STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675691	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntsville Health Care Center	2628 Milam Huntsville, TX 77340

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 43994 Based on interviews and record review, the facility failed to implement written policies and procedures to prohibit and prevent abuse, neglect, and exploitation for 1 of 15 staff (the DON) reviewed for develop and implement abuse policies. The facility failed to ensure HR implemented the facility's abuse/neglect policy and procedure when she failed to complete a Criminal History check for the DON upon hire. This failure could place residents at risk for abuse, neglect and/or exploitation. Findings included: Record review of the personnel file for the DON indicated he was hired at the facility on 4/8/2024 and his criminal history check was not done until 5/21/2024. During an interview on 5/22/2024 at 10:55 AM, HR said she started at the facility October 2023 but did was not assigned HR duties until January 2024. She said she was responsible for new hires and conducting background checks. She said the criminal history checks were to be completed before the new hire came into the facility for orientation and then yearly thereafter. She said she did not know what happened and why the DON's criminal history was not checked. She said it was checked on yesterday 5/21/2024 when they realized he did not have one. She said she received training from the previous Administrator on completing the criminal history and background checks. She said going forward she would make sure everyone had their backgrounds check and would check before and after they were hired. During an interview on 5/22/2024 at 11:34 AM, the Administrator said background checks and criminal history checks were the responsibility of HR. She said she was not sure why the DON did not have a criminal history check when he was hired at the facility. She said the criminal history check should be checked within 2 days of an offer letter and prior to starting employment. She said there could be a risk of hiring someone that has a criminal background. She said residents could be at risk for exploitation or abuse. She said going forward, the HR had a check list to use, and she was in-serviced on yesterday 5/21/2024 on background checks. Record review of an in-service dated 5/21/2024 on background checks was conducted by the Administrator to HR. (continued on next page)

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

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled Abuse, Neglect, Exploitation, and Misappropriation of Property Prevention, Protection and Response Policy and Procedures revised 12/17/2018 indicated, .1. Screening Issues: B. Criminal background checks as required . Record review of the facility's policy titled Background Screening Investigation revised March 2019 indicated, .Our facility conducts employment background screening checks, reference checks and criminal conviction investigation checks on all applicants for positions with direct access to residents. 2. Background and criminal checks are initiated within two days of an offer of employment or contract agreement, and completed prior to employment .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46273 Based on observation, interview, and record review, the facility failed to ensure the residents' environment remains as free of accident hazards as possible for 3 of 4 residents reviewed for quality of care, (Resident #5, #39, and #41) in that: The facility failed to remove worn and damaged mechanical lift slings from service. The facility failed to obtain physician orders for mechanical lift transfers. This deficient practice could result in a loss of quality of life due to injuries. Findings included: Record review of a facility's face sheet dated 5/21/24 for Resident #5 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: dementia, depression, and type 2 diabetes. Record review of a Quarterly MDS assessment dated [DATE] for Resident #5 indicated that she was rarely/never understood and that Resident #5 was severely cognitively impaired. Assessment also indicated that she was totally dependent with transfers. Record review of a comprehensive care plan dated 8/21/23 indicated that she was totally dependent on a mechanical lift with the assistance of 2 persons for transfers. Record review of a physician order report dated 5/21/24 for Resident #5 indicated that she did not have a physician order for mechanical lift transfers. Record review of a facility face sheet dated 5/21/24 for Resident #39 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: dementia, muscle weakness, and type 2 diabetes. Record review of a Comprehensive MDS assessment dated [DATE] for Resident #39 indicated that he had a BIMS score of 5, which indicated that he had severely impaired cognition. Assessment also indicated that he was totally dependent with transfers. Record review of a comprehensive care plan dated 7/21/23 for Resident #39 indicated that he was dependent on a mechanical lift with the assistance of 2 staff members for transfers. Record review of a physician order report dated 5/21/24 for Resident #39 indicated that he did not have a physician order for mechanical lift transfer. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a facility face sheet dated 5/21/24 for Resident #41 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (left side weakness/paralysis following a stroke), type 2 diabetes, and anxiety disorder. Record review of a Quarterly MDS assessment dated [DATE] for Resident #41 indicated that she had a BIMS score of 15, which indicated that she was cognitively intact. Assessment also indicated that she was totally dependent with transfers. Record review of a comprehensive care plan dated 8/21/23 for Resident #41 indicated that she required a mechanical lift with assistance of 2 staff members for transfers. Record review of a physician order report dated 5/21/24 for Resident #41 indicated that she did not have a physician order for mechanical lift transfer. During an observation on 5/20/23 at 11:45 am Residents #39 was observed in the dining area. Resident #39's mechanical lift sling straps were observed to be faded in color. Resident #39's sling was blue mesh and label indicated that it was a Medline brand sling. During an observation and interview on 5/20/24 at 12:33 pm, Resident #41 was observed in her room with mechanical lift sling underneath her in her wheelchair. The lift sling was observed to have straps that were faded in color. Label indicated that it was a Medline brand sling. Resident #41 said that she had not had any falls from the lift. During an observation on 5/21/24 at 10:00 am, Residents #39 and Resident #5 were observed in a common area. Resident #39 was up in his wheelchair and had a mechanical lift sling underneath him. Resident #39's sling was mesh and purple in color with multiple loose green strings noted along outer seam of sling, torn area next to hook straps, hook straps were noted to be faded in color, label was unreadable. Resident #5 was observed sitting up in a Broda (brand of wheelchair to assist with positioning) chair. She also had a mechanical lift sling underneath her. The mesh sling was observed to be purple in color, the label was unreadable, straps were faded in color (almost a grayish white), and multiple loose strings were observed along the edging of sling. During an interview on 5/21/24 at 10:06 am, Laundry Aide said she had been employed by the facility in laundry for [AGE] years. She said she would inspect mechanical sling pads for torn spots and loose strings before putting them out for use. She said if she observed any that she would take them out of service. She said she did not use bleach on the lift pad slings. She said worn sling pads could break during use causing residents to fall. During an interview on 5/21/24 at 10:10 am, DON observed the mechanical lift pads underneath Resident #5 and #39 in the common area and said they should not have been used to transfer the residents. He said sling pads should be inspected by the staff before using them to transfer a resident and that worn sling pads could put residents at risk for falls. During an interview on 5/22/24 at 12:15 pm, the Administrator said there could be a chance of the sling breaking if it was worn. She said they ordered new slings and the DON would be inspecting them routinely from then on. She said they educated the CNAs and they would be expecting the CNAs to inspect all slings prior to using them for a resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/24 at 1:00 pm, CNA D said she had been employed about a year and a half. She said she looked for signs of wear on the lift pads such as loose strings and faded coloring on the straps. She said if she observed any signs of wear, she would not use the lift pad to transfer a resident. She said worn pads could break causing a resident to fall. During an interview on 5/22/24 at 1:10 pm, CNA E said she had been employed for about a month. She said she would look for loose seams, faded colors, rips and tears on the lift pads before use. She said that lift pads that had faded coloring, loose seams, and rips or tears could break while using them, and a resident could fall. Record review of the facility's policy titled Lifting Machine, Using a Mechanical dated 2001 and revised July 2017 read .8. Make sure that all necessary equipment (slings, hooks, chains, straps and supports) is on hand and in good condition . and .Discard any worn, frayed or ripped slings . Record review of manufacture guidelines Full Body Slings - Instructions for use accessed at www.medline.com on 5/21/24 read .Always inspect slings prior to each use. Signs of rips, tears, or frays indicate sling wear which is unsafe and could result in injury. Signs of color fading, bleached areas, or permanent wrinkles on the straps indicate improper laundering which is unsafe and could result in injury. Any slings with signs of wear or improper laundering should be immediately removed from use . and .Do not remove sling labels. If sling labels are removed or no longer legible, sling must be immediately removed from use .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on observation, interview, and record review, the facility failed to assure that residents who were fed by enteral feeding, received appropriate treatment and services to prevent complications of enteral feeding for 1 of 1 resident (Resident #12) reviewed for quality of care. The facility failed to ensure that Resident #12's feeding tube bags were labeled which included the initials of staff that hung the bag and the time it was hung to ensure residents maintain nutritional status within optimal parameters on [DATE]. This failure could place residents receiving enteral feedings at risk of not receiving feeding care in a timely manner and receiving old or expired feed. Findings included: Record review of an Admission Record dated [DATE] for Resident #12 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnosis of hemiplegia and hemiparesis following cerebral infarction (paralysis on one side of the body following a stroke), gastrostomy status (tube inserted into the stomach for feeding), end stage renal disease (kidneys are no longer able to function on their own) and autistic disorder (a developmental disorder that can cause the inability to communicate or interact). Record review of a Significant Change MDS assessment dated [DATE] for Resident #12 indicated he was rarely/never understood. He was dependent with all ADLs. He was always incontinent of bowel and bladder. He had a feeding tube while a resident during the 7-day look back period. Record review of a care plan revised on [DATE] for Resident #12 indicated he required tube feeding related to CVA with dysphagia. Interventions included to administer enteral feeding, medications, and water flushes as ordered. Interventions also indicated to change feeding set/syringe/tubing daily and as needed. Record review of active physician orders dated [DATE] for Resident #12 indicated he was on a NPO diet, g tube (feeding tube) continuous feeding of Nepro 1.8 at 55 cc/hr x18 hours. During an observation on [DATE] at 11:10 AM, Resident #12 was in bed awake but nonverbal. He had tube feeding of Nepro on a pump infusing at 55 ml/hr with 30 ml water flush every 1 hr. A 1000 ml feeding bag that had approximately 500 ml of formula with a label dated [DATE], no time noted on bag or initials of who hung it. A 1000 ml bag of water noted with approximately 800 ml did not have a label on it. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on [DATE] at 9:36 PM, LVN A said she had been employed at the facility for 1 , d+[DATE] year and only worked the night shift from 6 pm to 6 am. She said the nursing staff were responsible for hanging feeding bags and labeling them. She said she took care of Resident #12 on the night of [DATE] and morning of [DATE]. She said her shift ended at 6 am on [DATE]. She said on Monday morning [DATE] at 4 am, she hung a new bag of feeding for him along with water. She said she always just placed a label on one of the bags because the bags came together as a set of two. She said the label should include the resident's name, date, time, rate of feeding, type of feeding and the initials of the staff that hung the bag. She said she did not realize that she did not put a time on the bag and probably should have labeled both bags. She said she had a skills check off in the past on medication administration with g-tubes and it included labeling the feeding bags. She said residents could be at risk of receiving incorrect feedings, incorrect flow rates or getting a feeding that was old if it was not labeled properly. She said residents could be at risk of GI issues because they ould not want to give a resident curdled milk. During an interview on [DATE] at 11:06 AM, the ADON said she had been employed at the facility for 6 months. She said feeding tubes should be labeled and that included the resident's name, type of feeding, water flush, rate of feeding, the time it was hung, date, and initials of staff. She said both the feeding and water bag should be labeled. She said there was a risk of potentially getting old feedings if there was not a time indicated and it should have been immediately changed and an assessment completed on the resident. She said nursing was responsible for labeling the feedings and water. She said going forward, she would in-service staff to make sure the labels were complete and give them more education. During an interview on [DATE] at 11:21 AM, the DON said he had been employed at the facility since [DATE]. He said g-tube feeding labels should include the initials of staff, time, type of feeding, date, and rate of flow, and the water bag should have a label also. He said the bags should be changed every 24 hours and the label should have a time to indicate when it was hung. He said going forward, he would in-service staff to ensure the feedings were labeled properly. During an interview on [DATE] at 11:34 AM, the Administrator said maintenance of feeding tubes were the responsibility of the nursing staff. She said there was a risk of a feedings being old if there was not a time on it to show when it was hung. She said going forward, they would be monitoring along with the DON to ensure they were labeled properly. Record review of a RN/LPN Competency Checklist dated [DATE] for LVN A by the ADON indicated she was competent in set up and maintain oxygen and maintenance of g-tubes. Record review of the facility's policy titled Care and Treatment of Feeding Tube dated [DATE] indicated, .It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible .

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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** 43994 Based on observation, interview, and record review, the facility failed to ensure that residents requiring respiratory care are provided care, consistent with professional standards of practices for 2 of 9 residents (Resident #17 and #34) reviewed for quality of care. 1.The facility failed to ensure Resident #17's oxygen concentrator had an external filter that was free of dust buildup on 5/21/2024 and 5/22/2024. 2. The facility failed to ensure Resident #34's oxygen concentrator had an external filter that was free of dust buildup on 5/21/2024 and 5/22/2024. This failure could place residents who require respiratory care at risk for respiratory infections, breathing in dust and allergens, decreased effectiveness of oxygen concentrators, and exacerbation of respiratory distress. Findings included: 1. Record review of an Admission Record dated 5/21/2024 for Resident #17 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnosis of COPD (lung disease that makes it difficult to breath), acute on chronic systolic congestive heart failure (heart is not able to pump effectively), myasthenia gravis (abnormal weakness of certain muscles) and pneumonia (lung infection). Record review of a Quarterly MDS assessment dated [DATE] for Resident #17 indicated he did not have any impairment in thinking with a BIMS score of 15. Special treatments, procedures and program for oxygen therapy indicated he used oxygen on admission and while a resident. Record review of a care plan revised on 4/9/2024 for Resident #17 indicated he required oxygen therapy related to CHF (heart not being able to pump effectively), pulmonary edema (swelling in the lungs) and respiratory failure. Interventions included oxygen settings: Oxygen via (through) nasal prongs at 2-4 L/minute prn as ordered. Record review of active physician orders dated 5/21/2024 for Resident #17 indicated he had an order that started on 4/14/2024 for oxygen: change oxygen tubing and clean filter on concentrator every week or when visibly soiled or malfunction present, every night shift every Sunday for dyspnea (difficulty breathing). Record review of a MAR dated 5/1/2024 to 5/31/2024 for Resident #17 indicated an order to clean the oxygen filter on concentrator q week was signed off by LVN A on 5/5/2024 and 5/19/2024 by a check mark and initials of staff. During an observation and interview at 5/21/2024 at 9:15 AM, Resident #17 was in bed, on oxygen via nasal cannula at 3 L/minute. The external filter had a thick buildup of dust. He said he did not remember the last time someone cleaned it. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of an Admission Record dated 5/21/2024 for Resident #34 indicated he was [AGE] years old with diagnosis of CHF (heart's inability to pump effectively), dependence on supplemental oxygen (required the use of oxygen), and anxiety disorder. Record review of a Modification of Annual MDS assessment dated [DATE] for Resident #34 indicated he had moderate impairment in thinking with a BIMS score of 11. Special Treatments, Procedures, and Programs indicated while a resident within the 14-day look back period, he was used oxygen therapy. Record review of a care plan revised on 8/19/2022 for Resident #34 indicated he had oxygen therapy related to end stage CHF. Interventions included oxygen settings: oxygen via nasal cannula as ordered. Record review of active physician orders dated 5/21/2024 for Resident #34 indicated an order to administer Oxygen at 2 L/minute via nasal cannula to keep saturations above 90% that started on 7/25/2023. During an observation and interview on 5/21/2024 at 9:11 AM, Resident #34 was sitting up in a wheelchair in his room on oxygen via nasal cannula at 2 L/min and the external filter had a thick buildup of dust. Resident #34 said he cleaned the filters himself about every 2 weeks. He said the facility staff cleaned it before, but he usually did it himself. During a phone interview on 5/21/2024 at 9:36 PM, LVN A said she had been employed at the facility for 1 1/2 year and only worked the night shift from 6 pm to 6 am. She said she checked the oxygen concentrators and put water in the humidifier bottles. She said it was her understanding that maintenance was supposed to clean the oxygen filters. She said she had taken the spongy filters off before and cleaned them. She said she had never been told yes or no by anyone to clean them. She said if a concentrator started making a squealing noise, then she would check it to see what was wrong with it. She said every Sunday, the charge nurses were to change out the water for the humidifiers and the tubing on the concentrators. She said she did not clean the filters that past Sunday for Residents on Hall 200 where Resident #17 and #34 resided. She said she did not notice on the TAR if a resident had an order to clean the filter weekly. She said residents could be at risk of inhaling particles and dust as it could come through the concentrator and the filter was supposed to keep that from happening and cause lung issues such as pneumonia or shortness of breath. During an observation and interview on 5/22/2024 at 9:08 AM-9:10 AM, the Maintenance Supervisor said he had been employed at the facility since October 2023. He walked in the room of Resident #17 and said the oxygen filter was dusty. He went into the room of Resident #34 and checked the oxygen concentrator filter and said it was dusty. He said he had cleaned Resident #34's filter in the past month. He said he was responsible for cleaning the filters on the oxygen concentrators once a month and only cleaned the external filters. He said the last time he cleaned the filters for the residents in the facility was about two weeks ago. He said he did not keep a log and would just go around and check them. He said he was not sure if he had ever cleaned Resident #17's filter. He said the filter was on the concentrator to make sure contaminants did not get through. He did not know of a risk of the residents. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/2024 at 11:21 AM, the DON said he had been employed at the facility since April 2024. He said the oxygen filters were on the maintenance schedule to be cleaned weekly and they changed the filters per the manufacturer's guidelines. He said nursing staff were responsible for cleaning the filters. He said he would in-service staff on checking the filters weekly. He said there was a risk of the filters being dirty and it could jam up the machine and make them not work properly if they were not cleaned. During an interview on 5/22/2024 at 11:34 AM, the Administrator said the oxygen concentrator filters were the responsibility of maintenance to clean and should be done monthly and as needed. She said if they were not clean, the concentrators could not function properly. She said going forward, maintenance would have a list of residents in the facility on oxygen to check. Record review of the facility's policy titled Oxygen Concentrator undated indicated, .An oxygen concentrator is a medical device that extracts oxygen from room air by filtering out or separating the nitrogen form the oxygen. The oxygen passes through a filter system and is then stored within the device for delivery based on the flow meter setting. 5. Care of the Concentrator: a. Follow manufacture recommendations for the frequency of cleaning filters and servicing the device .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50071 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food safety requirements and kitchen sanitation. 1. The facility failed to ensure the DA effectively wore a hair net to cover all his hair on 5/20/2024 and the Dietary Manager effectively wore a hair net to cover all her hair on 5/20/2024 and 5/21/2024. 2. The facility failed to ensure foods stored in the refrigerators, freezers and dry pantry were labeled, dated, and not kept past their expiration dates. 3. The facility failed to ensure containers of oil and sugar were sealed properly. 4. The facility failed to ensure frozen green bean and frozen egg and cheese omelets were sealed and stored properly in freezer. 5. The facility failed to ensure celery and bell peppers were stored properly and not kept beyond use by date. 6. The facility failed to ensure foods in the freezer were not stored under a dripping pipe. 7. The facility failed to ensure proper sanitation of the food processor between pureeing each food item. 8. The facility failed to ensure proper hand washing between tasks. These failures could place residents at risk of foodborne illness and food contamination. Findings included: During an observation on 5/20/2024 at 10:10 a.m. the DA and DM were observed in the kitchen wearing a hair net that did not completely cover their hair. They had hair that was sticking out on the sides of their heads by their ears and at the back of their head. During an observation and interview on 5/20/2024 at 10:12 AM, sugar was observed stored under a table with the lid half off and cooking oil was observed with no lid. The DM said someone had just used them for breakfast and left them off. During an observation 5/20/2024 at 10:20 AM the freezer had a pipe in the back wrapped with tape and water was observed dripping and refreezing. An open uncovered box of green beans was observed unsealed with no label or date and a box of frozen egg and cheese omelets was observed sitting under a dripping pipe frozen over with a thick layer of solid ice. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntsville Health Care Center	2628 Milam Huntsville, TX 77340

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 5/21/2024 at 10:50 AM kitchen staff (Cook, DA, and Dietitian) exited and reentered the kitchen several times during observation on 5/21/24 between 10:50 am and 11:45 am without washing or sanitizing their hands. During an observation and interview on 5/20/2024 at 10:35 AM, the refrigerator had 1 box of open uncovered celery with brown spots observed on most of the stalk and wilted with use by date of 4/18/2024, 1 box of open uncovered bell peppers with brown, black, and white spots with use by date of 4/18/2024, 3 loaves of bread with use by date of 4/8/2024. A cart observed sitting in the cooler had unlabeled and undated items on it, including: one pitcher of milk with no date or label, two pitchers of juice with no date or label, 6 glasses of juice with no date or label, 3 glasses of milk with no date or label. DM said items on cart were from breakfast and they would be discarding them immediately and that all undated or unlabeled items would be removed from the cooler and items would be dated and labeled in the future. During an observation and interview on 5/20/2024 at 10:40 AM, the dry storage area revealed 1 open bag of raisin bran cereal opened and sealed in zipper top bag with use by date of 4/30/2024, one package of rice crispies in sealed zippered plastic bag with use by date of 4/02/2024. DM said she did not know why they have raisin bran because they do not serve or have raisin bran on their menu. During an observation and interview on 5/20/2024 at 10:42, the dry storage area was observed with the sugar's lid half off and the vegetable oil was observed with no lid. The lid was observed laying away from the oil bottle on top of the storage shelf. The DM said that someone must have used it preparing breakfast and did not reseal it. During an observation and interview on 5/21/2024 at 10:50 AM, [NAME] was observed pureeing foods and failed to sanitize the food processor between each puree. She rinsed food processor with water and proceeded to puree next item. [NAME] was observed using ungloved hands when handling utensils to stir or dip out food for puree. During an interview on 5/21/2024 at 1:30 pm, Maintenance Director said the pipe was not dripping. He stated the water was condensation due to the kitchen staff getting deliveries, propping the door to the freezer open when unloading the delivery truck, and storing the food in the freezer prior to closing the door. During an interview on 5/21/24 at 3:00 pm, Dietician said not washing hands between tasks and not properly washing the food processor between foods could put residents at risk of cross contamination. He also said that improper food storage and outdated foods could put residents at risk of food borne illnesses. He said if dietary staff did not wear hair nets appropriately, foods could be contaminated with hair. He said he would ensure staff were educated and follow policy going forward. During an interview on 5/21/22 at 3:30 PM, DM said the ice came from condensation and they had that problem in the past. She also said she had removed the green beans and egg omelets from the freezer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/22/24 at 12:30 pm, [NAME] said she should have put the food processor through the dishwasher after every puree and changed her gloves more often. She also said she should have washed her hands when exiting and re-entering the kitchen and between tasks. She said not washing hands between tasks and not properly washing the food processor between foods could cause residents to become sick. During an interview on 5/22/24 at 12:35 pm, DM said she should have removed all undated and unlabeled foods. She said going forward, she would date and label all items and she would check dates and discard any items that were past the use by date. She said out of date items and improper storage could make residents ill. She said not covering all hair with hair nets could cause hair to get in the food and contaminate it. She said not properly washing your hands or not properly wearing gloves could transfer germs and bacteria. Record review of the facility's policy titled Employee Sanitation dated October 1, 2018, read: .Hairnets, headbands, caps, beard coverings or other effective hair restraints must be worn to keep hair from food and food-contact surfaces .; .Employees must wash their hands and exposed portions of their arms at designated hand washing facilities at the following times: .During food preparation, as often as necessary to remove soil and contamination and prevent cross contamination when changing tasks .after engaging in other activities that contaminate the hands .; .gloves are not a substitute for thorough and frequent hand washing. When using gloves, always wash hands before touching or putting on new gloves . .Change gloves: i. between each food preparation task .iv. When leaving food preparation area for any reason . Record review of the facility's policy titled Food Receiving and Storage dated 2001 with revision date of November 2022 read: .Food may not be stored .g. under leaking water lines, including leaking automatic fire sprinkler heads, or under lines on which water has condensed .; .Refrigerated foods are labeled, dated, and monitored so they are used by their use-by date, frozen, or discarded . Record review of the facility's policy titled General Kitchen Sanitation dated October 1, 2018, read .Clean and sanitize all food preparation areas, food-contact surfaces, dining facilities and equipment. After each use, clean and sanitize all tableware, kitchenware, and food-contact surfaces of equipment .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on observations, interviews, and record reviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 5 residents (Resident #12) reviewed for infection control. The facility failed to ensure CNA C sanitized or washed her hands after changing gloves when providing incontinent care to Resident #12 on 5/20/2024. This failure could place residents at risk of exposure to communicable diseases and infections. Findings include: Record review of an Admission Record dated 5/21/2024 for Resident #12 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnosis of hemiplegia and hemiparesis following cerebral infarction (paralysis on one side following a stroke), gastrostomy status (tube placed into the stomach for feeding), end stage renal disease (kidneys are no longer able to function on their own) and autistic disorder (a developmental disorder that could cause the inability to communicate or interact). Record review of a Significant Change MDS assessment dated [DATE] for Resident #12 indicated he was rarely/never understood. He was dependent with all ADLs. He was always incontinent of bowel and bladder. Record review of a care plan revised on 5/15/2024 for Resident #12 indicated he had an ADL self-care performance deficit related to confusion, impaired mobility with interventions to provide personal hygiene/oral care and was totally dependent on one staff. He had bowel/bladder incontinence and interventions to check on rounds as required for incontinence. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/20/2024 at 11:20 AM, RN B and CNA C were present in Resident #12's room to provide wound care. RN B and CNA C sanitized/washed their hands and donned a gown and gloves. Wound care supplies were on waxed paper on the over bed table, supplies were placed on the wax paper. CNA C rolled Resident #12 onto his left side and pulled his brief down. RN B removed the dressing from his sacrum and placed it in the trash along with her gloves. RN B sanitized her hands and walked away from the bed to the door and removed gloves that was on the wall and placed gloves on both hands. RN B cleaned the sacral area with normal saline and gauze and placed it in the trash. RN B removed her gloves and placed them in the trash and sanitized her hands. RN B walked away from the bed to the door to get more gloves and applied them to both hands and used a gauze and patted sacrum area dry. CNA C removed wipes from a plastic bag and started wiping stool from his rectum front to back. CNA C placed the wipes in a trash bag and removed her gloves and put on gloves without washing or sanitizing her hands. RN B removed her gloves and placed in the trash, sanitized her hands, and walked to the door to get more gloves and applied them to both hands. RN B placed an alginate dressing to the wound bed and removed her gloves and placed them in the trash. RN B sanitized her hands and walked to the door to get more gloves and applied them to both hands. RN B applied a foam dressing. CNA C removed more wipes from the plastic bag and wiped his periarea in the front and removed gloves and placed in the trash. CNA C applied gloves to both hands without washing or sanitizing her hands. CNA C rolled the resident onto his right side and removed the brief and placed a clean brief underneath his buttocks and secured it. RN B removed her gloves and placed them in the trash. The resident was positioned in bed, and CNA C removed her gloves and placed them in the trash. Both RN B and CNA C removed their ppe and washed their hands. During an interview on 5/20/2024 at 4:25 PM, CNA C said she had been employed at the facility for a year and worked the hall where Resident #12 resided. She said during the incontinent care/wound care provided to him earlier she should have washed or sanitized her hands between gloves changes. She said she did not have sanitizer with her. She said she could not leave the resident to go and wash her hands because RN B kept leaving the bedside to get more gloves from the wall mount after she removed her gloves. She said she had a check off about 3 months ago on hand hygiene. She said residents could be at risk of infections if staff did not wash or sanitize their hands between glove changes. During an interview on 5/22/2024 at 11:06 AM, the ADON said she had been employed at the facility for 6 months. She said staff should be washing or sanitizing their hands before care, during and between, when putting a new brief, and when changing gloves. She said she was responsible for conducting the skills check offs with staff. She said she conducted in-service training on hand hygiene every 3 months. She said if staff did not perform hand hygiene, there was a risk of infections to the residents and cross contamination. She said going forward they would in-service staff and continue education. During an interview on 5/22/2024 at 11:21, the DON said he had been employed at the facility since April 2024. He said staff should be washing or sanitizing their hands before care, during care and between glove changes. He said they would continue to in-service staff on hand wash/hygiene. He said residents could be at risk for infections and staff transferring infections to other residents. During an interview on 5/22/2024 at 11:34 AM, the Administrator said staff should be sanitizing or washing their hands between care, when taking off gloves, and changing contact areas. She said going forward, they would continue to train, educate, in-service, and observe staff on hand hygiene. She said there was a risk of infections to the residents if staff did not follow proper hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a competency evaluation dated 12/15/2023 for CNA C indicated that she was checked off on hand washing/hygiene by the ADON. Record review of the facility's policy titled Handwashing/Hand Hygiene revised August 2019 indicated, .This facility considers hand hygiene the primary means to prevent the spread of infection. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: a. Before and after coming on duty; m. After removing gloves; 8. Hand hygiene is the final step after removing and disposing of personal protective equipment .