During wound care RN G cleansed the wound with NS and patted dry with wet gauze then proceeded to place the dirty gauze on clean supplies field next to the clean dressing. She then took off her gloves, sanitized her hands, applied new gloves, picked up the clean dressing and applied it to Resident #5's wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/13/2025 at 02:27 PM CNA H stated he had been trained on enhanced barrier precautions and infection control policies. He stated he should have been wearing a gown when providing care to Resident #5, but he forgot to put it on. He stated not wearing a gown for a resident who is on enhanced barrier precautions could cause an infection for the resident. During an interview on 02/13/2025 at 02:30 PM RN G stated she had been trained on enhanced barrier precautions and infection control policies. She stated she didn't tie the gown around the waist because it didn't have a tie around the waist. She stated the gown should have been tied. RN G stated the gauze used to pat dry the wound should have been thrown directly in the trash. She stated the gown is used as a protection for the resident to prevent infection and putting the dirty gauze down on the clean field could contaminate the new dressing. During an interview on 02/14/2025 at 04:18 PM the DON stated she and the ADON were responsible for ensuring staff use enhanced barrier precautions for residents that have wounds. She stated they were constantly performing visual spot checks. She stated that all staff were to wear gown and gloves when providing any care to Resident #5. She stated she spoke with CNA H and he told her he didn't realized he was going to be providing care to the resident when he went in the room and he should have worn a gown. The DON stated she also spoke with RN G and RN G stated she was nervous and made some mistakes due to nerves. She stated RN G should have secured her gown with a tie around the waist prior to providing care to Resident #5. The DON stated enhanced barrier precautions were used to prevent transmission of infection to or from the resident that required it. She stated RN G should have put the gauze in the trash after using it and not next to the clean dressing. She stated by putting the dirty gauze next to the clean dressing it could have contaminated the clean dressing. During an interview on 02/14/2025 at 04:40 PM the ADM stated she had been trained on enhanced barrier precautions last week. She stated staff should use Enhanced Barrier Precautions for any resident that has a wound, ostomy (surgical opening in the abdomen), or dialysis. She stated that anytime staff was to provide care to residents with these conditions it was required to wear a gown and gloves to prevent the spread of infection to the resident. She stated the gown should be secured with a tie at the waist. The ADM stated the DON and ADON were responsible for ensuring nursing staff wear the correct PPE but ultimately it was her responsibility. Record review of undated facility provided document titled Treatment Nurse Competency check off revealed 6. Gathered all needed supplies for treatment, including pieve[sp?] of wax paper / barrier for over bed table, and set up items maintaining clean field. 7. Has plastic bag to dispose of soiled / used supplies appropriately, may tape plastic trash bag to over bed taible[sp?]. Note: a red bag is not necessary for handling soiled dressings at bedside. 18. If any area was contaminated, start over. Record review of undated facility provided document titled Donning and Doffing PPE revealed Donning (to apply) PPE 2. Gown *Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back *Fasten in back of neck and waist. Record review of facility policy titled Enhanced Barrier Precautions in Nursing Homes Algorithm, dated 06/2024, revealed Enhanced barrier precautions implementation In addition to following standard precautions, gown and gloves should be worn during the following high-contact resident care activities: *Dressing *Bathing/Showering *Transferring *Providing Hygiene *Changing linens *Changing briefs or assisting with toileting * Device care or use *Wound care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675649	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Health Rehab	11127 Circle Dr Austin, TX 78736

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50872 Based on interview and record review the facility failed to establish an infection prevention and control program (ICPC) that included, at a minimum, an antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use for 1 of 5 resident (Resident #22) reviewed for antibiotic stewardship program. The facility failed to follow antibiotic stewardship policy for Resident #22 by not ensuring an infection surveillance was performed per facility policy. This deficient practice could place residents at risk for unnecessary antibiotic use, inappropriate antibiotic use, and increased multi drug resistant organisms. Findings include: Record review of Resident 22's admission record, dated 2/14/2025, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included cerebrovascular disease (a condition that affect blood flow to the brain), vascular dementia (a condition affecting thought processes caused by impaired blood flow to the brain), muscle weakness, hypertension (high blood pressure), retention of urine (unable to urinate naturally), and hyperlipidemia (high cholesterol). Record review of Resident #22's quarterly MDS, dated [DATE], revealed a BIMS score of 14 which indicated no cognitive impairment. Record review of Resident #22's Medication Administration Record, dated January 2025, revealed Resident #22 received Azithromycin (an antibiotic) on January 10-14, 2025, for infection. Record review of Resident #22's progress note written by NP L, dated 01/10/2025, revealed Patient is seen in her room. She still has a cough, over 1 week in, has been flu negative, no fever but cough is productive, difficult sleeping. Will treat as URI and start x park[sp?] and prednisone. Assessment and plan 1. Cough: for over a week, productive, taking cough medicine, will treat with zpak and short course of Prednisone. Diagnoses Acute upper respiratory infection, unspecified. Record review of Resident #22's care plan on 02/14/2025 revealed no care plan related to upper respiratory infection. Record review of Resident #22's assessments revealed no infection control surveillance form for the month of January 2025. During an interview on 02/13/2025 at 01:11 PM, the DON reviewed Resident #22's chart and stated Resident #22 was started on antibiotics on January 10, 2025, for a presumed URI after NP L assessed her. The DON stated the infection surveillance form was not completed because the infection didn't meet McGeer criteria (a tool designed to support facility healthcare-associated infection surveillance). She stated, she didn't have a true infection, only a presumptive infection. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/14/2025 at 03:24 PM, LVN C stated new orders received for antibiotics needed to have an infection surveillance form completed. She stated the infection surveillance form indicated if the antibiotic was appropriate. She stated if the resident didn't meet the criteria for antibiotics according to the infection surveillance form, then the DON would need to be notified. LVN C stated she didn't know of any instance that completing an infection surveillance form would not be done when starting an antibiotic. She stated the form was completed to prevent giving antibiotic when they are not needed. During an interview on 02/14/2025 at 03:48 PM, LVN A stated the nurse completing the antibiotic order was responsible for the infection surveillance form. LVN A stated the infection surveillance should always be completed and he was not aware of any situation that it wouldn't be completed. He stated he wasn't sure if an infection surveillance form was completed for Resident #22 in January. LVN A stated he wasn't sure of an effect to the resident if the surveillance form was not completed. Record review of the Infection control trending per hallway for January 2025 revealed no infection monitored for Resident #22's room for the month. Record review of Infection Surveillance Monthly Report January 2025, dated 02/10/2025, revealed Resident #22 was not listed under Respiratory Infection Category. Record review of the Infection Prevention and Control Binder revealed ADON as Infection Preventionist Coordinator with the DON and LVN C as alternate infection preventionists. Record review of the facility's policy titled Antibiotic Stewardship Review and Surveillance of Antibiotic Use and Outcomes, dated 2001 and revised December 2016, revealed Policy statement: Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship. Policy Interpretation and Implementation: 1. As part of the facility Antibiotic Stewardship Program, all clinical infections treated with antibiotics will undergo review by the infection preventionist (IP), or designee. 2. The IP, or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics . 4. All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. Based on interview and record review the facility failed to establish an infection prevention and control program (ICPC) that included, at a minimum, an antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use for 1 of 5 resident (Resident #22) reviewed for antibiotic stewardship program. The facility failed to follow antibiotic stewardship policy for Resident #22 by not ensuring an infection surveillance was performed per facility policy. This deficient practice could place residents at risk for unnecessary antibiotic use, inappropriate antibiotic use, and increased multi drug resistant organisms. Findings include: (continued on next page)

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