STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675666	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcliff Health Center of Greenville	4400 Walnut St Greenville, TX 75401

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47612 Based on observations, interviews, and record review the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 2 of 24 residents (Resident #20 and Resident #74) reviewed for resident rights. The facility did not ensure Laundry Aide N knocked, introduced herself, and explained what she was doing prior to entering Resident #20's and Resident #74's room. This failure could place residents at risk for diminished quality of life, loss of dignity and loss of self-worth. Findings included: 1.Record review of the face sheet, dated 11/18/2024, revealed Resident #20 was a [AGE] year old female with diagnoses which included type 2 diabetes mellitus with diabetic neuropathy (diabetic neuropathy was a common and serious complication of type 2 diabetes that occurs when high blood sugar damages nerves over time), acute respiratory failure with hypoxia (a medical emergency where the lungs are unable to adequately provide oxygen to the blood, resulting in dangerously low oxygen levels in the body (hypoxia), and occurring rapidly or suddenly), unspecified diastolic (congestive) heart failure (occurs when the heart's left ventricle stiffens and can't fill properly with blood). Record view of the quarterly MDS assessment, dated 07/15/2024, revealed Resident #20 was usually able to make herself understood and understood others. The MDS assessment indicated Resident #20 had a BIMS score of 10, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #20 required assistance with toileting, partial moderate assistance with personal hygiene, and supervision for eating. The MDS assessment did indicate the use of oxygen. Record review of care plan, with a revision date of 08/02/2024, indicated Resident #20 was dependent on staff for activities, cognitive stimulation, social interaction, and interventions included for all staff to converse with resident while providing care. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675666	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 11/18/2024 at 11:00 a.m., Surveyor was in Resident #20's room and Laundry Aide N entered the room, went inside Resident #20's closet to place a clothing item, and exited the room. Laundry Aide N did not knock prior to entering the room, and she did not introduce herself. Laundry Aide N did not explain to Resident #20 what she was doing in her room or why she was going in her closet. Resident# 20 stated the staff did not ever knock before entering and she did not like it. 2. Record review of the face sheet, dated 11/18/2024, revealed Resident #74 was a [AGE] year-old male with diagnoses which included quadriplegia, unspecified (a diagnosis code for paralysis of all four limbs, including the arms and legs, and the chest and abdominal muscles), sick sinus syndrome (a heart condition that occurs when the heart's natural pacemaker, the sinoatrial (SA) node, was damaged and can't generate normal heartbeats), cervical radiculopathy (occurs when a nerve root in the neck was compressed or irritated). Record view of the quarterly MDS assessment, dated 09/15/2024, revealed Resident #74 was able to make himself understood and understood others. The MDS assessment indicated Resident #74 had a BIMS score of 15, which indicated his cognition was intact. Record review of care plan, with a revision date of 08/20/2024, indicated Resident #74 would maintain involvement in cognitive stimulation, social activities. Intervention: all staff will converse with resident while providing care. During an observation and interview on 11/18/2024 at 11:20 a.m., surveyor observed Laundry Aide N go into Resident # 74's room without knocking. Resident #74 stated he felt like it was disrespectful for the staff to enter into his room without knocking first. During an interview on 11/18/2023 at 11:33 a.m., Laundry Aide N stated when entering a resident's room, she was supposed to knock, introduce herself and let the resident know why she was in their room. Laundry Aide N stated she did not knock, identify herself, or let Resident #20 know what she was doing because she just forgot. Laundry Aide N stated it was important to knock, introduce herself, and let the residents know what she was doing in their room so they would not feel uncomfortable, for them to know who she was and that she was not a stranger, and to be respectful of the residents. During an interview on 11/20/2024 at 2:20 p.m., the DON stated the staff should knock before walking into a room and announce themselves. The DON stated she expected the staff to knock, introduce themselves, and explain what they were doing in the room. The DON stated it was important for the staff to let residents know what they are doing in their rooms to make them feel comfortable and safe. The DON stated she would in-service the staff. During an interview on 11/20/2024 at 2:37 p.m., the Administrator stated everybody was responsible for treating the residents with dignity and respect. The Administrator stated she expected the staff to knock, introduce themselves, and tell the residents what they were doing in their room. The Administrator stated it was important because the facility was their home. The Administrator stated she expected the staff to treat the residents with dignity and respect. Record review of the facility's policy titled, Quality of Life- Dignity, revised October 4, 2022, indicated residents' private space and property shall be respected at all times. Staff are to knock and request permission before entering residents' room

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on observations and interviews, the facility failed to ensure residents had the right to receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 24 residents (Resident #65) reviewed for accommodation of needs. The facility treatment nurse failed to ensure Resident #65's call light was in reach for her to use when assistance was needed on 11/17/24-11/19/24. This failure could have placed resident at risk of having needs gone unmet. Findings Included: Record review or Resident #65's face sheet dated 11/25/24 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] and readmitted to the facility on [DATE] with the diagnoses Alzheimer's (a progressive disease that destroys memory and other mental functions), high blood pressure, history of falling, and anxiety (a mental health characterized by worry, anxiety, or fear). Record review of Resident #65's MDS dated [DATE] indicated she could usually understand others and usually made herself understood. The MDS also indicated she had a BIMS score of 5 which meant she had severe cognitive impairment. The MDS also indicated Resident #65 required substantial/maximal assistance with transfers and toileting, supervision with dressing, and independent with eating and hygiene. Record review of Resident #65's care plan initiated on 06/21/24 indicated she had self-care deficit with bathing, dressing, and feeding related to her Alzheimer's and Dementia diagnosis with interventions in place for the staff to provide assistance with ADLs as needed. The care plan also indicated, after a revision completed on 11/20/24 related to surveyor intervention, that resident would come to the doorway and yell for help without using the call light. During an observation and interview on 11/17/24 at 11:14 AM, Resident #65 was laying in her bed sometimes she pressed her call light and the staff would poke their head in and leave. Resident #65's call light was on the floor at the foot of the bed. During an observation on 11/18/24 at 08:34 AM, Resident #65 was in her bed asleep. Call light on the floor under the bed. During an observation and interview on 11/19/24 at 08:30 AM, Resident #65 was laying in her bed and said come on here i need help as this surveyor was at the door. The call light continued to be on the floor under the bed. Resident said, i can't find my rooter(referring to the call light) to call you for help but it was here before. LVN K came into the room and noted the call light was on the floor under Resident #65's bed. She said she should have had the call light within her reach to call for help when she needed to. She said all staff who entered the room were responsible for ensuring all resident call lights were in reach for use. LVN K said the failure placed a risk for Resident #65 not to get help when she needed. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/24 at 02:33 PM, the DON said her expectation was for Resident #65 to always have the call light in reach so that she could use it if she needed help. The DON said the failure placed a risk for the resident not having the access to care that she needed. She said all staff that go in the rooms were responsible for ensuring the call lights were in reach. During an interview on 11/20/24 at 03:03 PM, the Administrator said she expected the call lights to be in the reach of the residents, that way the resident could use it if needed. She said the CNAs were immediately responsible for ensuring the call lights were in reach, but the department heads were responsible as well during rounding of the halls. The Administrator said the failure placed a risk of the resident's needs not being met or possible injury. Record review of the facility policy Resident Call Light System revised 6/2023 indicated: Purpose The purpose of this procedure is to respond to the resident's requests and needs. Policy Implementation A call light system (audible and visual) is in place and operative in the facility. This system allows individual residents to access a system that notifies nursing that the resident has a need .General Guidelines .4. Ensure that the call light is easily reachable by the resident .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on interviews and record reviews the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment for 4 of 24 residents (Residents #90, Resident #95, Resident #203, Resident #98) reviewed for care plans. 1.The facility failed to include Resident #90's diagnosis and interventions for the medication Eliquis Oral Tablet 2.5 MG (Apixaban) (an anticoagulant used for preventing coagulation of blood) in his comprehensive care plan. 2. The facility failed to ensure Resident #95's diagnosis of Clostridioides difficile also known as C-diff (a very contagious bacterium that can cause diarrhea and colitis) and precautions was on her care plan. 3. The facility failed to ensure Resident #98's Eliquis (a medication used to reduce the risk of stroke and blood clots), and interventions was on his care plan. 4. The facility failed to ensure Resident #203's oxygen and interventions was on her care plan These failures could have placed residents at risk for not having their needs met. The findings included: 1.Record review of Resident #90's face sheet indicated he was a [AGE] year-old male who readmitted to the facility on [DATE] with the diagnoses fracture of femur (broken hip), stage 4 pressure ulcer, and dementia (thinking and social symptoms that interfere with daily functioning). Record review of Resident #90's quarterly MDS dated [DATE] indicated he was sometimes understood and sometimes understood others, and he had a BIMS score of 7 which meant he had severe cognitive impairment. The MDS also indicated he required maximal assistance with transfers and hygiene, total assistance with toileting, dressing, and bathing, and independent with eating. The MDS also indicated he takes an anticoagulant. Record review of Resident #90's order summary report dated 11/20/24 indicated he had an order for: 1.Eliquis Oral Tablet 2.5 MG (Apixaban) Give 1 tablet by mouth two times a day with a start date of 09/14/2024. The order summary did not indicate any monitoring for the side effects of the anticoagulant medication. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/20/24 at 2:47 p.m., the DON said her expectation was for the care plan to be accurate, especially medications like anticoagulants. She said the MDS nurse was responsible for ensuring care plans was accurate, but the DON updated and oversaw care plans as well. The DON said the failure placed Resident #90 at risk for not being monitored for the side effects of the medication as well as the tools to be put in place for awareness and focused monitoring or the anticoagulant. The DON said she expected the care plans to be revised within at least the week of the order change. She said the failure also could prevent the resident care plan from being accurate. During an interview on 11/20/24 at 3:06 p.m., the Administrator said her expectation was for all medications to be care planned and especially the anticoagulant. She said the MDS nurse was responsible for ensuring the care plans were updated and accurate. The Administrator said the failure placed a risk for the staff not knowing the resident was taking the medication and could cause bleeding, she assumed because she was not a nurse. 45879 2.Record review of Resident #95's face sheet, dated 11/20/24 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included fracture of the humerus (a fracture or break in the upper arm bone), Clostridioides difficile also known as C-diff (a very contagious bacterium that can cause diarrhea and colitis {an inflammation of the colon}), diabetes, and high blood pressure. Record review of Resident #95's admission MDS assessment, dated 09/15/24, indicated Resident #95 was understood and understood by others. Resident #95 BIMS score was a 15 indicating she was cognitively intact. The MDS indicated she needed assistance with toileting. The MDS indicated Resident #95 was frequently incontinent of bowel and bladder. Record review of Resident #95's Physician order dated 11/12/24 indicated: enteric contact isolation and transmission-based precaution for C-diff every shift. Record review of Resident #95's Physician order dated 11/12/24 indicated: Vancomycin HCl Oral Suspension 50 mg/ml Give 2.5 ml by mouth four times a day for C-diff for 7 days. 3.Record review of Resident #98's face sheet, dated 11/20/24 indicated he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included muscle weakness, dementia (loss of memory), atrial fibrillation (a common type of irregular heartbeat), and high blood pressure. Record review of Resident 98's 5-day MDS assessment, dated 10/22/24, indicated Resident #98 was understood and understood by others. Resident #98 BIMS score was a 03 indicating he was severely cognitively impaired. The MDS indicated Resident #98 required extensive assistance with his ADLs. The MDS indicated he had taken an anticoagulant medication. Record review of Resident 98's Physician order dated 10/17/24 indicated he had an order for Eliquis (Apixaban) 2.5 MG, give 1 tablet by mouth two times a day for diagnosis of atrial fibrillation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4.Record review of Resident #205's face sheet, dated 11/20/24 indicated an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of congestive heart failure also known as CHF (a chronic condition that occurs when the heart can't pump enough blood to meet the body's needs), Atrial fibrillation also known as A Fib (is a heart condition that causes an irregular and rapid heartbeat in the upper chambers of the heart), stroke, high blood pressure and anxiety (a feeling of fear, dread, and uneasiness). Record review of Resident #205's admission MDS assessment, dated 09/15/24, indicated Resident #205 was usually understood and was usually understood by others. Resident #205's BIMS score was 03, which indicated she was severely cognitively impaired. The MDS indicated Resident #205 required assistance with dressing, personal hygiene, toileting, bathing, bed mobility, transfers, and set-up for eating. The MDS during the 7-day look-back period indicated Resident #205 was receiving oxygen. Record review of Resident #205 physician orders dated 09/12/24 indicated, Nasal Cannula Continuous at 1-3 liters per minute for congestive heart failure. During an interview on 11/20/24 at 10:22 a.m., MDS nurse #1 said she was responsible for the care plans for the long-term and private residents. She said the care plan was done so the staff would know how to care for the resident. She said she was made aware of the residents' changes in the morning meeting. She said she brought her computer to the morning meetings and updated any changes during the meeting. She said she was unaware of how she missed adding Resident #90's Eliquis to his care plan. She said failure to do a care plan could cause staff not to know how to care for the residents. During an interview on 11/20/24 at 2:36 p.m., MDS nurse#2 said she was responsible for the Medicare resident's care plans She said care plans were done for staff to know the needs of the residents. She said she was made aware of changes or new orders in the morning meeting. She said she was new to this position and was learning. She said she was unaware she had not updated Resident #98's, Resident #95's, or Resident #205's care plan. She said it was important to ensure the resident's care plan was updated with any new orders or changes. She said care plans should be done and or updated so that staff knew how to care for the resident. During an interview on 11/20/24 at 2:37 p.m., the DON said the MDS nurse was responsible for the care plans. She said the purpose of the care plans was to keep everyone informed of the resident's care She said they talked about the resident's changes during the morning meeting. She said she expected any changes to be done as soon as possible but no later than a week. She said she expected the care plans to be accurate to reflect the resident's care. During an interview on 11/20/24 at 3:07 p.m., the Administrator said the MDS nurse was responsible for the care plans. She said the DON was the overseer of the care plans. She said if care plans were not done residents might receive something they do not need or not receive something they do need. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled, Comprehensive Care Plan, dated December 2016 indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation:1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.8. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being;13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 14. The Interdisciplinary Team must review and update the care plan: a. When there has been a significant change in the resident's condition.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on interviews and record reviews, the facility failed to ensure that the comprehensive care plans were reviewed and revised by the interdisciplinary team after each assessment, for 3 residents (Resident #90, Resident #203, and Resident #8) out of 24 sampled residents whose care plans were reviewed for timing and revision. The facility failed to ensure Resident #90's care plan was updated and accurate by not resolving the care plan for a PICC line and antibiotic administration that resident no longer had an order for. The facility failed to ensure Resident #203's care plan was updated by resolving her melatonin and rash in which she no longer had those orders. The facility failed to ensure Resident #8's care plan was updated by resolving her antibiotics and IV fluids in which she no longer had those orders. These failures could place residents at risk for not receiving the care and services to meet their needs. Findings include: 1.Record review of Resident #90's face sheet indicated he was a [AGE] year-old male who readmitted to the facility on [DATE] with the diagnoses fracture of femur (broken hip), stage 4 pressure ulcer, and dementia (thinking and social symptoms that interfere with daily functioning). Record review of Resident #90's quarterly MDS dated [DATE] indicated he was sometimes understood and sometimes understood others, and he had a BIMS score 7 of which meant he had severe cognitive impairment. The MDS also indicated he required maximal assistance with transfers and hygiene, total assistance with toileting, dressing, and bathing, and independent with eating. Record review of Resident #90's care plan initiated 06/14/24 and revised 09/23/24 indicated he was on IV Medications r/t an infection to his sacral wound with interventions that included: 1. If IV is infiltrated: stop infusion and thoroughly examine the site. 2. If the catheter appears to be lodged in the tissues, an attempt to aspirate any fluid remaining in the catheter can be made in order to lessen the amount of drug at the site. After removing the cannula, elevate the affected arm, notify the physician (for large infiltrations and extravasations), and apply cool compresses (warm, if [NAME] alkaloids are involved). 3. IV DRESSING: PICC line dressing change q week & prn. Observe dressing q shift. Change dressing and record observations of site. Monitor/document/report PRN. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/20/24 at 02:47 PM, the DON said her expectation was for the care plan to be accurate. She said the MDS nurse was responsible for ensuring care plans were accurate, but the DON updated and oversaw care plans as well. The DON said she expected the care plans to be revised within at least the week of the order change. She said the failure could prevent the resident care plan from being accurate. During an interview on 11/20/24 at 03:06 PM, the Administrator said her expectation was for the care plans to be resolved as they were finished with the care. She said the MDS nurse was responsible for ensuring the care plans were updated and accurate. The Administrator said the failure placed a risk for Resident #90 getting care that was not needed (getting IV medications that were not ordered). 45879 2.Record review of Resident #203's face sheet, dated 11/20/24 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included fracture of the superior rim of the right pubis (a break in the pelvic area that usually caused by a direct blow, such as from a fall or a motor vehicle accident), pressure wounds (areas of damaged skin and tissue caused by sustained pressure that reduces blood flow to vulnerable areas of the body), and dementia (decline in mental abilities that affects a person's daily life). Record review of Resident #203's admission MDS assessment, dated 08/13/24, indicated Resident #203 was understood and usually understood by others. Resident #203's BIMS score was a 04 indicating she was severely cognitively impaired. The MDS indicated she required assistance with her activities of daily living. Record review of Resident #203's comprehensive care plan dated 08/08/24 indicated she was taking melatonin related to insomnia. The intervention was for staff to give medication as ordered. Record review of Resident #203's comprehensive care plan dated 08/08/24 indicated, she had a rash on the right side with a diagnosis of Shingles. The interventions were for staff to provide medication as ordered and for her to be in contact isolation. Record review of Resident #203's Physician order dated 11/01/24 through 11/20/24 did not indicate an order for a rash or diagnosis of shingles. Record review of Resident #203's Physician order dated 08/14/24 indicated all contact was discontinued for shingles. Record review of Resident #203's Physician order dated 11/01/24 through 11/20/24 did not indicate an order for melatonin. Record review of Resident #203's Physician order dated 09/10/24 indicated Melatonin was discontinued. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.Record review of Resident #8's face sheet, dated 11/20/24 indicated she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Cerebral palsy also known as CP (a group of neurological disorders that affect a person's ability to move, balance, and maintain postured), depression (sadness), high blood pressure, seizures (a sudden burst of electrical activity in the brain), and Quadriplegia (a medical condition that causes partial or total loss of movement and sensation in all four limbs and the torso). Record review of Resident #8's admission MDS assessment, dated 09/24/24, indicated Resident #8 was sometimes understood and understood by others. Resident #8's BIMS score was a 03 indicating she was severely cognitively impaired. The MDS did indicate she was on antibiotics. Record review of Resident #8's comprehensive care plan revised on 10/07/24 indicated she was on antibiotic therapy related to chronic urinary tract infections. The intervention was for staff to give medication as ordered. Record review of Resident #8's comprehensive care plan revised on 10/25/24 indicated she was at risk for altered fluid balance related to hydration and sodium chloride solution. The intervention was for staff to give medication as ordered. Record review of Resident #8's physician's orders dated 11/01/24 through 11/20/24 did not indicate any orders for an antibiotic for a urinary tract infection. Record review of Resident #8's physician's orders dated 11/01/24 through 11/20/24 did not indicate any orders for IV sodium chloride 0.9%. During an interview on 11/20/24 at 10:22 a.m., MDS nurse #1 said she was responsible for the care plans for the long-term and private residents. She said the care plan was done so the staff would know how to care for the resident. She said she was made aware of the residents' changes in the morning meeting. She said she brought her computer to the morning meetings and updated any changes during the meeting. She said she was unaware she missed deleting Resident #90's PICC and antibiotics off his care plan. She said failure to update a care plan could cause staff not to know how to care for the residents. During an interview on 11/20/24 at 2:36 p.m., MDS nurse #2 said she was responsible for the Medicare resident's care plans She said care plans were done for staff to know the needs of the residents. She said she was made aware of changes or new orders in the morning meeting. She said she was new to this position and was learning. She said she was unaware she had not updated Resident #8 or Resident #203's, care plan. She said it was important to ensure the resident's care plan was updated with any new orders or changes. She said care plans should be done and or updated so that staff knew how to care for the resident. During an interview on 11/20/24 at 3:07 p.m., the Administrator said the MDS nurse was responsible for the care plans. She said the DON was the overseer of the care plans. She said if care plans were not done residents might receive something they do not need or not receive something they do need. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Briarcliff Health Center of Greenville		STREET ADDRESS, CITY, STATE, ZIP CODE 4400 Walnut St Greenville, TX 75401	

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled, Care Plans and Comprehensive Person-Centered, dated December 2016 indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 14. The Interdisciplinary Team must review and update the care plan: a. When there has been a significant change in the resident's condition.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47612 Based on observation, interview and record review the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, personal and oral hygiene for 1 of 24 residents (Resident #59) reviewed for ADL (activities of daily living) care. The facility failed to provide nail care by removing black material from under fingernails for dependent female Resident #59 on 11/17/2024,11/18/2024, and 11/19/2024. This failure could place residents at risk of not receiving care and services to meet their needs. Findings included: Record review of the face sheet, dated 11/18/2024, revealed Resident #59 was a [AGE] year old female with diagnoses which included traumatic subdural hemorrhage without loss of consciousness, subsequent encounter (a medical situation where a patient has experienced a brain bleed (subdural hemorrhage) due to a head injury, but did not lose consciousness at the time of the injury, and was now being seen for follow-up care related to this condition), metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance in the blood that affects the brain), cognitive communication deficit (difficulty with communication that's caused by a disruption in cognition). Record view of the quarterly MDS, dated [DATE], revealed Resident #59 had a BIMS of 03 indicating severe cognitive impairment. Resident #59 required assistance of two person for dressing, bathing, and personal hygiene ADLs, Resident #59 required assistance of two person for dressing, bathing, and personal hygiene ADLs. The MDS revealed Resident #59 did not reject care. Record review of care plan, with a revision date of 07/14/2024, indicated Resident #59 had an ADL self-care performance deficit. Goal: Resident #59 will improve current level of function in ADLs. Interventions: personal hygiene resident was totally dependent in personal hygiene. During an observation on 11/17/2024 at 9:48 a.m. Resident #59 was observed with black material under fingernails. During an observation on 11/18/2024 at 9:32 a.m. Resident #59 was observed with black material under fingernails. During an observation on 11/19/2024 at 9:35 a.m. Resident #59 was observed with black material under fingernails. During an interview on 11/19/2024 at 10:37 a.m., CNA O stated it was the CNAs responsibility to ensure the residents fingernails were clean during showers or when needed. CNA O stated it was important to keep resident fingernails clean to keep bacteria down. CNA O stated Resident #59 could put her hand in her mouth and the bacteria could get into her mouth and cause an infection. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/19/2024 at 10:43 a.m., CNA P stated it was her responsibility to clean the resident's fingernails during showers. CNA P stated it was important to keep resident fingernails clean to keep bacteria from getting into Resident #59 mouth when eating. CNA P stated if Resident #59 had feces under her fingernail it could make her sick. During an interview on 11/20/2024 at 2:20 p.m., the DON stated it was the CNAs who usually cleaned the resident's fingernails on bath days. The DON stated it was important to keep Resident #59's fingernails clean for infection control and dignity. The DON stated she would monitor by making frequent rounds on every shift and at mealtime. During an interview on 11/20/2024 at 2:37 p.m., the Administrator stated she expected the CNAs to do nail care every Sunday or when needed. The Administrator stated it was important to keep Resident # 59's fingernails clean to prevent contamination. The Administrator stated there could potentially be a risk to Resident #59 by putting dirty fingernails in her mouth. The Administrator stated the department heads would monitor by making rounds. Record review of the facility's undated policy titled Care of Fingernails/Toenails the purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observations, interviews, and record reviews, the facility failed to ensure that the resident environment remained as free of accident hazards as possible for 1 of 24 Residents (Resident #98) reviewed for accidents and hazards. The facility failed to ensure Resident #98's fall mat was beside his bed on 11/17/24, 11/18/24 and 11/19/24. This deficient practice could place residents at risk of harm or injury and contribute to avoidable accidents. Findings included: 1.Record review of Resident #98's face sheet, dated 11/20/24 indicated he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included muscle weakness, dementia (loss of memory), atrial fibrillation (a common type of irregular heartbeat), and high blood pressure. Record review of Resident 98's 5-day MDS assessment, dated 10/22/24, indicated Resident #98 understood and was understood by others. Resident #98's BIMS score was a 03 indicating his cognition was severely impaired. The MDS indicated Resident #98 required extensive assistance with his ADLs including transfers and bed mobility. The MDS indicated he had a fall in the prior month. Record review of Resident #98's comprehensive care plan dated 11/13/24 indicated, he had an actual fall related to poor balance, and impaired mobility, and was at risk for further falls with injury. The intervention was for staff to apply a fall mat at the bedside. Record review of Resident 98's Physician order dated 11/13/24 indicated, he had an order for a fall mat at the bedside every shift. Record review of Resident 98's incident report dated 11/13/24 indicated he had a fall. The intervention was to place a fall mat beside his bed. During an observation on 11/17/24 at 11:35 a.m., Resident #98 was in bed with his eyes closed. No fall mat was noted beside his bed. During an observation on 11/18/24 at 4:35 p.m., Resident #98 was in his bed with no mat beside his bed. During an observation and interview on 11/19/24 at 9:00 a.m., LVN A went into Resident #98's room and verified he did not have a fall mat beside his bed. She then looked into his electronic chart and said Resident #98 had an order for a fall mat. She said Resident #98 had a fall the other day and they must have placed the fall mat as an intervention. She said fall mats were important to prevent falls or injuries from falling. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/24 at 2:37 p.m., the DON said Resident #98 was supposed to have a fall mat beside his bed because he had a fall and was at risk for further falls. She said all staff was responsible for ensuring the fall mat was beside his bed. She said if he did not have his fall mat down then he could fall and obtain an injury. During an interview on 11/20/24 at 3:07 p.m., the Administrator said if Resident #98 had an order for a fall mat to be beside his bed, then all staff were responsible for ensuring it was beside his bed. She said failure to have the fall mat could cause an injury from the fall. Record review of facility policy titled, Falls dated November 14, 2023, indicated, The Assessment: The Nursing Staff with physician's support will identify residents with a history of falls and risk factors for falling. a. The Staff Nurse will complete a Fall Risk Screening or equivalent form, on the resident upon admission, readmission, routine quarterly, annual, significant change MDS, and PRN. Treatment/Management: Based on the preceding assessment, the Nursing Staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. Monitoring and Follow-Up: The Nursing Staff will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling during the Standard of Care/High-Risk Management Meetings. If interventions have been successful in fall prevention, the staff will continue with current approaches and will discuss periodically with the physician whether these measures are still needed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observation, interview, and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 3 residents (Resident's #205) reviewed for respiratory care. The facility failed to date and follow the physician's order to change oxygen tubing weekly on Saturday nights for Resident #205. This failure could place residents who receive respiratory care at risk of developing respiratory complications and a decreased quality of care. Finding included: Record review of Resident #205's face sheet, dated 11/20/24 indicated an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of congestive heart failure also known as CHF (a chronic condition that occurs when the heart can't pump enough blood to meet the body's needs), Atrial fibrillation also known as AFib (is a heart condition that causes an irregular and rapid heartbeat in the upper chambers of the heart), stroke, high blood pressure and anxiety (a feeling of fear, dread, and uneasiness). Record review of Resident #205's admission MDS assessment, dated 09/15/24, indicated Resident #205 was usually understood and was usually understood by others. Resident #205's BIMS score was 03, which indicated she was severely cognitively impaired. The MDS indicated Resident #205 required assistance with dressing, personal hygiene, toileting, bathing, bed mobility, transfers, and set-up for eating. The MDS during the 7-day look-back period indicated Resident #205 was receiving oxygen. Record review of Resident #205 physician orders dated 09/12/24 indicated, Nasal Cannula Continuous at 1-3 liters per minute for congestive heart failure. Record review of Resident #205 physician orders dated 09/12/24 indicated Oxygen: Change Mask, oxygen tubing, water bottle, and clean concentrator filters every Saturday night shift related to congestive heart failure. Record review of Resident#205's care plan revised on 11/04/24 did not indicate a care plan for oxygen. During an observation on 11/17/24 at 11:49 a.m., Resident # 205 was lying in her bed with her eyes closed. Resident #205 had oxygen on via nasal cannula at 3 liters. Resident #205 oxygen tubing did not have a date on it. During an observation on 11/18/24 at 8:55 a.m., Resident #205's oxygen tubing was in a bag with no date. (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 observation and interview on 11/19/24 at 9:00 a.m., LVN A went into Resident #205's room and verified her oxygen tubing had no date on it. She said she was unaware when the oxygen tubing had been changed because it was not dated. She said the night shift usually changed the oxygen tubing, but she was unsure of which day on the night shift or how often. She went and asked the ADON who told her the oxygen tubing should be changed and dated on Saturday nights. She said the oxygen tubing should be changed for infection reasons. During an interview on 11/20/24 at 2:37 p.m., the DON said the charge nurses were responsible for following the physician's orders. She said the charge nurses were responsible for ensuring the oxygen tubing was changed and dated weekly on Saturday nights. The DON said oxygen tubing should be changed and dated for infection control. During an interview on 11/20/24 at 3:07 p.m., the Administrator said she expected the nurses to change and date the oxygen tubing. She said nurse managers were the overseers of oxygen. She said failure to change oxygen tubing should cause infection issues. Record review of facility policy titled, Oxygen Administration revision date as of October 2010, indicated Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45810 Based on observation, interview, and record review, the facility failed store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 1 medication cart (Hall 100 medication cart) of 5 medication carts. The facility failed to ensure LVN R the 100 Hall medication cart was locked when it was left unattended in the hallway with the door closed while he provided a treatment for a resident. This failure could place residents at risk for overdose or injury from sharp needles. Findings included: During an observation on 11/18/24 at 09:56 AM, LVN R left the treatment cart unlocked and unattended on the A hall with door closed while he provided a wound treatment to a resident who resided on A hall. During an observation and interview on 11/18/24 at 10:03 AM, LVN R walked out of the resident's room and locked the treatment cart that was left open and unattended. He said he was responsible for locking the cart, but he forgot to lock the cart because he got distracted. LVN R said he normally would have the cart against the door with it unlocked. He said the failure placed a risk for any resident, visitor, or staff to get into the cart and take medications or anything out of the cart. He said a resident could have ingested medications from the cart. During an interview on 11/20/24 at 02:43 PM, the DON said her expectation was for the medications to be secure and locked in the cart when the cart was not in direct vision. The DON said the nurse or medication aide using the cart was responsible to keep cart secure. The DON said the failure placed a risk for wandering resident getting medications or supplies that are harmful to them as well as risk for a drug diversion or theft. During an interview on 11/20/24 at 03:09 PM, the Administrator said her expectation was for the medication and treatment carts to be locked if they were unattended. She said all nurses and medication aides were responsible for ensuring the carts were locked when they were not in use. The Administrator said the failure placed a risk for anyone (residents, visitors, or staff) getting into the cart and having access to the medications. Record review of the facility policy Storage of Medications revised April 2019 indicated: Policy Statement The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.Drugs and Biologicals used in the facility are stored in locked compartments .9. Unlocked medication carts are not left unattended .12. Only persons authorized to prepare and administer medications have access to locked medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47612 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 reviewed for food and nutrition services. 1. The facility failed to ensure hair restraints were worn appropriately by dietary staff. 2. The facility failed to ensure the interior of the microwave was free of brown debris. These failures could place residents at risk for foodborne illness. Findings include: An observation in the kitchen on 11/17/2024 at 10:20 a.m., revealed [NAME] L was not wearing a hair restraint appropriately while preparing the lunch meal. [NAME] L hair was visible outside of the hairnet in the back approximately four inches. An observation in the kitchen on 11/17/2024 at 10:28 a.m., revealed dietary [NAME] M was not wearing a hair restraint while in the kitchen washing dishes. An observation in the kitchen on 11/17/2024 at 10:45 a.m., revealed the interior of the microwave was covered with a brown debris. During an interview on 11/18/2024 at 10:00 a.m., [NAME] L stated she did not realize her hair was not covered. [NAME] L stated it was important to wear hairnets correctly to keep hair out of the food. [NAME] L stated the residents would not enjoy eating food with hair in it. During an interview on 11/18/2024 at 10:15 a.m., the Dietary Manager stated she expected the staff to keep all hair covered. The Dietary Manager stated hairnets were important to ensure no hair got into the food. The Dietary Manager stated if hair was in the food, the residents may not want to eat. The Dietary Manager stated she expected the dietary staff to clean the microwave daily. The Dietary Manager stated it was important to make sure the microwave was clean to prevent cross contamination. The Dietary Manager stated the microwave had some damage on the inside and a new microwave was ordered. During an interview on 11/20/2024 at 9:10 a.m., [NAME] M stated she did not realize she did not have a hairnet on. [NAME] M stated it was important to cover their hair to keep it out of the food. [NAME] M stated the harm to the resident was they would not want to eat food that had hair in it, and they could lose weight. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/2024 at 2:37 p.m., the Administrator stated she expected anyone entering the kitchen to wear a hairnet. The Administrator stated it was important to keep hair from getting into the food. The Administrator stated hair in the food would not be pleasing to the residents. The Administrator stated she expected the microwave to be clean. The Administrator stated a new microwave had been ordered. Record review of the facility's policy Employee Sanitation, dated 10/01/2018, revealed Hairnets, headbands, caps, beard coverings or other effective hair restraints must be worn to keep hair from food and food-contact surfaces Record review of the facility's policy Microwave, dated 10/01/2018, revealed The facility will maintain the microwave in a sanitary manner to minimize the risk of food hazards

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observation, interview, and record review, 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 reviewed for 7 of 24 residents (Resident's#95, #203, #64, #20, #21, #74, #98) reviewed for infection control. 1. The facility failed to ensure CNA F, LVN C, and therapist E were following contact isolation for Resident #95 who had Clostridium difficile, also known as C-diff (a very contagious bacterium that can cause diarrhea and colitis). 2. The facility failed to ensure the treatment nurse performed hand hygiene while performing wound care, and CNA B was following Enhanced Barrier Precautions (EBP) for Resident #203 who had wounds. 3. The facility failed to ensure CNA D changed gloves or performed hand hygiene while providing incontinent care for Resident #64. 4. The facility failed to ensure CMA S used proper hygiene while she administered medications to Resident #20, Resident #21, and Resident #74. 5. The facility failed to ensure CMA S washed her hands before and after administering eye drops to Resident #21. 6. The facility failed to ensure LVN A followed the enhanced barrier precautions for Resident #98 while she administered his IV medication through his PICC line. These deficient practices could place residents at risk for infection due to improper care practices. Findings included: 1.Record review of Resident #95's face sheet, dated 11/20/24 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included fracture of the humerus (a fracture or break in the upper arm bone), Clostridium difficile, also known as C-diff (a very contagious bacterium that can cause diarrhea and colitis {an inflammation of the colon}), diabetes, and high blood pressure. Record review of Resident #95's admission MDS assessment, dated 09/15/24, indicated Resident #95 understood and was understood by others. Resident #95 BIMS score was a 15 indicating her cognition was intact. The MDS indicated she needed assistance with toileting. The MDS indicated Resident #95 was frequently incontinent of bowel and bladder. Record review of Resident #95's comprehensive care plan revised on 09/30/24 did not indicate a care plan for C-Diff. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Briarcliff Health Center of Greenville		STREET ADDRESS, CITY, STATE, ZIP CODE: 4400 Walnut St Greenville, TX 75401	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #95's Physician order dated 11/12/24 indicated: enteric (relating to the small intestine) contact isolation and transmission-based precaution for C-diff every shift. Record review of Resident #95's Physician order dated 11/12/24 indicated: Vancomycin HCl Oral Suspension 50 mg/ml Give 2.5 ml by mouth four times a day for C-diff for 7 days. Record review of Resident #95 Physician order dated 11/19/24 indicated: Fidaxomicin Oral Tablet 200 MG (Fidaxomicin) Give 1 tablet by mouth two times a day related to enterocolitis due to C-diff for 10 days. Record review of Resident #95's MAR (medication administration records) dated 11/12/24 through 11/18/24 revealed nurses were signing that Resident #95 received enteric contact isolation and transmission-based precautions for C-diff every shift. Record review of Resident #95's MAR dated 11/13/24 through 11/18/24 indicated Resident #95 received Vancomycin HCl Oral Suspension 50 mg/ml Give 2.5 ml by mouth four times. Record review of Resident #95's MAR with a start date of 11/20/24 indicated: Resident #95 received strict enteric contact isolation and transmission-based precautions for possible C-diff every shift. Record review of Resident #95's MAR with a start date of 11/20/24 indicated: Resident #95 received Fidaxomicin Oral Tablet 200 mg, give 1 tablet by mouth two times a day related to enterocolitis due to C-diff for 10 days. During an observation on 11/17/24 at 12:02 p.m., Resident #95 was sitting in her room in a wheelchair. Resident #95 had 2 signs posted outside her room door. The first sign indicated the use of enteric contact and said all staff who entered the room must wear PPE. The second sign was for EBP which indicated you must wear PPE when providing care. During an observation and interview on 11/17/24 at 4:39 p.m., LVN C went into Resident #95's room to answer the call light but did not put on any PPE. LVN C said the roommate wanted a cup and she did not have to put on PPE to answer the call light. The surveyor asked LVN C why Resident #95 was on contact precautions, and she said she had C-Diff. LVN C said she was only required to wear PPE if she was providing care to Resident #95. During an interview on 11/17/24 at 5:07 p.m. CNA F said she was the CNA for Resident #95. She said she had been in Resident #95's room without any PPE. She said she thought contact was just when you touched the resident. She said she was not sure why Resident #95 was in contact. During an observation on 11/18/24 at 8:45 a.m., Resident #95 was not in her room. No boxes or containers were noted in the room for linen or trash. Both contact and EBP signs remained outside Resident #95's door. During an observation on 11/18/24 at 9:07 a.m., a therapist was observed walking Resident #95 down the hallway. She did not have on any PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/18/24 at 9:13 a.m., Therapist E said she was not aware Resident #95 had C-Diff. She said she was told by an unknown person that her C-Diff had resolved some time ago (unknown time). She said she had worked with Resident #95 during the previous week and did not wear PPE. She said if Resident #95 was on contact isolation, she should have worn her PPE. She said she thought the sign outside the door for contact and EBP was for her roommate because she had a wound. During an interview on 11/18/24 at 9:29 a.m., Resident #95 said the facility physician had cleared her from C-Diff about a week ago. She said then they started her back on antibiotics last week (unknown date) for loose stools, but she was under the impression that she would have loose stools often, for a while, but was no longer on contact isolation. She said when she knew she was in contact isolation, she still went wherever she wanted and did not wear any PPE. She said some staff wore PPE and others did not. She said they did tell her she could not use any resident's restroom, and no one could use hers. She said her last loose stool was the other day (unknown date). During an observation on 11/18/24 at 9:37 a.m., the DON went into Resident #95's room without applying PPE. When the DON was leaving the room, she saw the contact sign on the door and went back into the room and performed hand hygiene. She then went to the nurse's station and got a contact isolation sign. The DON went to Resident #95's room, applied her gown and gloves, and then placed the sign over her bed. During a phone interview on 11/18/24 at 10:42 a.m., the facility physician said he was treating Resident #95 for C-diff because she was showing symptoms. He said he expected her to be in contact isolation. During an interview on 11/19/2024 at 2:00 p.m., Laundry staff N said she was unaware of any resident who required isolation precautions. She said normally the laundry would be provided with an in-service to notify them of any residents requiring isolation precautions. She said when they did have a resident on isolation, she had a protective cover that she would use when the clothing arrived. She said she expected the clothing to come in a water-soluble bag and they would have been washed alone. 2. Record review of Resident #203's face sheet, dated 11/20/24 indicated she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included fracture of the superior rim of the right pubis (a break in the pelvic area that's usually caused by a direct blow, such as from a fall or a motor vehicle accident), pressure wounds (areas of damaged skin and tissue caused by sustained pressure that reduces blood flow to vulnerable areas of the body), and dementia (decline in mental abilities that affects a person's daily life). Record review of Resident 203's admission MDS assessment, dated 08/13/24, indicated Resident #203 was understood and understood by others. Resident #203 BIMS score was a 04 indicating she was severely cognitively impaired. The MDS did not indicate Resident #203 had wounds. Record review of Resident #203's comprehensive care plan dated 08/16/24 and revised 09/12/24 indicated, she had potential/actual impairment to skin integrity related to fragile skin and a Stage 3(open wound) to her mid spine. The interventions were for staff to provide wound care as ordered. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident 203's Physician order dated 10/31/24 revealed Resident #203 had the order to implement and maintain enhanced barrier precautions when performing high-contact care activities. Record review of Resident #203 Physician order dated 11/14/24 indicated: Cleanse Stage 3 pressure wound to mid-spine with NS, apply Calcium alginate, cover with a dry dressing on Monday, Wednesday, Friday, and as needed for soiling/dislodgement every day shift for Stage 3 pressure wound. Record review of Resident #203's comprehensive care plan dated 09/19/24 and revised 11/18/24 indicated, she was on EBP related to being at an increased risk of MDRO acquisition because of Stage 3 to her right upper back. The interventions were for staff to provide patient standard precautions using gowns and gloves during dressing, bathing, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting, and while providing wound care. Post clear signage on the door or wall outside of the room indicating the type of precautions and required PPE and provide education to residents and visitors. During an observation on 11/17/24 at 12:08 p.m., an enhanced barrier sign was noted on Resident #203's door. During an observation and interview on 11/17/24 at 12:14 p.m., CNA B entered Resident #203's room. She went over to Resident #203's side pulled the curtain halfway, assisted her to put on her glasses, and then into the wheelchair, all without any PPE. CNA B said Resident #203 was not on any precautions, therefore she did not need to wear any PPE. She said the roommate, Resident #95, was on isolation for Shingles. She then said after looking at the door, she should have worn PPE (gown and gloves) when transferring Resident #203 into her chair for EBP. During an observation and interview on 11/17/24 at 12:14 p.m., the treatment nurse entered Resident #203's room to perform wound care. He explained what he was going to do and applied his gown and gloves. The treatment nurse removed the dirty dressing and then applied new gloves without hand hygiene. He then applied the wound dressing, removed his gloves and gown, and washed his hands. The treatment nurse said he was supposed to perform hand hygiene after he cleaned the wound and before he applied new gloves to prevent infection control issues. 3.Record review of Resident #64's face sheet, dated 11/20/24 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included fracture of the superior rim of the right pubis (a break in the pelvic area that usually caused by a direct blow, such as from a fall or a motor vehicle accident), pressure wounds (areas of damaged skin and tissue caused by sustained pressure that reduces blood flow to vulnerable areas of the body), and dementia (decline in mental abilities that affects a person's daily life). Record review of Resident 64's quarterly MDS assessment, dated 10/01/24, indicated Resident #64 had memory deficient and severe cognitive impairment. The MDS indicated Resident #64 was dependent on staff for toileting. The MDS indicated Resident #64 was always incontinent of bowel and bladder. Record review of Resident #64's comprehensive care plan revised on 06/24/24 indicated she had bladder incontinence related to bladder spasms, and bowel incontinence related to the diagnosis of Alzheimer's. The interventions were for staff to provide incontinence care with each incontinent episode. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 11/18/24 at 1:53 p.m., CNA, D was providing incontinent care for Resident #64 who had an incontinent episode. She explained what she was going to do and provided hand hygiene and gloves. CNA D washed Resident #64's peri area and then turned her over touching her side without hand hygiene, then cleaned her buttock. CNA D then changed her gloves but did not perform hand hygiene. CNA D pulled up the covers and lowered the bed. During an interview on 11/18/24 at 2:06 p.m., CNA D said she should have changed her gloves and performed hand hygiene when going from dirty to clean or any time she changed her gloves. She said she forgot, but knew it was important to prevent cross-contamination. During an interview on 11/20/24 at 10:00 a.m., the DON said she expected staff to perform peri-care, wound care, and hand hygiene correctly to prevent infection. The DON said she and the ADON usually did peri-care and wound care checkoffs with staff on hire, annually, and as needed. The DON said she expected staff to follow contact and EBP precautions. She said she was aware Resident #95 was on contact isolation. She said she entered her room to pick something up off the floor. She said she used an alcohol-based sanitizer at first to clean her hands, but then went back into the room to wash her hands. She said she should have worn PPE when she entered Resident #95's room. The DON said she was unaware staff did not have any containers in the room for the linen and trash. She said Resident #95 had them in her room as of today (11/20/24). The DON said failure to follow contact isolation or EBP precautions, perform incontinent care, wound care, and hand hygiene properly could lead to infection issues. During an interview on 11/20/24 at 3:07 p.m., the Administrator said all staff was responsible for infection control issues. She said failure to do proper incontinent care, wound care, and hand hygiene or follow contact isolation or EBP precautions could lead to infection. 45810 4. Record review of Resident #20's face sheet dated 11/18/24 indicated she was an [AGE] year-old female who was readmitted to the facility on [DATE] with the diagnoses of Dementia, Diabetes Mellitus, heart failure, and high blood pressure. Record review of Resident #20's quarterly MDS dated [DATE] indicated he made himself understood and could understand others. The MDS also indicated he had a BIMS score of 10 which meant he had moderate cognitive impairment. During an observation on 11/17/24 at 3:57 PM, CMA S provided Resident #20 with his medications and failed to wash her hands or use hand sanitizer before or after administering the medications. 5. Record review of Resident #21's face sheet dated 11/20/24 indicated he was a [AGE] year-old male who readmitted to the facility on [DATE] with the diagnoses cerebral infarction (a disorder that causes disrupted blood flow to the brain), intellectual disabilities, depression, and high blood pressure. Record review of Resident #21's quarterly MDS date 08/15/24 indicated he usually made himself understood, he usually understood others, and he had a BIMS score of 10 which meant he had moderate cognitive impairment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #21's care plan revised on 05/19/21 indicated he had an alteration in his neurological status with interventions to give his medications as ordered. The care plan also indicated he had impaired visual function related to glaucoma and the staff interventions were to give eye drops as ordered. Record review of Resident #21's order summary report dated 11/20/24 indicated he had an order for: Alphagan P Solution 0.15 % (Brimonidine Tartrate) Instill 1 drop in both eyes two times a day for GLAUCOMA with a start date of 02/21/2024. During an observation on 11/17/24 at 04:00 PM, CMA S administered Resident #21's oral medications without washing hands or using hand sanitizer before or after medication administration. CMA S then went to the medication cart and retrieved Resident #21's eye drops, Alphagan P Solution 0.15 % (Brimonidine Tartrate), put on gloves in the room and administered 1 drop to Resident #21's right and left eye. She gave Resident #21 a tissue, removed gloves, and returned to cart. CMA S did not use hand sanitizer or wash hands after administering the eye drops. 6. Record review of Resident #74's face sheet dated 11/18 24 indicated he was a [AGE] year-old male who readmitted to the facility on [DATE] with the diagnoses heart failure, atrial fibrillation (irregular and rapid heartbeat), and quadriplegia (paralysis that affects all 4 of a person's limbs). Record review of Resident #74's quarterly MDS dated [DATE] indicated he could understand others, made himself understood, and he had a BIMS score of 15 which meant he was mentally intact. During an observation on 11/17/24 at 04:12 PM, CMA S administered Resident #74'smedications without washing (his/her) hands or using hand sanitizer before or after administration of the medications. During an observation and interview on 11/17/24 at 04:15 PM, CMA S started to prepare next resident after Resident #74 and surveyor intervened. CMA S said hand hygiene and the use of hand sanitizer slipped her mind. She said she should have used hand sanitizer between medication administration for Resident #20, Resident #21, and Resident #74. CMA S said she should have washed hands before and after administering Resident #21's the eye drops. She said the failure placed a risk of spreading infection and disease. During an interview on 11/20/204 at 02:45 PM, the DON said she had completed a 1 on 1 in-service with the medication aides. She said she expected all CMAs to perform hand hygiene between each resident and to perform hand washing before and after eye drop administration. The DON said the failure placed a risk for residents to get infections. During an interview on 11/20/24 at 03:11 PM, the Administrator said her expectation was for the CMAs' hands to be washed prior to any type of care or eye drops given and afterwards. She said all nurses and CMAs should be performing hand hygiene between each resident. She said the failure placed the risk for infection. 7. Record review of Resident #98's face sheet, dated 11/20/24 indicated he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included muscle weakness, dementia (loss of memory), atrial fibrillation (a common type of irregular heartbeat), and high blood pressure (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident 98's 5-day MDS assessment, dated 10/22/24, indicated Resident #98 was understood by others and able to understand others. Resident #98 BIMS score was a 03 indicating he was severely cognitively impaired. The MDS indicated Resident #98 required extensive assistance with his ADLs. Record review of Resident #98's care plan revised on 11/17/24 indicated he was currently taking an IV medication, meropenem, through his PICC line for an infection. The care plan also indicated Resident #98 required enhanced barrier precautions as long as he continued to have the PICC line in place with interventions to wear a new gown and gloves while providing care. Record review of Resident #98's order summary report dated 11/20/24 indicated he had and order for: 1.Merrem Intravenous Solution Reconstituted 1 GM (Meropenem) Use 1 gram intravenously two times a day for surgical infection for 28 administrations with a start date of 11/08/2024 and an end date of 11/22/2024. 2.Nursing intervention: Implement and maintain enhanced barrier precautions when performing high contact care activities every shift with a start date of 10/28/2024 During an observation on 11/18/24 at 09:33 AM, LVN A used hand sanitizer and donned gloves but failed to don a gown. She administered Resident #98's IV medication. During an interview on 11/20/204 at 02:46 PM, the DON stated the expectation was for residents receiving IV therapy to be provided care using the proper PPE since they were at a heightened risk for infections, and she expected the nurses to provide extra precautions. The DON said the nurses, CNAs, and CMAs were expected to be aware of residents who needed enhanced barrier precautions, and the IV administration was an obvious reason for PPE to be worn. During an interview on 11/20/24 at 03:11 PM, the Administrator said she expected the nursing staff (nurse, CNA, and CMA) to be using PPE when providing care to anyone with the enhanced barrier precautions in place. The Administrator said the failure placed a risk for infection. Record review of the facility policy for Infection Control Guidelines for All Nursing Procedures revised August 2012 indicated: Purpose To provide guidelines for general infection control while caring for residents .I. Standard Precautions will be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. Standard Precautions apply to blood, body fluids, secretions, and excretions regardless of whether or not they contain visible blood, non-intact skin, and/or mucous membranes. 2. Transmission-Based Precautions will be used whenever measures more stringent than Standard Precautions are needed to prevent the spread of infection. 3. Employees must wash their hands for ten (10) to fifteen (15) seconds using antimicrobial or non antimicrobial soap and water under the following conditions: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Before and after direct contact with residents; b. When hands are visibly dirty or soiled with blood or other body fluids; Record review of the facility policy Implementation of Standard and Transmission-Based Precautions dated 3/2024 indicated: Policy Statement Infection control measures are implemented in attempts to prevent the spread of communicable diseases . Policy Implementation 2. The facility will incorporate Transmission-Based Precautions as second tier of basic infection control and used in addition to Standard Precautions for resident who are or maybe Infected, colonized with certain Infectious agents for which additional precautions are necessary to prevent infection transmission .Contact Precautions- (Transmission-Based Precautions or TSP) are used with a known infection thit It spread by direct or indirect contact with the resident or the resident's environment (e.g., [NAME]). Examples: a. Acute diarrhea; . 3. Enhanced Barrier Precautions (EBP)- Expand the use of PPE and refer to the use of gown and gloves during a high-contact resident care activities that provide opportunities for transfer of MDRO to staff hands and clothing, MDROS may be indirectly transferred from resident-to-resident during these high-contact care activities. Record review of the facility policy titled, Clostridium Difficile, dated October 2018, indicated, Policy Statement: Measures are taken to prevent the occurrence of Clostridium difficile infections (CDI) among residents. Precautions are taken while caring for residents with C. difficile to prevent transmission to other residents. Policy Interpretation and Implementation: 1. Clostridium difficile infection is suspected in residents with acute, unexplained onset of diarrhea (three or more unformed stools within 24 hours) 5. Steps toward prevention and early intervention include: a. Ongoing surveillance or C-Diff; b. Increasing awareness of symptoms and risk factors among staff, residents, and visitors; c. Considering C. difficile in differential diagnoses, especially in residents with symptoms or risk factors; d. Frequent hand washing with soap and water by staff and residents; e. Wearing gloves when handling feces or articles contaminated with feces .9. Resident with diarrhea associated with C. difficile (i.e., residents who are colonized and symptomatic) are placed on Contact Precautions 10. Residents with diarrhea and suspected C-Diff are placed on Contact Precautions while awaiting laboratory results. Precautions: 12. Residents who are asymptomatic (diarrhea-free) for 48 hours can be removed from precautions. 13. Residents with C-Diff are placed in a private room if available. If a private room is not available, resident will be cohorted with a dedicated commode for each resident. 14. When caring for residents with C-Diff, staff is to maintain vigilant hand hygiene. Hand washing with soap and water is superior to ABHR for the mechanical removal of C. difficile spores from hands. 15. Enhanced infection control measures may be used on units with high rates of C. diff infection, in including a. Universal glove use; b. Enhanced environmental cleaning; c. Reduced sharing of or dedicated medical equipment; and D. staff cohorting.