STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675702	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Place Two	3505 S Buckner Blvd Bldg 3 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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50222 Based on observations, interviews, and record reviews the facility failed to accommodate the needs and preferences of four of 10 residents (Resident #3, Resident #20, Resident #96, and Resident #19) reviewed for accommodation of needs. The facility failed to place Resident #3's call light within reach on 12/11/2024. The facility failed to place Resident #20's call light within reach on 12/11/2024. The facility failed to place Resident #96's call light within reach from 12/10/2024 until 12/11/2024. The facility failed to place Resident #19's call light within reach on 12/11/2024. This failure could place residents at risk of being unable to obtain assistance for activities of daily living or in the event of an emergency. Findings included: Record review of Resident #3's quarterly MDS assessment dated [DATE] revealed Resident #3 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of stroke, seizure disorder, unsteadiness on feet, and aphasia (language disorder that affects the ability to speak). The MDS also revealed a BIMS score of 09 (suggested moderate cognitive impairment). Record review of Resident #3's care plan, updated on 10/23/2024, revealed Resident #3 was at risk for falls, and an intervention for this focus area was to ensure the resident's call light was within reach. Record review of Resident #20's quarterly MDS assessment dated [DATE] revealed Resident #20 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of stroke, aphasia (language disorder that affects the ability to speak), unsteadiness on feet, need for assistance with personal care, and lack of coordination. The MDS also revealed a BIMS score of 04 (suggested severe cognitive impairment). (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #20's care plan, updated on 10/18/2024, revealed Resident #20 was at risk for falls, and an intervention for this focus area was to ensure the resident's call light was within reach. Record review of Resident #96's admission MDS assessment dated [DATE] revealed Resident #96 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of necrotizing fasciitis (serious bacterial infection that destroys tissue under the skin), cellulitis (bacterial skin infection) of the right upper limb, and hypertension (high blood pressure). The MDS also revealed a BIMS score of 15 (suggested no cognitive impairment). Record review of Resident #96's care plan, updated on 12/10/2024, revealed Resident #96 had a potential for an ADL self-care deficit, and an intervention for this focus area was to encourage the resident to use bell to call for assistance. Record review of Resident #19's quarterly MDS assessment dated [DATE] revealed Resident #19 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of stroke, urgency of urination, need for assistance with personal care, and unsteadiness on feet. The MDS also revealed a BIMS score of 06 (suggested severe cognitive impairment). Record review of Resident #19's care plan, updated on 11/15/2024, revealed Resident #19 had a potential for an ADL self-care deficit, and an intervention for this focus area was to encourage the resident to use bell to call for assistance. In an observation on 12/10/2024 at 10:15 a.m., Resident #96 was resting in bed with his eyes closed. Resident #96's call light was observed curled up under the resident's bed. In an observation and interview on 12/11/2024 at 9:37 a.m., Resident #96's call light was observed curled up under the resident's bed. Resident #96 stated he did not know where his call light was, but it was usually clipped to his bed. Resident #96 stated he would have to leave his room and look for help if he needed assistance. Resident #96 stated he was not concerned with not having his call light because he did not use it often. In an observation and interview on 12/11/2024 at 9:43 a.m., Resident #19's call light was observed on the floor next to her bed. Resident #19 stated she could not reach the call light and did not know where it normally was. Resident #19 was unable to provide further information due to cognitive impairment. In an observation and interview on 12/11/2024 at 1:58 p.m., Resident #3 was sitting in a wheelchair on the left side of her bed. Resident #3's call light was clipped on a curtain on the right side of the bed. Resident #3 was able to point at the call light, but shook her head no, when asked if she could reach it. Resident #3 was unable to provide additional information due to aphasia (language disorder that affects the ability to speak). In an observation and interview on 12/11/2024 at 2:02 p.m., Resident #20 was sitting in a wheelchair near the foot of his bed. Resident #20's call light was laying on a pillow at the head of the bed. Resident #20 stated he would like to lay down but was not able to reach the call light. Resident #20 would not state anything else except he wanted to lay down. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 12/11/2024 at 2:04 p.m., ADON L entered Resident #20's room and stated Resident #20 could not use his call light because it was not within reach. ADON L stated this placed Resident #20 at risk for not being able to call for help, and that he would ensure Resident #20's call light remained within reach after assisting him to bed. In an interview on 12/11/2024 at 3:36 p.m., the DON stated the nursing team was responsible for monitoring that call lights were appropriately placed. The DON stated department heads also monitored call light placement when they rounded first thing in the morning and rounded one time in the afternoon. The DON stated each department head was assigned two halls. The DON reported the risk to the residents was that they would not be able to tell staff what they needed or felt. The DON did not state the expectation but stated call lights were important. In an interview on 12/12/2024 at 10:07 a.m., the ADM stated call lights were expected to be placed where residents could reach them. The ADM stated the risk to the residents was that they may not get their needs met or it could lead to an injury. The ADM stated everybody was responsible for monitoring call light placement and should check call light placement every time they entered a room. Review of facility policy titled Communication - Call System, with a revision date of 6/2020, revealed Call cords will be placed within the resident's reach in the resident's room.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070 Based on observations, interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents for two (Hall 100 and Hall 600) of six halls observed for physical environment. The facility failed to ensure rooms and bathrooms toilets, and sinks were clean, safe, and in good repair in several rooms on Hall 100 and Hall 600. These failures could place residents at risk for diminished quality of life. Findings included: An observation on 12/12/2024 at 8:30 a.m. revealed in resident room [ROOM NUMBER]'s bathroom, the sink was hanging loosely on the wall. The base of the toilet was black with grim, and the caulking was missing surrounding the entire base of the toilet. The wall on the A side of the room had the paint missing, with black marks across the entire lower part of the wall. An observation on 12/12/2024 at 8:45 a.m., revealed in resident room [ROOM NUMBER]'s bathroom the door protector was loose on the top left corner of the door. Further observation revealed inside the bathroom, the sink was hanging loosely on the wall and there was a liquid stain down the wall next to the toilet. An observation on 12/12/2024 at 9:00 a.m. revealed, in resident room [ROOM NUMBER]'s bathroom, the toilet seat had the white paint chipped off exposing the veneer underneath. Further observation revealed the sink hanging loosely on the wall. An observation on 12/12/2024 at 09:07 a.m. in resident room [ROOM NUMBER]'s bathroom, revealed the base of the toilet was black with grim, and the caulking was missing surrounding the entire base of the toilet. The toilet seat was missing, the white paint was chipped off and the veneer underneath was exposed. Further observation revealed the paint missing from the entire lower part of the wall on the A side of the room. An observation on 12/12/2024 at 09:15 a.m., in resident room [ROOM NUMBER]'s bathroom, the base of the toilet was black, and the caulking was missing around the entire base of the toilet. An observation on 12/12/2024 at 09:20 a.m., in resident room [ROOM NUMBER]'s bathroom, revealed the entire front of the toilet seat had the white paint chipped off and the veneer was exposed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/12/2024 at 9:45 a.m. with the Plant Operations revealed that he would make sure that the repairs were made by the maintenance supervisor for this facility. He stated the staff was supposed to use the electronic system for reporting, but they did not. The Plant Operations stated they have been in-serviced on the system, but they still just tell the supervisor. The Plant Operations stated he could review all the facilities and if there was something in the system that had been reported that was not corrected, he would contact the maintenance supervisor for the campus and follow-up to see why the repairs had not been completed. The Plant Operations checked the electronic system and there were no entries concerning sinks and toilets in the system. In an interview on 12/12/2024 at 11:17 a.m. with Resident #60 revealed he wanted his room and bathroom to be cleaned and he knew that the man who could fix it, needed to come and do it. The resident said it had been that way for a long time; the stains on the wall by the toilet. In an interview on 12/12/2024 at 11:30 a.m. with Resident #79 revealed that he wanted his bathroom to be clean and he wanted a new toilet seat, he stated he had not told anyone that he wanted a new toilet seat. In an interview on 12/12/2024 at 11:27 p.m., Housekeeper E revealed she was responsible for cleaning the rooms and bathrooms on hall 100 and sometimes hall 600. The Housekeeper stated she would report to her supervisor if she found something in one of the resident's rooms that required repair. Housekeeper A stated she had noticed that some of the bathroom's sinks were loose, but she did not report it because she thought the sinks were not that loose. The housekeeper stated if the repairs were not completed it could cause harm to the residents. In an interview on 12/12/2024 at 12:18 p.m., LVN B revealed that if there were maintenance issues for the hallway, there was an electronic system the staff would use to report needed repairs. The LVN stated she had not reported any maintenance problems recently. LVN B stated she would report because something broken could cause harm to the resident. In an interview on 12/12/24 at 2:30 p.m. with the Administrator revealed the bathrooms had been renovated last year and the resident's treated everything so poorly, it was hard to keep everything in good repair. The Administrator stated this was the residents' home and by not keeping it clean and in good repair it can develop germs. Review of the Policy and Procedure Resident Room and Environment dated revised August 2020 reflected to provide residents with a safe, clean, comfortable, and homelike environment I. Facility Staff aim to create a personalized, homelike atmosphere, paying close attention to the following: A Cleanliness and order;

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070 Based on observations, interviews, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, including acute charting guidelines and high blood pressure necessary to care for resident's needs as identified through resident assessments and nursing documentation, for 1 (Resident #63) of 2 residents reviewed for quality of care. 1. MA K failed to communicate, and use the acute charting guidelines in the MAR, for charting of the increased blood pressure, and report to the charge nurse. By not reporting or domenting LVN B was unaware Resident #63 required a follow-up assessment, due to an increased blood pressure. These failures placed residents at risk for complications to include unnoticed change in condition and for residents not to receive needed nursing assessments. Findings included: Review of Resident #63's quarterly MDS dated [DATE] revealed the resident was a [AGE] year-old male admitted on [DATE]. Diagnoses to included: Kidney failure (Kidneys weak), hypertension (increased blood pressure), multiple intracranial hemorrhages (bleeding in the brain), diabetes (increased sugar), anxiety (anxious), and cerebral infarction due to thrombosis (stroke due to blood clot in the brain). Resident #69 was severely cognitively impaired, unable to make decision for himself, and required extensive assistant for activities of daily living. Review of Resident #63's care plan dated 10/05/24 revealed problems addressed included the resident's needs for functional status, and high blood pressure. The care plan reflected Resident #69 required assistance of two for ADLs to include bed mobility. Goals included the resident's high blood pressure, the cerebral infraction, he would receive adequate assessment, and treatment with communication for any change of condition. Review of Resident #63's consolidated physician orders dated December 2024 reflected, Lisinopril (blood pressure medication) tablet 10mg give one tablet by mouth one time a day for hypertension. Hold for systolic blood pressure less than 110 and diastolic blood pressure less than 60 and pulse less than 60 notify MD/NP/PA for related changes. Norvasc (blood pressure medication) oral tablet 5mg 2 tablets by mouth one time a day for hypertension hold for systolic blood pressure less than 110, diastolic blood pressure less than 60 and pulse less than 60 notify MD/NP/PA for related changes, and Ativan (anti-anxiety medication) oral tablet 0.5mg give tablet by mouth two-times a day for anxiety. Review of Resident #63's Medication Administration Record dated 11/2024 reflected the resident had received: 1) Lisinopril tablet 10mg one time a day, 2) Norvasc 5mg two tablets one time a day for the entire month of November. Further review reflected Resident #69 had his blood pressure checked prior to the medication administration. MA K had taken the blood pressure and administered the blood pressure medications seventeen times in the month of November. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes dated 12/01/2024 through 12/12/2024, reflected Resident #63 had no documented changes in his condition. There had been no assessment of Resident #69 or communication with the physician, nurse practitioner, or physician assistant related to the change in the resident's condition. In an observation and interview on 12/10/2024 at 10:22 a.m. with MA K revealed the MA took the blood pressure of Resident #69 on his right arm, the results were 136/124. MA K stated he was going to administer the resident's blood pressure medications and his anti-anxiety medication and then recheck his blood pressure in about twenty minutes. The MA stated he was not going to document the blood pressure of the resident at this time, he would wait and see if it goes down and then document those results of his blood pressure. MA K did not inform his charge nurse and proceeded to move to the next resident to administer medication. In a follow-up interview on 12/10//2024 at 10:45 a.m. revealed MA K had already rechecked the blood pressure and showed the state surveyor in the Medication Administration Record that the results of Resident #63's blood pressure was 147/89. The MA had stated he had not told the charge nurse, since the blood pressure went down to a normal range. In an interview on 12/10/24 at 11:00 p.m. with LVN B revealed that if a resident's blood pressure was abnormal, the MA should report to the nurse. LVN B showed the state surveyor in the clinical record the dashboard where vital signs as well as other information concerning residents' conditions was located. LVN B stated if there was an abnormal blood pressure, when the staff member documented the blood pressure it would show-up. Review of the dashboard with LVN B reflected no abnormal blood pressures documented for Resident #63. The LVN stated she was not aware of any changes in Resident #63's blood pressure, and she had not noted any change in his condition in the past two weeks. The LVN stated if the nurse is not informed then they cannot assess the resident and inform the physician, this could result into a problem for the resident that could have been prevented. In an interview on 12/11/2024 at 10:00 a.m. with MA K revealed he had been in-serviced on blood pressures and reporting. MA K validated when he took the blood pressure the first time, he did not report it to his charge nurse and he waited twenty minutes and rechecked the blood pressure of Resident #63 and that was the blood pressure he documented. In an interview on 12/11/2024 at 10:49 a.m. with MA K revealed he could not recall how often in a week he had completed this process with Resident #63, and he had no other residents that he did this with. MA K stated he had attended an in-service on the procedure for reporting blood pressures to the charge nurse, but in a follow-up interview he stated he did not say that. In an interview on 12/11/2024 at 10:55 a.m. with MA C revealed if a resident had a high or low blood pressure when she took it, she would report to her charge nurse right away. She stated she would administer the medications, but still inform my charge nurse. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN O on 12/10/2024 at 2:30 p.m. revealed that the MA was supposed to report to the nurse in charge when checking blood pressures if the blood pressure was high or low, then we call the physician, and follow orders. LVN O stated he was unaware of any blood pressure problems related to Resident #69 and had not noted any changes in his condition in the past 2 weeks. LVN O stated he had sent the month of November's blood pressures for Resident #63 to the nurse practitioner. LVN O stated that was what the nurse practitioner that wanted us to , so she can review the blood pressures. LVN O stated if the blood pressure was not reported then the resdiet could suffer an unnoticed change of condition, causing a decline. In an interview with the DON on 12/12/24 at 9:45 a.m., revealed that all staff nurses and medication aides had received in-services on reporting abnormal blood pressures. The DON provided the in-services for reporting blood pressure changes dated 10/2024 and 11/2024. MA K had attended the in-service in October 2024. The DON stated, I have trained the staff, if the staff do not listen then I do not know what else to do with them. The DON did not respond concerning follow-up to the training to assure the staff understood. The DON stated, I should get credit for at least training the staff. The DON stated he could not understand why the MA did not report the blood pressure to the charge nurse. The DON provided to the state surveyor a one-on-one in-service dated 12/12/2024 with MA K on reporting abnormal blood pressures to the charge nurse. If the staff does not follow my in-service and training it could cause problems for the residents not receiving quality care. In an interview on 12/12/2024 at 3:00 p.m. with Physician N revealed he was not aware of blood pressure changes with Resident #63. The physician stated the nursing staff was particularly good about communicating with him and his staff concerning changes in resident's conditions. Physician N stated if a resident had changes in his/her blood pressure the charge nurse should contact him, so that medication changes could occur, or monitoring could begin. The physician stated the MA should be communicating with the nurse in charge about any changes related to a resident. The physician stated not communicating appropriately about changes in a resident could result in a negative outcome for the resident, but in this case the resident was stable. Review of the policy and procedure Change of Condition Notification date June 2020 reflected to ensure residents, family, legal representatives, and physician are informed of changes in the resident's condition in a timely manner. II. The Facility will promptly inform the resident, consult with the resident's Attending Physician, and notify the resident's legal; representative when the resident endures a significant change in their condition cause by, but not limited to: . B. Significant change in the resident's condition . Procedure I. the Licensed Nurse will notify the resident's Attending Physician when there is an: . C. A significant change in the resident's physical, mental, or psychosocial status .deterioration in health .D. A need to alter treatment . III Notifying the Physician: A. The Attending Physician will be notified timely with a resident's change in condition

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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** 27070 Based on observations, interviews, and record review, the facility failed to ensure all assistive devices were maintained and free of hazards for six (Residents #22, #34, #48, #60, #67, and #89) of 6 residents reviewed for essential equipment. The facility failed to properly maintain wheelchairs for Residents #22, #34, #48, #67, and #89. The facility failed to properly maintain the overbed table for Resident #60. These failures could place residents at risk for equipment that is in unsafe operating condition, that could cause injury. Findings included: Review of Resident #22's quarterly MDS assessment, dated 10/08/2024, reflected she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses of unsteadiness on feet (unsafe standing), muscle wasting and atrophy (weakness), abnormalities of gait and mobility (unable to walk safely), and diabetes (high blood sugar). Further review of the MDS reflected the resident was cognitively severely impaired and unable to make decisions for themselves. Review of Resident #22's plan of care dated 10/24/2024 with updates reflected goals and approaches to include wheelchair mobility for locomotion. Observation on 12/10/2024 at 12:30 p.m., revealed Resident #22 was sitting in her wheelchair, in the dining room, and had no skin problems. The wheelchair's right armrest was cracked with foam exposed. The left armrest was missing. Review of Resident #34's quarterly MDS assessment, dated 11/08/2024, reflected she was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses of hypertension (high blood pressure), muscle weakness (muscle deterioration), difficulty in walking, and unsteadiness on feet (no balance). Further review of the MDS reflected the resident was cognitively moderately impaired and able to make decisions for themselves. Review of Resident 34's plan of care dated 10/08/2024 with updates reflected goals and approaches to include wheelchair mobility. Observation and interview on 12/10/24 at 12:45 p.m., revealed Resident #34 was sitting in her wheelchair in the dining room and the wheelchair's right armrest was cracked with exposed foam. There were no skin tears on her arms. Resident #34 stated she would like to have a smooth arm rest, this one was rough. The resident stated she had not told anyone, but staff could have noticed it and got her a new armrest. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #48's admission MDS assessment, dated 10/08/2024, reflected he was a [AGE] year-old male admitted to the facility on [DATE], with diagnoses of nontraumatic intracerebral hemorrhage in brain stem (bleeding in the back of your brain) cerebral infraction (stroke), lack of coordination (cannot walk), and unsteadiness on feet (cannot stand alone safely). Further review of the MDS reflected the resident was cognitively severely impaired and unable to make decisions for themselves. Review of Resident #48's updated plan of care dated 10/24/2024 with updates reflected goals and approaches to include wheelchair mobility. Observation and interview on 12/02/2024 at 12:47 p.m., revealed Resident #48 was sitting in his wheelchair in the dining room and the wheelchair's left and right armrests were cracked with exposed foam. There were no skin tears on his arms. Review of Resident #60's annual MDS assessment, dated 09/17/2024, reflected he was a [AGE] year-old male admitted to the facility on [DATE], and readmission on 09/14/2024, with diagnoses of osteomyelitis of the left foot and ankle (infection of the bone of the left foot), absence of right leg below the knee (leg is missing below knee), lack of coordination (cannot walk), and unsteadiness on feet (cannot stand alone safely). Further review of the MDS reflected the resident was not cognitively impaired and able to make decisions for themselves. Review of Resident #60's updated plan of care dated 10/08/2024 with updates reflected goals and approaches to include wheelchair mobility. Observation and interview on 12/02/2024 at 1:50 p.m., revealed Resident #60 was sitting on the side of his bed in his room. There were no skin tears on his arms. The resident was getting a drink out of his water pitcher sitting on the overbed table. The overbed table was missing all the veneer on the outer end of the table and exposing rough wood substance underneath. The resident stated he had not paid too much attention to the overbed table, but now he sees it and he wanted a new one. Review of Resident #67's quarterly MDS assessment, dated 09/16/2024, reflected he was a [AGE] year-old male admitted to the facility on [DATE], with diagnoses of hypertension (high blood pressure), muscle weakness (muscle deterioration), difficulty in walking, and unsteadiness on feet (no balance). Further review of the MDS reflected the resident was cognitively moderately impaired and able to make decisions for themselves. Review of Resident #67's updated plan of care dated 11/18/2024 with updates reflected goals and approaches to include wheelchair mobility. Observation and interview on 12/10/24 at 12:49 p.m., revealed Resident #67 was sitting in his wheelchair in the dining room and the wheelchair's right armrest was cracked with exposed foam. The entire back of the wheelchair was cracked open and peeling off. There were no skin tears on his arms. Review of Resident #89's quarterly MDS assessment, dated 10/16/2024, reflected she was a [AGE] year-old female admitted to the facility on [DATE], and readmission on 09/28/2024, with diagnoses of cerebral infarction (stroke), muscle weakness (muscle deterioration), and unsteadiness on feet (no balance). Further review of the MDS reflected the resident was cognitively alert and able to make decisions for themselves. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #89's updated plan of care dated 11/15/2024 with updates reflected goals and approaches to include wheelchair mobility. Observation and interview on 12/10/24 at 12:52 p.m., revealed Resident #69 was sitting in her wheelchair in the dining room and the wheelchair's right armrest was cracked with exposed foam. There were no skin tears on her arms. In an interview on 12/11/2024 at 10:30 a.m., MA C stated when a resident's wheelchair needed repair the staff were to report it to the Maintenance Director. MA C stated we report to the Maintenance Director by writing in the electronic system or just telling him. MA C was unaware of any wheelchair that required repair. The MA stated the equipment had to be safe or the residents could get hurt. In an interview on 12/11/2024 at 11:00 a.m., with the Plant Operations revealed the staff informed the Maintenance Supervisor of equipment repair by logging into the electronic system. The Plant Operations verified the Maintenance Supervisor was the person who repaired the wheelchairs, but checking the Plant Operations did not see anything in the electronic system for any wheelchairs that required new armrest or backs. The Plant Operations stated the equipment needed to be in good repair so the residents did not get hurt. In an in interview on 12/12/2024 at 10:20 a.m., with the DON revealed he was not aware of any wheelchairs that required repair in the facility. The DON stated between therapy and the maintenance department the staff would tell them if a wheelchair required repair. Attempts were made to interview the therapy department, but they were all unavailable. In an in interview on 12/12/2024 at 2:20 p.m., with the Administrator revealed he was not aware of any wheelchairs that required repair in the facility. The Administrator stated there were plenty of parts and other wheelchairs available, he would see that the wheelchairs were repaired. The Administrator stated the staff was responsible to let the maintenance department know. Review of the Facility's Policy titled Maintenance services dated revised August 2020 reflected Maintenance service shall be provided to areas of the building, grounds, and equipment . G. establishing proprieties to providing repair services . j. maintaining all mechanical, electrical, and patient care equipment in safe operating condition .3. The maintenance director is responsible for developing and maintaining a schedule of maintenance services to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50222 Based on interviews, observations, and record reviews, the facility failed to obtain timely laboratory services to meet the needs of its residents for one (Resident #59) of five residents reviewed for laboratory services. The facility failed to collect labs for Resident #59 on 12/06/2024 as ordered by the physician. This failure could place residents at risk for a delay in ensuring treatment needs are identified and addressed. Findings included: Record review of Resident #59's annual MDS assessment dated [DATE] revealed Resident #59 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of stroke, diabetes, and heart failure. The MDS also revealed a BIMS score of 15 (suggested no cognitive impairment). Record review of Resident #59's care plan, updated on 12/10/2024, revealed Resident #59 was on antibiotic therapy for bone infection and urosepsis (urinary tract infection that has spread to the rest of the body). An intervention for this focus area was to report pertinent lab results to the physician. Record review of Resident #59's physician order dated 11/22/2024 revealed an order to obtain laboratory tests in the morning every Friday. The order listed the laboratory tests as CBC with diff (provided information about cells in the bloodstream), CMP (measured electrolytes in the bloodstream), CRP (assisted in measuring the inflammation within the body), ESR (assisted in measuring the inflammation within the body), CK (assisted with measuring inflammation or muscle injury within the body), and liver function tests. Record review of Resident #59's laboratory results on 12/12/2024 at 12:39 p.m., revealed laboratory tests were completed for Resident #59 on 11/29/2024 then again on 12/10/2024 at 8:45 p.m. No laboratory tests were performed on Friday, 12/06/2024. In an interview and observation on 12/10/2024 at 2:00 p.m., ADON L reported the laboratory tests for Resident #59 should have been performed last week but had not been completed. ADON L stated this could place the resident at risk for infection or getting sick. ADON L reported that the ADONs and the DON monitored laboratory tests by checking the laboratory book every day. Observed ADON L check the laboratory book and ADON L reported the laboratory tests were not written down for last week. ADON L stated there was no way to know if the laboratory tests should have been repeated unless it had been written down in the laboratory book. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/11/2024 at 3:36 p.m., the DON reported that ADON M was responsible for monitoring laboratory tests and that the DON was the backup. The DON reported that he and ADON M checked the laboratory book daily. The DON reported that he did not know how the laboratory tests for Resident #59 were missed, and the risk to the residents was delayed decision making by the doctor. The DON stated his expectation was if laboratory tests were not collected 100% of the time, then to at least be close. In an interview on 12/11/2024 at 3:42 p.m., ADON M reported she monitored the laboratory tests daily by checking the laboratory book and the laboratory website daily. ADON M reported she was unsure how the laboratory tests for Resident #59 were missed. ADON M did not state how this would affect the residents. In an interview on 12/12/2024 at 10:07 a.m., the ADM stated the expectation was that laboratory tests would be completed as soon as possible. The ADM stated the risks to residents if laboratory tests were not completed was that the residents' condition could deteriorate and require hospitalization . The ADM stated the nurses and the ADONs were responsible for monitoring laboratory tests. In an interview on 12/12/2024 at 10:42 a.m., Physician N reported laboratory tests for Resident #59 were ordered weekly because Resident #59 was receiving antibiotics for osteomyelitis (bone infection) from a wound. Physician N stated that laboratory tests were completed weekly to monitor for adverse reactions. Physician N stated the expectation was for the facility to obtain laboratory tests weekly if ordered and report the results to him. Physician N stated there was no potential for adverse reactions with just one week of laboratory tests missed. Review of facility policy titled Laboratory, Diagnostic and Radiology Services, with a revision date of 6/2020, revealed Laboratory, diagnostic and radiology services will be coordinated pursuant to an order by a physician and the facility is responsible for the quality and timeliness of services provided by the laboratory, diagnostic or radiology provider.

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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. 50948 Based on observations, interviews, 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 kitchen reviewed for food safety. 1. The facility failed to ensure dented cans were placed in a separate storage area. These failures could place residents at risk for food-borne illness and cross contamination. Findings included: Observation of the dry storage area on 12/10/2024 at 9:20am revealed the following: -1 46oz can of tomato juice was dented on the middle right. -1 66.5oz of light chunk tuna was dented on the top left. -1 6lbs diced tomatoes was dented on the top right. In an interview with the DM on 12/10/2024 at 9:30am she stated dented cans were stored in her office. She stated when dented cans were identified, the dented cans were returned to the vendor. She stated dented cans were provided weekly to the vendor. She stated the risks of dented cans not stored in a separate area was they could cause food poison and food borne illness if used. In an interview with [NAME] F on 12/10/2024 at 11:47am she stated dented cans were stored separately. She stated the risks of dented cans not stored separately was they could cause bacteria if used. Record review of the facility ' s Food Storage Policy, dated revised September 26, 2024 reflected, Policy Statement: food items will be stored, thawed, and prepared in accordance with good sanitary practice. XI. Dented or bulging cans should be placed in separated area and returned for credit. Record review of the U.S. FDA Food Code 2022 reflected: Chapter 3 . section 3-101.11. Safe, Unadulterated, and Honestly Presented: . A primary line of defense in ensuring that food meets the requirements of S 3-101.11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting and processing, they do not fall victim to conditions that endanger their safety, make them adulterated, or compromise their honest presentation. Th: e regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard. eCFR- Code of Federal Regulations are indicating within the text by an *- www.ecfr.gov

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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** 27070 Based on observations, interviews, 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 seven of eight (RN A, CNA D, CNA G, CNA H, CNA I, CNA J, and MA K) staff members and forty-four of 106 residents (Residents #79, #46, #2, #84, #8, #34, #4, #1, #31, #55, #6, #13, #65, #5, #87, #107, #4, #28, #7, #76, #10, #21, #106, #93, #16, #103, #104, #74, #27, #64, #29, #33, #72, #40, #54, #47, #81, #43, #63, #24, #58, #97, and #99) reviewed for infection control procedures. MA K failed to sanitize the blood pressure cuff before and after usage on Resident #63. RN A failed to disinfect her treatment scissors prior to starting a treatment on Resident #99's foot. CNA G failed to sanitize their hands after direct contact with residents #79, #46, #2, #84, #8, #34, #1, #31, #55, #6, #13, #65, and #5, while serving meals on Hall 100. CNA D failed to sanitize their hands after direct contact with residents #87, #107, #4, #28, #7, #76, #10, and #21 while serving meals on Hall 200. CNA H failed to sanitize their hands after direct contact with residents, #106, #93, #16, #103, 104, 74, #27, #64, #29, and #33 while serving meals on Hall 300. CNA J failed to sanitize their hands after direct contact with residents, #72, #105, #40, #54, #47, #81, and #66 while serving meals on Hall 400. CNA I failed to sanitize their hands after direct contact with residents, #43, #63, #24, #58, and #97 while serving meals on Hall 600. This failure could place residents at risk for healthcare associated cross contamination and infections. Findings included: Record review of Resident #99's admission MDS assessment, dated 11/12/24, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #99 had diagnoses which included: Diabetes (high sugar), hypertension (high blood pressure), and peripheral vascular disease (blood does not flow to the legs well). Resident #99 was cognitively alert and able to make decisions and required assistance of one staff for activities of daily living. Record review of Resident #46's annual MDS Assessment, dated 09/12/2024, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #46 had diagnoses which included: Diabetes (high blood sugar), schizo-affective schizophrenia (mental illness), and hypertension (high blood pressure). Resident #46 was severely cognitively impaired, unable to make decisions, and required one staff for assistance with activities of daily living. (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 #2's quarterly MDS Assessment, dated 11/27/2024, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2 had diagnoses which included: Hypertension (high blood pressure), heart failure (heart not pumping well), and diabetes (high blood sugar). Resident #2 was alert, able to make decisions, and required one staff for assistance with activities of daily living. Record review of Resident #84's quarterly MDS Assessment, dated 10/03/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #84 had diagnoses which included: hypertension (increased blood pressure), schizophrenia (mental illness), and trans-ischemic attacks (small strokes). Resident #84 was cognitively alert, able to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #8's quarterly MDS Assessment, dated 11/27/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #8 had diagnoses which included: Diabetes (increased blood sugar), and depression (mental illness). Resident #8 was cognitively alert, able to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #34's quarterly MDS Assessment, dated 11/08/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #34 had diagnoses which included: Hypertension (increased blood pressure), depression (mental illness), and convulsions (seizures). Resident #34 was severely cognitively impaired, unable to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #79's quarterly MDS Assessment, dated 10/09/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #79 had diagnoses which included: Hypertension (increased blood pressure), schizophrenia (mental illness), and depression (mental illness). Resident #79 was cognitively alert, able to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #1's annual MDS assessment, dated 11/20/2024, revealed an [AGE] year-old male who admitted to the facility on [DATE] and readmission on 08/02/2024. Resident #84 had diagnoses which included: Hypertension (increased blood pressure), schizophrenia (mental illness), and dementia (confusion and forgetfulness). Resident #84 was severely cognitively impaired, unable to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #31's quarterly [in process] MDS assessment, dated 12/12/2024, revealed a [AGE] year-old female who admitted to the facility on [DATE]. Resident #31 had diagnoses which included: Diabetes (increased blood sugar), and cardio-vascular accident (stroke). Resident #31 was severely cognitively impaired, unable to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #55's quarterly MDS assessment, dated 11/15/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #55 had diagnoses which included: Hypertension (increased blood pressure), bi-polar disorder (mental illness), and depression (mental illness). Resident #55 was moderately cognitively impaired, able to make decisions, and required assistance of one staff for activities of daily living. (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 #6's quarterly MDS assessment, dated 12/06/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #6 had diagnoses which included: Hypertension (increased blood pressure), schizophrenia (mental illness), and dementia (confusion and forgetfulness). Resident #6 was severely cognitively impaired, unable to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #13's annual MDS assessment, dated 12/09/2024, revealed a [AGE] year-old male who admitted to the facility on ,d+[DATE]. Resident #13 had diagnoses which included: Hypertension (increased blood pressure), diabetes (increased blood sugar), and heart failure (heart weak and unable to pump correctly). Resident #13 was alert cognitively, able to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #65's quarterly MDS assessment, dated 10/11/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE] and readmission on 08/14/2024. Resident #65 had diagnoses which included: Diabetes (increased blood sugar), depression (mental illness), and paraplegia (loss of usage legs). Resident #65 was alert cognitively, able to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #5's quarterly MDS assessment, dated 12/07/2024, revealed a [AGE] year-old female who admitted to the facility on [DATE]. Resident #5 had diagnoses which included: Depression (mental illness), and diabetes (increased blood sugar). Resident #5 was severely cognitively impaired, unable to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #87's quarterly MDS assessment, dated 09/27/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #87 had diagnoses which included: Hypertension (increased blood pressure), diabetes (increased blood sugar), and end-stage renal disease (kidneys do not work without assistance through a machine). Resident #87 was severely cognitively impaired, unable to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #107's 5-day Medicare MDS assessment, dated 12/08/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #107 had diagnoses which included: Hypertension (increased blood pressure), depression (mental illness), and diabetes (increased blood sugar). Resident #107 was cognitively alert, able to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #4's quarterly MDS assessment, dated 11/25/2024, revealed a [AGE] year-old female who admitted to the facility on [DATE] and readmit on 03/15/2023. Resident #4 had diagnoses which included: Alzheimer's disease (degeneration of brain), depression (mental illness), and psychotic disorder (mental illness). Resident #4 was severely cognitively impaired, unable to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #28's quarterly MDS assessment, dated 11/28/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #28 had diagnoses which included: Hypertension (increased blood pressure), depression (mental illness), and dementia (confusion and forgetfulness). Resident #28 was severely cognitively impaired, unable to make decisions, and required assistance of one staff for activities of daily living. (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 #7's annual MDS assessment, dated 11/07/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE] and readmission on 10/18/2021. Resident #7 had diagnoses which included: Hypertension (increased blood pressure), psychotic disorder (mental illness), and diabetes (increased blood sugar). Resident #7 was cognitively alert, able to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #76's quarterly MDS assessment, dated 11/20/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #76 had diagnoses which included: Hypertension (increased blood pressure), cardio-vascular accident (stroke), and diabetes (increased blood sugar). Resident #76 was cognitively alert, able to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #10's annual MDS assessment, dated 11/01/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #10 had diagnoses which included: Chronic obstructive pulmonary disease (lungs do not work correctly), psychotic disorder (mental illness), and insomnia (does not sleep well at night). Resident #10 was cognitively alert, able to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #21's quarterly MDS assessment, dated 09/30/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #21 had diagnoses which included: Hypertension (increased blood pressure), schizophrenia (mental illness), and cerebral infract (stroke). Resident #21 was cognitively alert, able to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #106's admission MDS assessment, dated 11/24/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #106 had diagnoses which included: Renal insufficiency (kidneys do not work well), hypoglycemia (low blood sugar), and respiratory failure (could not breath without assistance). Resident #106 was cognitively alert, able to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #93's annual MDS assessment, dated 11/28/2024, revealed a [AGE] year-old female who admitted to the facility on [DATE] with a readmission on 11/22/2024. Resident #93 had diagnoses which included: Anemia (not enough iron), depression (mental illness), and heart failure (weak heart). Resident #93 was cognitively alert, able to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #16's quarterly MDS assessment, dated 10/17/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #16 had diagnoses which included: Hypertension (increased blood pressure), schizophrenia (mental illness), and bipolar disorder (mental illness). Resident #16 was moderately cognitively impaired, able to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #103's admission MDS assessment, dated 11/12/2024, revealed a [AGE] year-old female who admitted to the facility on [DATE]. Resident #103 had diagnoses which included: Hypertension (increased blood pressure), cardio-vascular accident (stroke), and diabetes (increased blood sugar). Resident #103 was moderately cognitively impaired, able to make decisions, and required assistance of one staff for activities of daily living. (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 #104's admission MDS assessment, dated 11/19/2024, revealed a [AGE] year-old female who admitted to the facility on [DATE]. Resident #104 had diagnoses which included: Hypertension (increased blood pressure), cardio-vascular accident (stroke), and diabetes (increased blood sugar). Resident #10 was cognitively alert, able to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #74's quarterly [in progress] MDS assessment, dated 12/12/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #74 had diagnoses which included: Hypertension (increased blood pressure), cardio-vascular accident (stroke), and diabetes (increased blood sugar). Resident #74 was cognitively alert, able to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #27's quarterly MDS assessment, dated 10/03/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #27 had diagnoses which included: Hypertension (increased blood pressure), cardio-vascular accident (stroke), and hyperlipidemia (increased cholesterol). Resident #27 was severely cognitively impaired, unable to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #64's quarterly MDS assessment, dated 10/15/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #64 had diagnoses which included: Hypertension (increased blood pressure), cardio-vascular accident (stroke), and diabetes (increased blood sugar). Resident #64 was cognitively alert, able to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #29's quarterly MDS assessment, dated 09/14/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #29 had diagnoses which included: Hypertension (increased blood pressure), depression (mental illness), and diabetes (increased blood sugar). Resident #29 was cognitively alert, able to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #33's quarterly MDS assessment, dated 11/22/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #33 had diagnoses which included: coronary artery disease (clogged up arteries), peripheral vascular disease (poor circulation to the legs), and dementia (confusion and forgetfulness). Resident #33 was cognitively alert, able to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #72's quarterly MDS assessment, dated 11/15/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #72 had diagnoses which included: Hypertension (increased blood pressure), heart failure (heart is weak, fluid on heart), and diabetes (increased blood sugar). Resident #72 was cognitively alert, able to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #40's quarterly MDS assessment, dated 10/11/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #40 had diagnoses which included: Hypertension (increased blood pressure), cardio-vascular accident (stroke), and dementia (confusion and forgetfulness). Resident #40 was severely cognitively impaired, unable to make decisions, and required assistance of one staff for activities of daily living. (continued on next page)

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	675702	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Place Two	3505 S Buckner Blvd Bldg 3 Dallas, TX 75227

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #54's quarterly MDS assessment, dated 10/12/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE] with readmission on 04/04/2024. Resident #54 had diagnoses which included: Dementia (forgetfulness and confusion), anxiety (anxious), and depression (mental illness). Resident #54 was severely cognitively impaired, unable to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #47's annual MDS assessment, dated 10/19/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #47 had diagnoses which included: Chronic pain (pain), cardio-vascular accident (stroke), and quadriplegia (no full use of arms and legs). Resident #47 was cognitively alert, able to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #81's quarterly MDS assessment, dated 11/27/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #81 had diagnoses which included: Hypertension (increased blood pressure), cardio-vascular accident (stroke), and history of mental and behavioral disorders (mental illness). Resident #81 was cognitively alert, able to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #43's quarterly MDS assessment, dated 11/08/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE] with readmit on 04/13/2024. Resident #43 had diagnoses which included: Dementia (forgetfulness and confusion), bi-polar disorder (mental illness), and malignant carcinoid tumor of rectum (rectal cancer). Resident #43 was severely cognitively impaired, unable to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #63's quarterly MDS assessment, dated 10/03/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #63 had diagnoses which included: Hypertension (increased blood pressure), cardio-vascular accident (stroke), and diabetes (increased blood sugar). Resident #63 was moderately cognitively impaired, unable to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #24's quarterly MDS assessment, dated 10/31/2024, revealed a [AGE] year-old female who admitted to the facility on [DATE] with readmission 10/18/2023. Resident #24 had diagnoses which included: Hypertension (increased blood pressure), osteomyelitis (infection of the bone), and depression (mental illness). Resident #24 was cognitively alert, able to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #58's quarterly MDS assessment, dated 09/22/2024, revealed a [AGE] year-old female who admitted to the facility on [DATE]. Resident #58 had diagnoses which included: Hypertension (increased blood pressure), heart failure (heart weak, fluid around the heart), and dementia (forgetfulness and confusion). Resident #58 was severely cognitively impaired, unable to make decisions, and required assistance of one staff for activities of daily living. Record review of Resident #97's admission MDS assessment, dated 10/13/2024, revealed a [AGE] year-old female who admitted to the facility on [DATE]. Resident #97 had diagnoses which included: Hypertension (increased blood pressure), anemia (not enough iron), and dementia (forgetfulness and confusion). Resident #97 was cognitively alert, able to make decisions, and required assistance of one staff for activities of daily living. (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 #66's quarterly MDS assessment, dated 11/02/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #66 had diagnoses which included: Diabetes (increased sugar), and hypertension (increased blood pressure). Resident #99 was cognitively alert, able to make decisions, and required assistance of one staff for activities of daily living. Observation and interview on 12/10/2024 at 10:22 a.m. with MA K revealed the MA checking the blood pressure on Resident #63. The MA did not clean the blood pressure cuff prior to using the cuff on the resident. The MA did not attempt to clean the blood pressure cuff after using, until the DON stepped up to the cart and whispered to MA K and showed the MA a container of purple top sanitizing wipes. MA K stated he had not cleaned the blood pressure cuff in between usage on the other residents because he had forgotten. MA K stated if the blood pressure cuff was not cleaned between usage it could spread infections. Observation on 12/10/24 beginning at 12:10 p.m., CNA G was observed to enter Hall 100. CNA G entered Resident's #46, #2, #84, #8, #34, #79, #1, #31, #55, #6, #13, #65, and #5 rooms. While serving the meals to the residents, CNA G moved and adjusted bedside tables, positioned, and assisted residents to sit up, opened, and unwrapped utensils, and removed tops off drinks for the residents. CNA G did not cleanse his hands with hand sanitizer or wash his hands, between each meal tray served. CNA G did not have on gloves. He did not complete hand hygiene before going to the next resident. Observation on 12/10/24 beginning at 12:21 p.m., CNA D was observed to be serving meals on Hall 200. CNA D entered Resident's #87, #107, #4, #28, #7, #76, #10, and #21 rooms. While serving the meals to the residents, CNA D moved and adjusted bedside tables, positioned, and assisted residents to sit up, opened, and unwrapped utensils, and removed tops off drinks for the residents. CNA D did not cleanse his hands with hand sanitizer or wash his hands, between each meal tray served. CNA D did not have on gloves. He did not complete hand hygiene before going to the next resident. Observation on 12/10/24 beginning at 12:30 p.m., CNA H was observed to be serving trays on Hall 300. CNA H entered Resident's #106, #93, #16, #103, #104, #74, #27, #64, #29, and #33 rooms. While serving the meals to the residents, CNA H moved and adjusted bedside tables, positioned, and assisted residents to sit up, opened, and unwrapped utensils, and removed tops off drinks for the residents. CNA H did not cleanse her hands with hand sanitizer or wash her hands, between each meal tray served. CNA H did not have on gloves. She did not complete hand hygiene before going to the next resident. Observation on 12/10/24 beginning at 12:39 p.m., CNA J was observed to be serving meal trays Hall 400. CNA J entered Resident's #72, #40, #54, #47, #81, and #66 rooms. While serving the meals to the residents, CNA J moved and adjusted bedside tables, positioned, and assisted residents to sit up, opened, and unwrapped utensils, and removed tops off drinks for the residents. CNA J did not cleanse her hands with hand sanitizer or wash her hands, between each meal tray served. CNA J did not have on gloves. She did not complete hand hygiene before going to the next resident. Observation on 12/10/24 beginning at 12:46 p.m., CNA I was observed to be serving meal trays Hall 600. CNA I entered Resident's #43, #63, #24, #58, and #97 rooms. While serving the meals to the residents, CNA I moved and adjusted bedside tables, positioned, and assisted residents to sit up, opened, and unwrapped utensils, and removed tops off drinks for the residents. CNA I did not cleanse her hands with hand sanitizer or wash her hands, between each meal tray served. CNA I did not have on gloves. She did not complete hand hygiene before going to the next resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 12/11/24 at 10:00 a.m., revealed RN A did not cleanse her treatment scissors prior to using the scissors to treat Resident #99's right leg and foot ulcer. RN A stated she cleaned them after use, but when the state surveyor walked up to her treatment cart and said she wanted to go see her treat this wound, she was not prepared. RN A stated she just forgot, she did state if the scissors were not cleaned prior to use and after this could cause germs to spread. An interview on 12/10/2024 at 12:32 p.m. with CNA H revealed she was in a hurry to serve the trays, she did not want the food to get cold and she saw me watching her, so she just forgot. The CNA stated she had been trained on hand hygiene and how to use hand sanitizer between each tray, and it could spread infection if she did not clean her hands. An interview on 12/10/24 at 1:00 p.m., CNA G stated he did not complete hand hygiene after having direct contact with residents. CNA G stated he was supposed to use the hand sanitizer in between serving each tray or wash his hands. CNA G said he had been educated on completing hand hygiene. CNA G stated he did not sanitize his hands, after the first meal tray that was served because he was nervous, and he forgot. CNA G stated he knew it could spread germs if he did not sanitize his hands properly. An interview on 12/10/2024 at 1:15 p.m. with CNA D revealed he was helping to serve in the dining room and when he came out of the dining area, the trays were already on the hallway, so he was in a hurry to get the trays served so the food did not get cold. The CNA stated he had been in-serviced on hand hygiene and when to use hand sanitizer between each meal served. An interview on 12/10/2024 at 1:37 p.m. with CNA J revealed she had been called in because someone had called in today and she had been trying to catch up all morning. CNA J stated she just forgot to use hand sanitizer between each meal. The CNA stated if you do not use sanitizer or wash your hands then you could spread germs. An interview on 12/10/2024 at 1: 45 p.m. with CNA I revealed the trays on the hallway were already on the hall and she was serving them late, so she was in a hurry. She stated she had residents she had to assist to eat on the hallway, so she was in a hurry and forgot to use the hand sanitizer. The CNA stated she did know to use hand sanitizer and it was there on the hall available to use but she just forgot. An interview with the DON on 12/12/24 at 9:45 a.m., revealed that all staff has been trained on infection control. The DON offered the in-services that had been completed for hand hygiene dated 11/2024, the CNAs that served today were listed on the in-service. The DON stated, I have trained the staff, if the staff do not listen then I do not know what else to do with them. The DON did not respond concerning follow-up to the training to assure the staff understood and was following the hand hygiene. I should get credit for at least training the staff. The DON stated if the CNAs do not use appropriate hygiene, they can spread germs to the residents and themselves. The DON stated he had trained the nursing staff and the medication aides on cleaning equipment after each use, including the glucometers, thermometers, and blood pressure cuffs. The DON stated he could not understand why the MA did not clean the blood pressure cuff. This DON stated this could also spread infection, it the equipment was not cleaned properly. The DON was the infection control preventionist. (continued on next page)

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