

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675680	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/22/2025
NAME OF PROVIDER OR SUPPLIER  Brentwood Place One		STREET ADDRESS, CITY, STATE, ZIP CODE  3505 S Buckner Blvd Bldg 2 Dallas, TX 75227	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50910</p> <p>Based on observation, interviews, and record review the facility failed to provide a safe, clean, comfortable environment, including but not limited to receiving treatments and supports for daily living for 3 of 4 residents (Resident #88, Resident #44 and Resident #92) reviewed for quality of life.</p> <p>The facility failed to provide Resident #88 and Resident #44 a comfortable and warm room above 71 degrees for 1/20/25 and 1/21/25.</p> <p>The facility failed to provide Resident #92 a comfortable and warm room with the temperature above 71 degrees on 1/20/25 through 1/21/25.</p> <p>The facility failed to provide residents who attended a confidential interview in the Rehab/Therapy room, a warm and comfortable room between above 71 degrees on 1/21/25.</p> <p>These failures could affect the residents by causing hypothermia or exacerbating existing conditions.</p> <p>Findings included:</p> <p>A record review of Resident #88's MDS assessment dated [DATE] reflected Resident #88 was a [AGE] year-old female with a BIMS score of 08 of 15, indicating moderate cognitive impairment. Resident #88 was admitted to the facility on [DATE] with diagnoses of Non-Alzheimer's Dementia (a General term for types of progressive loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), Depression (a mental illness that can cause a persistent low mood and loss of interest in activities), Dysphagia (Difficulty swallowing foods or liquids, arising from the throat or Esophagus, ranging from mild difficulty to complete and painful blockage) and Asthma (a condition in which a person's airway becomes inflamed, narrow and swell and produce extra mucus, making it difficult to breath). The review further reflected the resident was partially dependent on staff for ADLs.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A record review of Resident #88's Comprehensive Care Plan initiated date 1/9/25 reflected .Resident #88 has an ADL Self Care Performance Deficit r/t muscle weakness and unsteadiness on feet. Date Initiated: 01/06/2024 Revision on: 12/24/2024 o Resident #88 will maintain current level of function in (Specify Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene; ADL Score) through the review date.</p> <p>o BED MOBILITY: Resident #88 requires (Specify Supervision, cueing, weight bearing assistance, lifter sheet, trapeze) to turn and reposition. Date Initiated: 01/06/2024 Revision on: 02/02/2024 o PERSONAL HYGIENE/ORAL CARE: Resident #88 requires partial/moderate assistance (X1) staff participation with personal hygiene and oral care. Date Initiated: 09/12/2024 Revision on: 09/25/2024o DRESSING: Resident #88 requires setup or clean-up assistance (X1) staff participation with upper body dressing and supervision assistance with lower body dressing. Date Initiated: 07/23/2024 Revision on: 08/09/2024 o EATING: Resident #88 is able to (Specify: hold cup, feed self, eat finger foods independently) Date Initiated: 01/06/2024 Revision on: 02/02/2024 o TRANSFERS: Extent/Type of assist may fluctuate within the day or day to day, depending on level of strength, if in pain, mood, etc. May require more staff assist or less. Sit to stand: Independent.</p> <p>Chair/bed to chair: Independent. Toilet transfer: Independent. Tub/shower transfer: Independent. Date Initiated: 04/08/2024 Revision on: 04/12/2024 o TOILET USE: Resident #88 is able to (Specify: wash hands, hold grab bars, wipe self, adjust clothing) Date Initiated: 01/06/2024 Revision on: 02/02/2024 .</p> <p>Observation and interview with Resident #88 in her room on 01/20/25 at 12:14pm revealed her room was colder than the other rooms in the 200 hall. Resident #88 stated she felt weak and was unable to answer other questions. She was sitting on her bed covered with a blanket and sheet.</p> <p>Observation and interview with Resident #88 in her room on 1/21/25 11:05am revealed resident in bed covered with a blanket. Resident #88 popped her head up and stated she was good. She nodded her head up and down when asked if the room temperature was okay, despite the room feeling cold.</p> <p>Observation of Maintenance Director checking the temperature of Resident #88's room on 1/21/25 11:30 am revealed room was tempted at 67 degrees (back outer wall), 68 degrees (side outer wall), and 71 degrees (inner wall where TV was at). The hallway thermostat for the 200 hall was set at79 degrees.</p> <p>A record review of Resident #44's MDS assessment dated [DATE] reflected Resident #44 was a [AGE] year-old male with a BIMS score of 15 of 15, indicating no cognitive impairment. Resident #44 was admitted to the facility on [DATE] with diagnoses of Anemia (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin.), Non-Alzheimer's Dementia (a General term for types of progressive loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), Depression (a mental illness that can cause a persistent low mood and loss of interest in activities), Hypertension (a condition in which the force of blood against the artery walls is too high) and Diabetes. The review further reflected the resident was mostly independent or setup assistance by staff for ADLs.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A record review of Resident #44's Comprehensive Care Plan initiated date 11/2/23 reflected . o Resident #44 is resistive to care AEB refuses showers and refusing for housekeeping to clean his room. Date Initiated: 11/02/2023 Revision on: 11/03/2023 o Resident #44 will cooperate with care through next review date. Date Initiated: 11/02/2023 Revision on: 12/02/2024 Target Date: 02/10/2025 o Allow Resident #44 to make decisions about treatment regime, to provide sense of control. Date Initiated: 11/02/2023 Revision on: 11/03/2023 o Encourage as much participation/interaction by the resident as possible during care activities. Date Initiated: 11/02/2023 o If possible, negotiate a time for ADLs so that the resident participates in the decision-making process. Return at the agreed upon time. Date Initiated: 11/02/2023 CNA o If resident resists with ADLs, reassure resident, leave and return 5-10 minutes later . o Resident #44 has an ADL Self Care Performance Deficit r/t medical diagnosis Dementia and Symptoms and Signs involving Cognitive Functions. Date Initiated: 06/03/2023 Revision on: 06/15/2023 o Resident #44 will maintain current level of function in (Specify Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene; ADL Score) through the review date. o TOILET USE: Resident #44 requires supervision/set-up from staff participation to use toilet. Date Initiated: 06/03/2023 Revision on: 06/15/2023 o BATHING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Date Initiated: 06/03/2023 o BATHING: Resident #44 requires partial/moderate assistance from staff participation with bathing. Date Initiated: 11/10/2024 Revision on: 11/26/2024 CNA o BED MOBILITY: Resident #44 requires setup or clean-up assistance to turn and reposition. Date Initiated: 06/03/2023 Revision on: 11/26/2024 CNA o PERSONAL HYGIENE/ORAL CARE: Resident #44 is able to (Specify: rinse and spit, brush teeth, clean dentures) requires setup or clean-up assistance. Date Initiated: 06/03/2023 Revision on: 11/26/2024 o DRESSING: Resident #44 requires SPECIFY: assistance with choices, supervision, cueing, encouragement, physical assistance) to dress. Date Initiated: 06/03/2023 Revision on: 06/15/2023 o EATING: Resident #44 is able to (Specify: hold cup, feed self, eat finger foods independently) Date Initiated: 06/03/2023 Revision on: 06/15/2023o TRANSFERS: Extent/Type of assist may fluctuate within the day or day today, depending on level of strength, if in pain, mood, etc. May require more staff assist or less. Sit to stand: Independent Chair/bed to chair: Independent Toilet transfer: Independent Tub/shower transfer: Independent Date Initiated: 04/12/2024 Revision on: 04/14/2024 .</p> <p>Observation and interview with Resident #44 on 1/21/25 at 11:00 am revealed Resident #44 was covered with 4 blankets and a sheet. He stated that it was freezing in the room. Resident #44 stated that he had complained many times, but nothing had been done.</p> <p>Observation of Maintenance Director checking temperatures of Resident #44's room on 1/21/25 11:30 am revealed 67 degrees (back wall with windows) and 69.4 degrees (side wall with the door to the hallway). The hallway thermostat for the 600 hall was set at 78 degrees.</p> <p>A record review of Resident #92's MDS assessment dated [DATE] reflected Resident #92 was a [AGE] year-old male with a BIMS score of 15 of 15, indicating no cognitive impairment. Resident #92 was admitted to the facility on [DATE] with diagnoses of Schizophrenia (a disorder that affects a person's ability to think, feel and behave clearly) and Other reduced mobility (a person has difficulty moving around due to a condition that is not specifically as a known mobility impairment, but still significantly impact their ability to perform daily activities). The review further reflected the resident required partial/moderate assistance from staff with ADLs.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with Director of Rehab on 1/22/25 at 2:38pm revealed that the heater in therapy/rehab room was not working on 1/21/25 and someone worked on it but had not fix it. They came back on 1/22/25 and still could not fix it and would return later that day with the correct part. The heater in the therapy/rehab room had not been working for two days. Per the AC/Heater thermostat in the therapy room, the set temperature was 72 and the actual temperature of the room was 68. She stated there was no risk to the residents having therapy in a cold room.</p> <p>A record review of Oasis Healthcare Partners, Maintenance Log from 12/18/24 to 1/21/25 reflected 1 complaint on 12/30/24 for heater not working .)</p> <p>A record review of Facility's policy, Resident Rooms and Environment Operational Manual - Physical Environment revised on 8/2020 reflected .Facility Staff aim to create a personalized, homelike atmosphere, paying close attention to the following: G. Comfortable temperatures .</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42971</p> <p>Based on observations, interviews, and record review the facility failed to provide the necessary services for residents who were unable to carry out activities of daily living to maintain good grooming and personal hygiene for 2 residents ( Resident #7 and #Resident #82 ) of 16 residents reviewed for ADLs.</p> <p>The facility failed to ensure:</p> <ol style="list-style-type: none"> <li>1. Resident #7 had her fingernails cleaned and trimmed on 01/20/25.</li> <li>2. Resident #82 had her fingernails cleaned and trimmed on 01/21/25.</li> </ol> <p>These failures could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections, and a decreased quality of life.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Record review of Resident #7's Quarterly MDS assessment dated [DATE] reflected Resident #7 was [AGE] year-old male with initial admitted to the facility of 5/16/2024. Resident #7 had diagnoses of heart failure, Hypertension, hyperlipidemia, Muscle weakness. Resident #7 had BIMS of 4 which indicated severe genitive impairment. Resident #7 needed moderate assistance for personal hygiene.</li> </ol> <p>Record review of Resident #7's Comprehensive Care Plan revised on 5/29/2024 reflected, Focus: [ Resident #7] has an ADL Self Care, Performance Deficit related to Confusion, Impaired balance. Goal: [Resident #7] will maintain current level of function in (Specify Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene; ADL Score) through the review date. Intervention: o PERSONAL HYGIENE/ORAL CARE: the resident requires partial/moderate assistance (times one) staff participation with personal hygiene and oral care.</p> <p>In an observation on 01/20/25 at 3:40 PM with revealed Resident #7 had dirty and jagged nails.</p> <p>Another observation and interview on 01/21/25 8:51 AM with Resident #7 revealed resident fingernails were dirty with black discoloration underneath the nailbed. Resident #7 stated that the staff trim his nails, but he does not remember cleaning them.</p> <p>In an interview and observation on 01/21/25 at 10:42 AM with LVN D stated that both nurses and CNAs were responsible for doing nail care for the residents. She Stated that fingernails should be trimmed and cleaned on shower days and as needed. She stated that Resident #7 had dirty, untrimmed nails and will provide nail care to the resident after the interview ended. She stated that dirty, jagged nails could lead to risk in infections.</p> <p>In an interview on 01/21/25 at 11:38 AM CNA C stated that both CNAs and Nurses were responsible for nailcare. She said that if Resident has diabetes, then nurses trim their fingernails. She stated that if nails were long and dirty, residents may be at risk of infection. She stated that Resident #7 was compliant with care and did not refuse ADL care as far as she knew.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Record review of Resident #82's Quarterly MDS assessment dated [DATE] reflected Resident #82 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses included perforation of intestine, colostomy status, and need for assistance with personal care. Resident #84's BIMS score of 13, which indicated Resident #82 was cognitively intact. The MDS assessment indicated Resident #82 required moderate assistance with personal hygiene.</p> <p>Record review of Resident #82's Care Plan dated 06/20/24, reflected the following: Focus: [Resident #82 has an ADL selfcare performance deficit . Goal: will maintain current level of function . Interventions Toilet use: The resident requires partial assistance of one staff participation to use toilet, . Personal hygiene/oral care: The resident requires partial/moderate assistance of one staff participation with personal hygiene .</p> <p>In an observation and interview on 01/21/25 at 10:04 AM revealed Resident #82 was laying in her bed. The nails on both hands were approximately 0.4cm in length extending from the tip of her fingers. The nails were discolored tan and had yellow greenish colored residue underside and on the nails' bed. Resident #82 stated it was bowel movement because sometimes she tried to secure the colostomy bag.</p> <p>In an interview on 01/21/25 at 10:29 AM, CNA M stated CNAs and nurses were responsible to clean and cut the residents' nails. CNA M stated did not notice Resident #82's nails. She stated she would do it right then. She stated the risk would be infection control and injury.</p> <p>In an observation on 1/21/25 at 2:05 PM revealed Resident #82's nails were trimmed and clean.</p> <p>In an Interview on 01/21/25 at 2:13 PM, the DON stated nail care should be completed as needed and every time aides wash the residents' hands. The DON stated nails should be observed daily. The DON stated nurses were responsible for trimming the nails of residents who were diabetic, and CNAs could trim other residents' nails. The DON stated she expected CNAs to offer to cut and clean nails if they were long and dirty. The DON stated the ADON, and the DON would do the routine rounds to monitor. The DON stated residents having long and dirty could be an infection control issue.</p> <p>Record review of the facility policy titled, Grooming Care of the Fingernails and Toenails undated reflected, Nail care is given to clean and keep the nails trimmed . Fingernail are trimmed by Certified Nursing Assistants except for residents with the following condition A. Diabetes or circulatory impairment of the hands, B. Ingrown, infected, or painful nails .</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34918</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for one of one resident (Resident #79) reviewed for catheter and incontinence care.</p> <ol style="list-style-type: none"> <li>The facility failed to ensure RA F maintained the foley catheter drainage bag below Resident #79's bladder while she and CNA G transferred the resident with a mechanical lift on 01/20/25</li> <li>The facility failed to ensure CNA B did not place the urine catheter bag on the bed while performing incontinence care for Resident #79 and failed to maintain the drainage bag below the bladder while she and ADON E transferred the resident with a mechanical lift on 01/21/25.</li> </ol> <p>These failures could place residents at risk for not receiving care appropriate to address their incontinence and could increase the risk of urinary tract infections.</p> <p>Findings included:</p> <p>Record review of Resident #79's quarterly MDS assessment, dated 12/04/24, reflected a [AGE] year-old male with an admitted [DATE]. He had a BIMS of 12, which indicted he was moderately cognitively impaired. Resident #79 required substantial/maximum assist with ADLs and was dependent of 2 persons assist with transfers. He had an indwelling catheter and was always incontinent of bowel. Resident #79 had diagnoses which included neurogenic bladder (condition caused by nerve problems affecting the bladder), diabetes and heart failure.</p> <p>Record review of Resident #79's care plan, with a revision date of 09/11/24, reflected, [Resident #79] has indwelling Foley Catheter 16 French (measurement of the circumference of the outer catheter tube) for neuromuscular dysfunction of the bladder .Goal .will show less frequent signs and symptoms of urinary infection through the review period .Interventions .Position catheter bag and tubing below the level of the bladder</p> <p>Record review of Resident #79's Order summary report, dated 01/22/25, reflected .Foley catheter care every shift and as needed . with a start date of 01/20/25.</p> <p>In an observation on 01/20/25 at 02:15 PM RA F and CNA G entered Resident #79's room to transfer him from his wheelchair to the bed with a mechanical lift. Both staff hooked the mechanical sling to the lift. RA F unhooked the urinary drainage bag and handed to bag to the resident. The resident held the urinary drainage bag at his waist level. CNA G then raised the lift. Once the lift went up the resident was in a supine position with his urinary drainage bag laying on his chest. The resident was positioned over the bed and lowered onto the bed. RA F then laid to urinary drainage bag on the bed. Urine was observed in the tube flowing up and down. Both staff rolled the resident side to side to remove the mechanical sling and then fished the urinary drainage bag through the residents' pants to remove his pants. Both staff repositioned the resident and then CNA G placed the urinary drainage bag on the bed rail.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In a second observation 01/21/25 at 10:30 AM, CNA B was observed completing incontinent care on resident #79 in preparation of the nurse coming to perform wound care. CNA B had placed the urinary drainage bag on the resident's bed where it remained during the wound care performed by LVN K and ADON E. Once the wound care was completed ADON E and CNA B dressed the resident. ADON E fished the catheter bag through the resident pants leg and placed the mechanical sling under the resident. ADON E then placed the urinary drainage bag on the bedrail while the hooked up the sling to the mechanical lift. ADON E unhooked the catheter bag and handed it to CNA B who laid it on the resident's lap. Once the resident was lifted in the air, the catheter tubing was observed fluctuating back toward the resident. The resident was lowered into his wheelchair and CNA B picked up the urinary drainage bag and hooked it to the front of the wheelchair.</p> <p>In an interview with CNA B on 01/21/25 at 11:25 AM she stated she had been taught to always keep the catheter bag below the bladder. She stated they were not supposed to lay it on the bed because it cannot drain. She stated she had placed it on the bed and on his lap to prevent it from pulling when turning him and when lifting him in the mechanical lift because he had it pulled on before during transfers. She stated the facility had not showed them how they were supposed to position the catheter bag while transferring with the Hoyer lift and was not sure how they should handle the drainage bag during a transfer.</p> <p>In an interview with RA F on 01/21/25 at 11:12 AM she stated they had been taught to keep the catheter bag below the bladder. She stated she did not even think about that when she handed the resident his catheter bag during his transfer on 01/20/25. She stated the facility had not showed them how they were supposed to handle the catheter bag when using the mechanical lift. She stated the risk of having it above the bladder could be urine backing up into his bladder which could cause an infection.</p> <p>In an interview with ADON E on 01/21/25 at 12:17 PM she stated she realized the staff had the urinary drainage bag laying on the bed which is when she placed it on the bed rail. She stated if it remained flat on the bed, it could not drain. She stated it should always be positioned below the bladder and acknowledged when they had it in the resident lap during the transfer it was not below the bladder. She stated if you do not keep it below the bladder there was a risk of the urine backing up into the bladder and causing an infection. She stated she and the DON are responsible for competency checks and stated positioning the urinary drainage bag during transfer was not included, but stated going forward they would include this so staff knew how to handle the catheter during transfers.</p> <p>In an interview with the DON on 01/21/25 at 01:20 PM, she stated the staff were taught to keep the urinary drainage bag below the bladder to ensure proper drainage and prevent urine from backing up into the bladder. She stated she and the ADON do the competency checks on all the CNA staff. She stated proper placement of the foley catheter bag during a Hoyer transfer was not part of their current check off skills, but stated going forward it would be included. She stated the risk of placing the catheter bag in a resident's lap or on the bed could prevent proper drainage and backflow into the bladder and potential spread of germs from the bag itself.</p> <p>Record Review of CNA B's skills check off dated 10/16/24 reflected she was competent in the care of indwelling catheters which included keeping the drainage below the bladder.</p> <p>Record Review of CNA G's skills check off dated 10/16/24 reflected she was competent in the care of indwelling catheters which included keeping the drainage below the bladder.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Brentwood Place One		STREET ADDRESS, CITY, STATE, ZIP CODE  3505 S Buckner Blvd Bldg 2 Dallas, TX 75227	

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record Review of RA F's skills check off dated 10/15/24 reflected she was competent in the care of indwelling catheters which included keeping the drainage below the bladder.</p> <p>Record review of the facility's policy, Catheter-care of, dated June 2020, reflected, Daily Catheter Care . Position the catheter, drainage system and bag utilizing gravity to facilitate drainage. The collecting bag will be kept below the level of the bladder .Collection bags should always be kept below the level of the bladder, including during transport .</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34918</p> <p>42971</p> <p>Based on observation, interview and record review the facility failed to provide pharmaceutical services to ensure the accurate acquiring, receiving, dispensing, administering, and securing of medications for 1 (med aid cart hall400/500) of 3 medication carts reviewed for pharmacy services and for 1 (Resident #31) of 5 residents reviewed for pharmacy services in that:</p> <p>The facility failed to ensure:</p> <p>1- MA responsible for Nurses Cart Hall 500, removed medications in unsecure containers from the Nurses Cart when on 01/20/25 a-controlled medication used for pain had 1 blister seal broken and the pill still inside the broken blister and tapped over.</p> <p>2- LVN J followed the manufacturer's instructions to prime the Novolog Insulin (Hormone) Pen prior to dialing in required amount of Insulin to be administered to Resident #31 on 01/21/25.</p> <p>These failures placed residents at risk of not receiving full dosage of medication, and place residents at risk of not having the medication available due to possible drug diversion.</p> <p>Findings included:</p> <p>1- Record review and observation on 01/20/25 at 11:02 AM of medication aid cart hall400/500, with MA N revealed the blister pack for Resident #84's hydrocodone acetaminophen 5-325 mg tablet (controlled medication used for pain) had 1 blister seal broken and the pill still inside the broken blister and tapped over.</p> <p>Interview on 01/20/25 at 11:08 AM, MA N stated the count was done at shift change and the count was correct. She stated she did not check the blister packs during the count. She stated she was unaware when the blister pack seal was broken, and she was not aware of who might have damaged the blister and taped it over. She stated the risk would be a potential for drug diversion. She stated the nurses and med aides were responsible to check the medication blister packs for broken seals during the count of narcotics during the change of the shift. She stated when a broken seal was observed, she would report it to the nurse.</p> <p>Interview on 01/21/25 at 1:13 PM, the DON stated she expected if a blister pack medication seal was broken the pill should be discarded. The DON stated it would not be acceptable to keep a pill in a blister pack that was opened. The DON stated the risk would be potential for drug diversion and infection control issue. She stated nurses were responsible for checking the medication blister packs for broken seals during the count on the change of shifts. The DON stated the ADON, and the DON were supposed to check the carts weekly.</p> <p>2- Record review of Resident #31's, Face sheet, dated 01/22/25 reflected a [AGE] year-old male with an admitted [DATE]. Resident #31 had a diagnosis which included Type 2 diabetes.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #31's Physician Order report dated 01/22/25 reflected, Novolog Flexpen subcutaneous 100 unit/ml .Inject sliding scale .201-250=4 units .</p> <p>An observation on 01/21/25 at 11:55 AM revealed LVN J at the medication cart calibrating a new glucometer in preparation of obtaining Resident #31's finger stick blood sugar. LVN J performed hand hygiene and donned gloves and obtained Resident #31's blood sugar with a reading of 207. LVN J checked the computer to determine the amount of insulin per sliding scale was 4 units of Novolog insulin. LVN J dialed in the amount of insulin required (4 units) without priming the pen and administered the insulin.</p> <p>In an interview with LVN J on 01/21/25 at 12:05 PM she stated she was supposed to [NAME] the pen if she saw an air bubble in the pen. She stated she looked at the pen and did not see any air bubbles, so she just dialed in the required amount of insulin without priming the pen. She stated she was not aware the pen was supposed to be primed before each dose. She stated you [NAME] the pen to remove air, but stated she had not seen air, so she did not see the need to prime the pen.</p> <p>In an interview with the DON on 01/21/25 at 1:15 PM she stated she was not aware of the need to [NAME] the Insulin pen. She stated she would have to get with Corporate to see what their policy was. She stated she was not aware it was a manufacture recommendation.</p> <p>In a follow up interview with DON on 01/22/25 at 1:00 p.m. she stated Corporate had developed a policy after she had reached out to them for insulin Pens. She stated they were to follow the manufactured guideline for the insulin pen, and the guidelines indicated the pen should be primed before each dose to ensure no air and ensure a resident received the full amount of insulin. She stated they would be training all the nursing staff on the new policy. She stated she had also reached out to their pharmacy consultant to ensure when they were checking off staff for competency, they included this procedure.</p> <p>Record review of the facility's policy titled Storage of Medication, dated September 2018, revealed in part .8. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists .</p> <p>Record review of the Facility's policy, Insulin Pen Administration, dated January 2025, reflected, To improve the accuracy of insulin dosing .Insulin pens should be primmed per manufactures' guidelines Always refer to the instructions of the manufacturer when preparing your pen for use as pens from different manufacturers may operate differently .</p> <p>Review of manufacturer instructions for Novolog obtained from <a href="https://www.novomedlink.com/">https://www.novomedlink.com/</a> searched on 01/23/25 reflected, .Giving the air shot before each injection .Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: Turn the dose selector to select 2 units .Hold your Novolog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push-button all the way in. A drop of Insulin should appear at the needle tip, if not .repeat the process .make sure the dose selector is set at 0. Turn the dose selector to number of units you need to inject .</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>48560</p> <p>Based on observation, interview, and record review, the facility failed to provide food prepared that conserved nutritive value, flavor, and appearance for 10 residents on pureed diets of 10 residents on pureed diet , reviewed for nutritive value, in that:</p> <p>Cook A did not follow the recipe for the pureed (is cooked food, usually vegetables, fruits, or legumes, that has been ground, pressed, blended, or sieved to the consistency of a creamy paste or liquid) Spaghetti served for lunch service on 1/21/25.</p> <p>This failure could place residents at risk of weight loss, altered nutritional status, and diminished quality of life.</p> <p>Findings included:</p> <p>During an observation and interview on 01/22/25 at 12:06 PM, [NAME] A prepared puree meal for lunch. [NAME] A took about one-third pan of regular texture spaghetti that was in the buffet steam table ready to be served. She took the pan to the blender and added all of the regular texture spaghetti to the blender jar and started the blender. After about two minutes of blending the spaghetti, [NAME] A walked to the kitchen sink and took water in a pitcher. The pitcher was about 1/4 full. She came back to the blender and added the water to the spaghetti mixture in the blender. [NAME] A stated, I added some warm water to make it thin. She stated she did not look at the recipe. [NAME] A proceeded to serve meals for the lunch service.</p> <p>During a follow-up interview 01/22/25 at 1:38 PM with [NAME] A revealed she stated she did not look at the standardized recipe binder. She stated that she added water instead of other liquid to adjust the consistency of the pureed spaghetti. She stated that the risk of not following standardized recipe was decreasing the nutritional content of the meal.</p> <p>During an interview on 02/21/205 at 1:40 PM with the Dietary Manager revealed her expectation was all the cooks follow standardized recipe to cook all meals. She stated that if the recipe called for using broth or milk for pureed foods, then [NAME] A should have used it. She stated she provided in-service to cook on following recipes for all meals in the past. She stated that the risk of not following recipe was diluting the nutritional content and compromising on the quality of foods.</p> <p>During an interview on 01/22/25 at 12:51 PM with the Dietitian, she stated that her expectation was that the Cooks and the Dietary Manager should always follow standardized recipes to prepare meals for the residents at the facility. She stated that using broth versus water would not make a lot of difference in the nutrition content of the final product however she stated standardized recipes should always be followed in the facility so that food quality was maintained. She stated that both herself and the Dietary Manager were responsible for conducting in-services for the kitchen staff.</p> <p>Record review of the facility's Pureed Spaghetti with Meat sauce recipe undated indicated .FW 24-25- Day 10-Lunch .Place prepared noodles in a sanitized food pressor. Blend until smooth. Add hot prepared broth if product is too thick .NOTE: .if product needs thinning , gradually add appropriate amount of liquid (No Water) to achieve a smooth pudding or soft mashed potato consistency .</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of facility's policy titled, Standardized Recipes dated 9/26/2024, reflected, Food products prepared and served by the dietary department will utilize standardized recipes .V. The Dietary Manager or designee will monitor and routinely verify the recipes used by the cooks.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34918</p> <p>42971</p> <p>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 for 2 resident (Resident #38 and Resident #82) of 8 residents observed for infection control, and for 1 closet of 1 closet observed for sanitary environment.</p> <p>The facility failed to ensure:</p> <p>1- CNA H changed her gloves and performed hand hygiene while providing incontinence care to Resident #38 on 01/21/25.</p> <p>2- Clean linen closets were kept sanitary on 01/21/25.</p> <p>3- Resident mattress was cleaned from the bowel movement before putting new fitted sheet on the bed for Resident #82 on 01/21/25.</p> <p>These failures could place residents at risk of cross-contamination and development of infections.</p> <p>Findings included:</p> <p>1-In an observation on 01/21/25 at 9:30 AM CNA H and CNA I entered Resident #38 's room to transfer her back to bed. Both staff washed their hands and put on gloves and transferred the resident via a mechanical lift from her Geri-chair to the bed. Both staff removed their gloves, washed their hands and re-gloved to provide peri-care. CNA H unfastened the resident brief revealing she had a moderate bowel movement. CNA H rolled the resident on her left side, removed the soiled brief, and wiped the anal area from front to back and then the buttocks, changing to a clean wipe with each swipe. CNA H then pushed the soiled draw sheet under the resident and with soiled gloves placed a clean draw sheet and brief under the resident. Both staff then rolled the resident over and CNA I removed the soiled sheet and pulled the clean the sheet under the resident. Both staff removed their gloves, washed their hands, and put on clean gloves. CNA H then cleaned the resident's perineal area from front to back, revealing bowel movement had oozed up into the resident's vaginal vault. It took several wipes to remove all the bowel movement, with each wipe going toward the clean brief. Once the bowel movement was removed the staff closed the resident brief, repositioned her in bed, offloaded her feet and covered the resident. Both staff then removed their gloves and washed their hands.</p> <p>In an interview on 01/21/25 at 9:45 AM CNA H and CNA I stated they were supposed to clean from front to back. CNA H stated they had been told if a resident had a bowel movement, they could clean the movement off first and then do complete peri care. She stated they should had rolled her back over and cleaned her again and placed a clean brief under her. She stated they were supposed to change their gloves and wash their hands when the gloves were soiled. CNA H stated she did not realize she had soiled gloves on when she put the clean sheet and brief under the resident.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 01/22/25 at 11:44 AM the DON stated they had trained at length on when staff were to change their gloves and sanitize their hands. She stated even if the staff wipes away the bowel movement first, they still must clean the peri area and then re-clean the anal area since they wipe from front to back. She stated staff needed to change their gloves when they go from dirty to clean. She stated the risk was increased risk of infections. She stated she and the ADON do skills competency with the staff before they ever go on the floor. She stated they would be re-training and observing care to ensure staff compliance.</p> <p>Record review of CNA H's competency check off for hand hygiene and peri-care revealed she was proficient in care as of 10/15/24.</p> <p>Record review of CNA I's competency check off for hand hygiene and peri-care revealed she was proficient in care as of 10/16/24.</p> <p>2-In an observation on 01/21/25 at 11:22 AM of the clean linen closet in the facility revealed there was a personal handbag placed right above the clean linens on a cart marked as 600 Hall.</p> <p>In an interview and observation on 01/21/25 at 11:25 AM with the Laundry Supervisor revealed personal handbag placed right above the clean linens on a cart marked as 600 Hall in the facility's clean closet. The Laundry Supervisor stated clean linen closet and carts were supposed to have only clean linen and should not had any personal belongings. He stated that the risk of having any other non-sanitary item such as personal handbag can cause cross contamination and infection control lapses.</p> <p>In an interview on 01/21/25 at 11:33 AM with CNA B revealed the handbag in the clean linen closet belonged to her. She stated she knew she could not keep any personal items in the clean linen closet because of risk of infection and cross contamination.</p> <p>In an interview on 01/21/25 at 1:12 PM with the DON revealed that her expectation was that the clean linen closet and cart shall only have clean linens and no other items. She stated that the risk to residents was cross contamination and lapses in infection control.</p> <p>3- Record review of Resident #82's Quarterly MDS assessment dated [DATE] reflected Resident #82 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses included perforation of intestine, colostomy status, and need for assistance with personal care. Resident #84's BIMS score of 13, which indicated Resident #82 was cognitively intact. The MDS assessment indicated Resident #82 required moderate assistance with personal hygiene.</p> <p>Record review of Resident #82's Care Plan dated 06/20/24, reflected the following: Focus: [Resident #82 has an ADL selfcare performance deficit . Goal: will maintain current level of function . Interventions Toilet use: The resident requires partial assistance of one staff participation to use toilet, . Personal hygiene/oral care: The resident requires partial/moderate assistance of one staff participation with personal hygiene .</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 01/21/25 at 10:29 AM revealed CNA M entered Resident #82's room for routine check, it smelled bowel movement in the room. She uncovered Resident #82 by removing her blanket, revealed loose bowel movement on the fitted sheet coming from the colostomy bag. CNA M left the room to call the nurse and to bring a clean linen. Resident #82 got out of the bed, she removed the soiled linen including the fitted sheet, she put them in the trash can. Mattress was contaminated with the bowel movement. LVN K and CNA M came back to the room with clean linen. LVN K took resident to the toilet, she cleaned her and changed her colostomy bag. CNA M put a clean fitted sheet without cleaning and disinfecting the mattress.</p> <p>In an interview on 01/21/25 at 10:29 AM, CNA M stated she should clean the mattress using sanitary wipes since the old sheet was soiled with the bowel movement. CNA M stated it slid from her mind because Resident #82 removed the soiled linen when CNA left the room to get the clean linen. CNA M stated failing to clean the mattress properly increased risk for contamination and spread of infections.</p> <p>In an interview on 01/21/25 at 2:13 PM, the DON, stated if the fitted sheet was soiled with the urine or bowel movement, she expected the staff to clean the mattress with wipes before putting clean fitted sheet. She stated failure to do so would potentially lead to cross-contamination and possible spread of infection. She stated that ADON and herself were responsible for ensuring safe practices were utilized to control infection spread by doing routine rounds and random checks.</p> <p>Record review of the facility's policy, Perineal Care, dated June 2020, reflected, Wash hands .Put on gloves . Separate the labia .moving from front to back, on each side of the labia and in the center .using a clean washcloth/cleansing wipe for each stroke .Turn the resident o side .wash, rinse and dry buttocks and per-anal area without contaminating perineal area .Remove gloves. Wash hands or use alcohol-based sanitizer .Note: Do not touch anything with soiled gloves after procedure (i.e., curtain, side rails, clean liens, call bell, etc.) .put on clean gloves .Clean and return all equipment to its proper place .Place soiled linen in proper container .Removed gloves. Wash hands.</p> <p>Record review of the facility's policy titled, Hand Hygiene, dated June 2020, reflected, The facility considers hand hygiene the primary means to prevent the spread of infections Facility Staff .must perform hand hygiene procedures in the following circumstances .Wash hands with soap and water .when soiled with visible dirt or debris .Hand hygiene is always the final step after removing and disposing of personal protective equipment .</p> <p>Record review of the facility policy titled, Laundry - Supply &amp; Storage revised 8/2020 reflected, To ensure that all laundry on premises is supplied and stored properly</p> <p>Record review of the facility policy titled, Infection Prevention and Control Program revised 10/24/2022, reflected, . The ensure the Facility establishes and maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection in accordance with Federal and State requirements.</p> <p>48560</p>		