STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675751	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Odessa	2443 W 16th St Odessa, TX 79763

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 26221 Based on observation, interview, and record review the facility failed to treat residents with respect, dignity and care for each resident in a manner that promotes maintenance or enhancement of his or her quality of life for 13 of 13 residents in the confidential group interview. Staff used cell phones in residents' presence causing residents to feel disrespected and ignored. Staff had residents sit at assigned seating in the dining room. Staff labeled resident's clothing in large print over their clothing. These failures could result in a diminished quality of life for the identified residents and could affect additional residents by causing a loss of self-esteem and increased isolation. The findings included: Observations on 10/1/24 at 10:06 a.m. during initial rounds revealed Resident #9 (unsampled) was in a wheelchair in his room. His t-shirt was labeled in black marker about 2 inches wide. In an interview on 10/1/24 at 10:47 a.m. Laundry Aide I said sometimes family members labeled the shirts and sometimes the housekeepers had to do it. Laundry Aid I said they would go up and down the hall and find out who an unlabeled piece of laundry belonged to and label it. Laundry Aide I confirmed they would always label it 1 -2 inches big and on the front of the shirt. In an anonymous interview on 10/1/24 at 11:30 a.m. a resident said the CNAs just sat in the halls playing on their phone. The resident said it was an open secret and there was no use complaining about it. Observation on 10/1/24 at 11:50 a.m. revealed Resident #12 happily sitting at the center table in the dining room. CNA G moved Resident #12 from the center table to a corner table where he was facing the corner while telling him why don't we move you to another table? CNA G then moved a second resident. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a second anonymous interview on 10/1/24 at 2:10 p.m., the resident asked to speak with surveyor. The resident stated the nurses were nice, but the CNAs were on their phones all the time and they (the aides) could be using that time making sure the residents were ok and not wet. The resident said it felt like the aides were ignoring them. During the confidential resident council meeting on 10/2/24 at 10:00 a.m. 8 alert, lucid residents stated the staff were on their phone while residents were either waiting for care or receiving care. One resident stated they had to wait 40 minutes for care, and they already had a rash on their bottom. The residents were in 100% agreement the staff were on personal calls that could take hours. One resident said the evening shift was worse than the day shift. When asked how long it took for the call light to be answered, one resident responded, it's like getting to the center of a tootsie roll pop, no one knows. The residents when asked if there was one thing that could be changed said they would like the staff off the phones because the staff were like zombies when they were on them. The other residents said they would like to be treated like adults and not on house arrest. Interview on 10/2/24 at 1:27 p.m. LVN F stated some aides were on their phones more than others and they had seen the aides on the phone in the dining room. LVN F had seen aides on the phone in the resident rooms. Observation on 10/2/24 at 2:00 p.m. revealed residents on their smoke break, there was one staff present texting on their phone not paying attention to the residents. Interview on 10/2/24 at 4:55 p.m. LVN C stated he saw aide on the phone all the time. LVN C stated he told the aides to get off the phone, but they got right back on the phone and what was he supposed to do then? In an interview on 10/3/24 at 4:53 the DM stated there was assigned seating, but the residents had been sitting in those seats forever. In an interview on 10/3/24 at 4:58 p.m. with the DON and ADON, the DON said the last time she had assigned seating was grade school probably. The ADON said we do have assigned seating, it had to be changing because we have had some changes, the only residents who were really assigned were the residents at the feeder table because they needed to be there (residents needing assistance with eating). The DON said that was how the trays came out and the nurses did not want the residents waiting a long time for the residents at a table to wait for their food. The ADON said she made the seating chart. The DON said the staff cell phone use was a constant battle and she talked to the staff when she saw it. The DON said the staff did use their cell phones when they were clocking in and clocking out, but the staff should not be using the phone in the middle of providing care. The DON said she would feel bad if she was receiving care while someone was on the phone while providing care. The ADON stated they asked families to label clothing for the residents when they brought it in. The ADON said if the clothes were not labeled the staff would label it, but some did get missed. The DON held her fingers apart approximately 1.5 - 2 inches apart and said that was how big the labeling was. When held against her name tag, the name tag was approximately half the size as what the resident's label was. The DON said if helped keep her clothes from getting lost she would not mind. Review of the Nursing Facility Resident Rights posted in the facility revealed: Residents had the resident to be treated with dignity, courtesy, consideration, and respect.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 5 residents (Resident #17) reviewed for care plans in that: The facility failed to ensure there was a care plan in place for Resident #17's ankle enabler. This failure could affect residents by placing them at risk of not receiving individualized care and services to meet their needs. The findings included: Review of Resident #17's Admission Record dated 10/2/24 revealed he was a was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included stroke, hemiplegia of the right side, and convulsions. Review of Resident #17's Quarterly MDS assessment dated [DATE] revealed: He had a mental status score of 3 of 15 (indicating severe cognitive impairment). He was identified as having no range of motion impairment and he used a wheelchair. He received 232 minutes of occupational therapy. Review of Resident #17's Order Summary dated 10/2/24 revealed no order for any type of enabler. Review of Resident #17's care plan initiated 6/12/23 revealed: The resident has limited physical mobility related to weakness. Goal: the resident will demonstrate the appropriated use of wheelchair to increase mobility through the review date. Identified interventions included: - PT/OT evaluation and treatment as per MD orders initiated 6/12/23. - Resident has one-sided weakness initiated 6/12/23. - Locomotion: Resident uses wheelchair for locomotion on and off unit. Requires limited to extensive staff assistance to propel. Initiated 6/12/24, revised 9/4/24. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Alteration in mobility related to inability to ambulate, generalized weakness, inability to turn and reposition self, status post hemiplegia right dominant side. Goal: Resident will maintain current mobility status throughout the review date. Identified interventions included: - PT/OT to evaluate and treat as indicated -Assess resident's potential for Restorative Program as needed -Identify and address underlying cause of impaired mobility. -Provide appropriate level of assistance to promote safety of resident. -Instruct resident to use handrails in corridor. -Monitor resident's gait and assist as necessary. -Provide assistive devices as required -Modify environment as needed to enhance mobility -Encourage resident to participate in ambulation and praise. There was no care plan for the use of a device to the ankle. Observation on 10/1/24 at 1:41 p.m. revealed Resident #17 was in the lobby with his right leg secured to the foot-rest pole with a gait belt. Resident #17 requested a nurse to look at his contracted arm. LVN H came and repositioned the arm, LVN H came and repositioned the arm and did not ask Resident #17 if he needed his right leg repositioned. Observation on 10/2/24 at 9:42 a.m. revealed Resident #17 was up in his wheelchair in the lobby with his right leg secured to the wheelchair with a gait belt. Observation on 10/2/24 at 12:13 p.m. revealed Resident #17 was up in his wheelchair in the dining room with his right leg secured to the wheelchair with a gait belt. Observation on 10/2/24 at 1:25 p.m. revealed Resident #17 up in his wheelchair in the lobby with his leg secured to the wheelchair with a gait belt. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/2/24 at 2:54 p.m. PT D stated Resident #17 was currently on OT and most days he was already out of bed when therapy came and got him. PT D stated Resident #17 had hemiparesis (Paralysis) on the right side of the body. PT D stated therapists put the gait belt on Resident #17's leg while transporting him to the gym but immediately took it off when they arrived at the gym. PT D stated they (therapy) secured Resident #17's leg to the foot pedal because Resident #17's foot would fall off and cause him pain. PT D said Resident #17 was not supposed to have the belt around his leg when he was not in therapy, and he (PT D) never issued an order saying the aides could use the belt to secure Resident #17's leg in transport. PT D stated maybe the aides did not know Resident #17 was not supposed to use it when not in therapy because Resident #17 would ask for it. PT D stated he had never assessed Resident #17 for the use of the belt. In an interview on 10/3/24 at 5:36 p.m. the MDS Coordinator stated he was not aware the gait belt was being used on Resident #17's leg. The MDS Coordinator said he care planned it on 10/2/24 because no one made him aware of the belt used around his leg. Review of the facility's policy and procedure on Comprehensive Care Plan, effective 1/20/21, revealed: Every resident will have an individualized interdisciplinary plan of care in place. A The interdisciplinary Team will continue to develop the plan in conjunction with the RAI (MDS 3.0) CAAs, completed and conducting Comprehensive Care Plan Meeting and Reviews by day 21 after Admission. The Care Plan is revised every quarter, significant change of condition, Annual or as the resident condition changes on an individualized basis. The Care Plan process is an ongoing review process. The Resident's Care Plan will include participation from residents' representatives, external partners PASSR, Hospice, Therapy, Clinicians, and not as all-inclusive. Procedure: The Interdisciplinary Team will review the healthcare practitioner's notes and orders (e.g. dietary needs, medications, routine treatments etc.) and implement a Comprehensive Care Plan to meet the residents' immediate care needs.

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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** 26221 Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 3 of 5 residents (Residents #17, #18 and #51) reviewed for transfers and supervision in that: Nursing staff and Resident #17's doctor were not aware Resident #17 had his right leg secured to his footrest with a gait belt. CNA A transferred Resident #18 from his bed to his wheelchair by taking him from his under arms. CNA G and CNA H transferred Resident #51 from his wheelchair to his bed taking him from under his arms and by the back of his pants. These failures could put residents at risk of accidents and serious injuries which could result in a reduced quality of life. Findings included: Resident #17 Review of Resident #17's Admission Record dated 10/2/24 revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included stroke, hemiplegia of the right side, and convulsions. Review of Resident #17's Quarterly MDS assessment dated [DATE] revealed: He had a mental status score of 3 of 15 (indicating severe cognitive impairment) He was identified as having no range of motion impairment and he used a wheelchair. He received 232 minutes of occupational therapy. Review of Resident #17's Order Summary dated 10/2/24 revealed no order for any type of enabler. Review of Resident #17's care plan initiated 6/12/23 revealed: The resident has limited physical mobility related to weakness. Goal: the resident will demonstrate the appropriated use of wheelchair to increase mobility through the review date. Identified interventions included: PT/OT evaluation and treatment as per MD orders initiated 6/12/23. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident has one-sided weakness initiated 6/12/23. Locomotion: Resident uses wheelchair for locomotion on and off unit. Requires limited to extensive staff assistance to propel. Initiated 6/12/24, revised 9/4/24. Alteration in mobility related to inability to ambulate, generalized weakness, inability to turn and reposition self, status post hemiplegia right dominant side. Goal: Resident will maintain current mobility status throughout the review date. Identified interventions included: -PT/OT to evaluate and treat as indicated -Assess resident's potential for Restorative Program as needed -Identify and address underlying cause of impaired mobility. -Provide appropriate level of assistance to promote safety of resident. -Instruct resident to use handrails in corridor. -Monitor resident's gait and assist as necessary. -Provide assistive devices as required -Modify environment as needed to enhance mobility -Encourage resident to participate in ambulation and praise. There was no care plan for the use of a device to the ankle. Observation on 10/1/24 at 1:41 p.m. revealed Resident #17 in the lobby with his right leg secured to the foot-rest pole with a gait belt. Resident #17 requested a nurse to look at his contracted arm. LVN H came and repositioned the arm and did not ask Resident #17 if he needed his right leg repositioned. Observation on 10/2/24 at 9:42 a.m. revealed Resident #17 was up in his wheelchair in the lobby with his right leg secured to the wheelchair with a gait belt. Observation on 10/2/24 at 12:13 p.m. revealed Resident #17 was up in his wheelchair in the dining room with his right leg secured to the wheelchair with a gait belt. Observation on 10/2/24 at 1:25 p.m. revealed Resident #17 up in his wheelchair in the lobby with his right leg secured to the wheelchair with a gait belt. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and observation on 10/2/24 at 2:34 p.m. LVN C stated he did not know anything about Resident #17 having a gait belt around his ankle (securing right leg to wheelchair). LVN C went to Resident #17's room to check. Aides were preparing to transfer Resident #17 from his wheelchair into his bed. LVN C observed that Resident #17 did have the right leg secured to the wheelchair footrest with a gait belt. LVN C stated there was no way Resident #17 could take the belt off and took the belt away from the aides. In an interview on 10/2/24 at 2:39 p.m. PT D stated the therapy department had found Resident #17 out of bed with the gait belt around his leg (securing right leg to wheelchair footrest) when he was not in therapy. PT D stated Resident #17 should not have it on unless he was being transported from point A to point B because it could cause pressure. In an interview on 10/2/24 at 2:41 p.m. the DON stated Resident #17 had redness to the bilateral lower legs. The DON stated she did not know anything about a gait belt around Resident #17's right leg. LVN C explained to the DON his observation of Resident #17 with the gait belt around the wheelchair and he (LVN C) was sure it was therapy that applied the gait belt. The DON stated therapy should be taking the belt on and off (with transport). LVN C explained Resident #17's leg bowed out so his foot would fall off the foot pedal during transport. In an interview on 10/2/24 at 2:54 p.m. PT D stated Resident #17 was currently on OT and most days he was already out of bed when therapy came and got him. PT D stated Resident #17 had hemiparesis (Paralysis) on the right side of the body. PT D stated therapists put the gait belt on Resident #17's leg while transporting him to the gym but immediately took it off when they arrived at the gym. PT D stated they (therapy) secured Resident #17's leg to the foot pedal because Resident #17's foot would fall off and cause him pain. PT D said Resident #17 was not supposed to have the belt around his leg when he was not in therapy, and he (PT D) never issued an order saying the aides could use the belt to secure Resident #17's leg in transport. PT D stated maybe the aides did not know Resident #17 was not supposed to use it when not in therapy because Resident #17 would ask for it. PT D stated he had never assessed Resident #17 for the use of the belt. In an interview on 10/3/243 at 8:55 a.m. the DON stated they put a cradle on Resident #17's wheelchair yesterday (10/2/24) to hold his leg in place better than the belt and ordered him a bigger wheelchair. The DON stated what she found out was therapy started using the belt in transport and the CNAs kept going with it. The DON said the aides told her therapy told them to use it and everyone just went along with it. The DON said Resident #17 could not move his leg voluntarily. The DON repeated Resident #17's foot would not stay on the wheelchair footrest without the assistance of something securing the leg. The DON stated the facility initially tried a pillow and the pillow did not work. The DON said the facility could try a bigger wheelchair because that would make for a wider foot base and the facility talked about a foot board yesterday but the facility did not have one right now. The DON stated the gait belt was the first thing tried. The DON said there was no monitoring because the nurses did not know it was there either because therapy did not communicate it needed to be used or the aide just saw it and thought it was a good idea. In an interview on 10/3/24 at 9:33 a.m. Resident #17's doctor stated he did not give an order for Resident #17's leg to be secured to a wheelchair the Doctor would not give an order like that. The Doctor stated the facility did not tell him Resident #17's leg was being secured and he did not know how long that had been going on. The Doctor said when he saw Resident #17, he was usually and bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/3/24 at 9:46 a.m. Resident #17 stated he was much more comfortable with the leg cradle the facility provided. Resident #17 was unable to say how long the staff used the belt. In an interview on 10/3/24 at 10:19 a.m. Resident #17's Responsible Party stated Resident #17 had the belt to keep his leg on the wheelchair. The Responsible Party stated Resident #17 had it a little longer than a month. The Responsible Part was not sure if the nurses were aware if Resident #17 had it. In an interview on 10/3/24 at 10:38 a.m. PT D said he was aware of Resident #17's history of convulsions but Resident #17 never had one at the facility. PT D said Resident #17 had the belt for his leg for approximately 2 months, it started when Resident #17 was in physical therapy. PT D said they usually did therapy with Resident #17 after lunch when he was awake so if any observations were in the morning the aides put it on. PT D said Resident #17 did not have therapy on 10/2/24. PT D said he never told the aides to put the belt on Resident #17 and had provided no in-services on how to do it. In an interview on 10/3/24 at 11:04 a.m. CNA E stated Resident #17 had the belt for months (was unable to recall exact time). CNA E stated she received no training to put it on and therapy never instructed the aides to put it on. In an interview on 10/3/24 at 10:58 a.m. the Treatment Nurse confirmed Resident #17 had skin tears to his legs. The Treatment nurse stated that she was not able to determine how skin tears occurred. The Treatment Nurse stated she never saw Resident #17 with the belt on because she did the treatments when he was already in bed. In an interview on 10/3/24 at 11:08 LVN F stated she did not know anything about a gait belt to Resident #17's leg. LVN F said she repositioned Resident #17's arm on 10/1/24 and did not notice the belt on Resident #17's leg and monitored the dining room [ROOM NUMBER]/2/24 and did not notice the belt on his leg. LVN F stated she knew the aides got Resident #17 up on 10/2/24. RESIDENT #51 Review of Resident #51's Admission Record dated 10/2/24 revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including brain cancer, esophageal cancer, muscle weakness, and repeated falls. Review of Resident #51's Admission MDS, dated [DATE], revealed: He had a mental status score of 14 of 15 (indicating he was cognitively intact) He used a wheelchair. He needed partial/moderate assistance for chair-to-bed transfers. He was on hospice care. Review of Resident #51's Care Plan revealed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident had and ADL self-care performance deficit related to disease process Terminal Prognosis. The identified goal was: The resident will maintain current level of function through the review date. Identified interventions included: Transfer: The resident required limited staff assistance with transferring. Initiated on 9/13/24. Observation on 10/1/24 revealed CNA G and CNA H placed Resident #51's wheelchair at a 90-degree angle to the bed and locked the wheelchair. Then both aides hooked their arms under Resident #51's arms and grabbed the waistband of his pants. Resident #51 dangled while the aide pivoted and placed Resident #51 in bed. In an interview on 10/2/24 at 2:05 p.m. CNA H stated she remembered CNA G was on the other side of Resident #51. CNA H said they hooked their arms under Resident #51 and put him to bed. CNA H stated that was how they were trained to do transfers. CNA H stated Resident #51 said Resident #51 was able to bear weight, but he was feeling weak on 10/1/24. CNA H said they held Resident #51 by the pants because when he was dead weight, he pulled everyone down. CNA H said she did not know why they did not use a gait belt with Resident #51 because it would be safer. CNA H said the aides had to get the belts from therapy and there was only one resident who had a gait belt on the hall 24/7. RESIDENT #18 Record review of Resident #18's admission record dated 10/01/24 indicated he was admitted to the facility on [DATE] with diagnoses of dementia, unsteadiness on feet, reduced mobility and muscle weakness. He was [AGE] years of age. Record review of Resident #18's MDS dated [DATE] indicated in part: BIMS score = 03 indicating resident had severe impairment. (Chair/bed-to-chair transfer: 02 Substantial/maximal assistance = Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort). (Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. 01. Dependent - Helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity). Record review of Resident #18's care plan revised 09/25/2024 indicated in part: Focus: I have an ADL self-care performance deficit r/t impaired mobility & poor safety awareness. GOAL: The resident will maintain current level of function through the review date. Interventions: The resident is dependent on staff for assistance with transferring. During an observation on 10/01/24 at 03:34 PM CNA A transferred Resident #18 from his bed to his wheelchair by herself. CNA A took Resident #18 from underneath his armpits and moved him into his wheelchair. During the transfer Resident #18 was unable to bear any weight. (continued on next page)

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Focused Care at Odessa	2443 W 16th St Odessa, TX 79763

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/02/24 at 02:46 PM CNA A said the way she knew the transfer status of any resident was by asking the resident, seeing if a resident had a mechanical lift sling under them or by asking the nurse. CNA A said they had gait belts and that they used them sometimes for transfers. CNA A said the way she transferred Resident #18 was not necessarily safe and that it was kind of difficult as he did not help with the transfer. CNA A said that at times it took 2 aides to transfer the resident but had not thought about getting help. CNA A said if she transferred Resident #18 by herself and not use a gait belt, she could injure the resident such as dropping him. During an interview on 10/03/24 at 04:20 PM the DON was made aware of the observation of how CNA A transferred Resident #18 from his bed to his wheelchair . The DON said the transfer status was in the CNAs care plan also known as the Kardex which was located in the CNAs computer system and all the CNAs had access to that. The DON provided a copy of the Kardex but it was not clear on the transfer status for Resident #18. The DON said the Kardex just indicated the resident is dependent on staff for assistance with transferring but was not specific as to how many staff to assist or how. The DON said CNA A should have used a gait belt for the transfer or gotten help. The DON said if the CNA transferred Resident #18 by herself and by his armpits there was a chance the resident and the staff member could be injured. The DON said the staff had competencies done on transfers as well and were done by the ADON. The DON said the failure probably occurred because CNA A had gotten nervous. During an interview on 10/03/24 at 04:24 PM the ADON said she performed competency checks to include transfers. The ADON said the competency was on the use of the mechanical lift but not necessarily on gait belts or staff conducting transfers by themselves. The ADON said they would have to conduct training on gait belt use. The ADON provided a copy of the competency for CNA A. During an interview on 10/03/24 at 05:28 PM the Administrator was made aware of the transfer of Resident #18 and Resident #51 performed by the CNAs. The Administrator said the CNAs should have known to use a gait belt and also to know where to check for the transfer status of each resident. The Administrator said if the CNAs did not perform the transfer safely it could result on the resident and staff getting injured. The Administrator said they would have to conduct more training. Record review of Resident #18's and Resident #51's Kardex dated 10/03/2024 indicated in part: Transferring: The resident is dependent on staff for assistance with transferring. (Note: The Kardex did not specify how to transfer the resident). Record review of the facility's policy titled Safe lifting and movement of residents dated 07/2017 indicated in part: In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents. Manual lifting of residents shall be eliminated when feasible. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices.

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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** 48593 Based on observation, interview, and record review, the facility failed to ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice for 2 (Resident #20, Resident #41) of 6 residents observed for oxygen management. The facility failed to ensure Oxygen was ordered for both Resident #20 and Resident #41. This failure could place residents at risk of not receiving appropriate respiratory care. The findings were: Resident #41 Record review of Resident #41's Admission record dated 10/02/2024 indicated the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. The admission record revealed the resident had diagnoses that includes end stage renal disease, Type 2 diabetes mellitus, muscle weakness, and heart failure. Record review of Resident #41's MDS dated [DATE] revealed a BIMS score of 15 indicating resident was cognitively intact. There was no indication of oxygen use in the MDS. Record Review of residents #41's order summary dated 10/02/24 revealed no orders for Oxygen Interview on 10/02/24 at 09:44 AM with Resident #41 revealed that the resident wears oxygen occasionally when she feels short of breath. Observation during interview noted there is oxygen concentrator on the wall. Resident #20 Record review of Resident #20's Admission record dated 10/02/2024 indicated the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. The admission record revealed the resident had diagnoses that include muscle weakness, reduced mobility, type 2 diabetes mellitus, morbid obesity, obstructive sleep apnea and cellulitis. Record review of Resident #20's MDS dated [DATE] revealed BIMS score of 15 indicating resident was cognitively intact. The MDS revealed under respiratory treatments= Oxygen therapy - while a resident . Record Review of residents #20's order summary dated 10/02/24 revealed no orders for Oxygen Interview on 10/01/24 at 10:47 AM with Resident #20 revealed that she does wear oxygen when she feels like she needs it. Observation during interview noted there is oxygen concentrator on the wall. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/03/24 at 02:39 PM with the DON revealed she was aware that these two residents were on oxygen and was not sure why there were no orders for these residents. The DON stated she was typically the person who supplies the oxygen tubing. The DON states since there was not an order there will not be a care plan in place for oxygen.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 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. The facility failed to ensure: Food that was beginning to rot (discoloration and had rotten smell) was discarded. Staff knew how to check the sanitizer level in the dishwasher. Staff knew how to wash their hands. Food was dated per the facility's policy. Food was not stored on the floor. The dry storage and refrigerator were clear of debris and food under the shelves. These failures could affect residents who received meals prepared from the kitchen at risk for food borne illness and cross contamination. Findings included: Initial observation on [DATE] beginning at 9:05 a.m. of the facility's only kitchen revealed: The refrigerator revealed: the bananas in the refrigerator were simultaneously green and brown and the sandwich snacks were not dated. The dry storage revealed: food debris including an apple were under the shelves; 13 boxes of canned goods were on the floor; a box of rotting potatoes on the shelf that were slimy. At that time, The DM said the night shift was responsible for putting up the cans and sweeping under the shelves. She said she had spoken to the night shift about this before. The DM stated she did not know how old the potatoes were because the box was not dated. In an interview on [DATE] at 9:20 a.m. DA J and DA K stated potatoes going bad had had been like that since they were hired. They said they cut off the bad parts and did the best they could. Observation and interview of the walk-in freezer revealed food debris, including 2 whole hashbrown cakes, under the shelves. At the time of the observation, the DM stated it was not ok, and it had been a while since she had been out to check the walk-in freezer and she had to rearrange the shelves. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At the end of the initial kitchen on [DATE] observation DA K washed her hands and then turned off the faucet with her bare hands. Observation and interview on [DATE] at 1:26 p.m. DA J said he worked at the facility since February and had no training on how to test the sanitizer level on the dish machine, but he was happy to try. DA J ran the dish washer and tested the sanitizer level with the test strips that should be used on the three-compartment sink. At that point the DM took over. The DM said DA J was using the wrong test strips. The DM got the right test strips, and the dish machine was within the right parameters. In an interview on [DATE] at 4:24 p.m. the DM stated the facility's policy on dating was everything was to be dated when it was received. The DM said it was policy things were dated when they were cooked, labeled what they were and when they expired. The DM said she did some investigation and said the rotten potatoes were 3.5 weeks old. The DM said she did not know how the bananas were both green and brown at the same time, but it came off the truck that way, but the dietary staff would peel them for the residents and if they were bad the banana would be thrown away. The DM said the afternoon shift was responsible for putting up food when it came in off the truck every night. The DM said the expectation for washing hands was to wet hands, soap, wash up to wrist, rinse, dry with paper towel, use a new paper towel and turn off the faucet with a new paper towel. The DM said she felt the DAs were good about doing that when she was in the kitchen. The DM said she said she did handwashing proficiencies at the end of August. The DM said she thought DA J was trained on the dishwasher when he was at another facility. The DM said DA J was using the test strips that were up on the testing area. Review of the facility's policy and procedure on Preparation of Foods, effective date [DATE], revealed: Food is to be prepared by methods that conserve nutritive value, flavor and appearance. Review of the facility's policy and procedure on Food Storage, effective date ,d+[DATE], revealed: All food purchased will be wholesome, manufactured, processed, and prepared in compliance with all State, Federal, and local laws and regulations. Food will be handled in a safe and sanitary method to prevent contamination and food-borne illness. Process: Foods are stored at least 6 inches off the floor. Separate raw animal foods, such as eggs, fish, meat, and poultry from ready to eat foods such as produce. Cooked and ready to eat foods are stored above raw foods (including shell eggs) in the refrigerator to prevent cross-contamination. Review of the facility's Cleaning Schedule (undated) revealed: Daily/After Each Use Cleaning Schedule Log: Floor, Freezers. Review of In-service dated [DATE] revealed the DM in serviced the dietary staff on handwashing.

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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** 30057 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 3 (Resident #18, Resident #41 and Resident #20) of 6 residents reviewed for incontinent care in that: CNA A failed to change her gloves after they became contaminated and wash or sanitize her hands in between glove change while assisting Resident #18 with incontinent care. CNA B failed to change their gloves after they became contaminated while assisting Resident #41 and Resident #20 with incontinent care. These failures could place resident's risk for cross contamination and the spread of infection. Finding included: RESIDENT #18 Record review of Resident #18's admission record dated 10/01/24 indicated he was admitted to the facility on [DATE] with diagnoses of dementia, unsteadiness on feet, reduced mobility, and muscle weakness. He was [AGE] years of age. Record review of Resident #18's care plan revised 09/25/2024 indicated in part: Focus: I am incontinent of bladder and bowel incontinence and at risk for skin breakdown. GOAL: I will remain clean, dry, and odor free with no occurrence of skin breakdown throughout the review date. Interventions: Monitor for incontinence Q2H/PRN (every 2 hours/as needed), change promptly and apply protective skin barrier. Record review of Resident #18's MDS dated [DATE] indicated in part: BIMS = 03 indicating resident had severe impairment. Bladder and bowel: Urinary continence = Frequently incontinent. Bowel continence = Frequently incontinent. During an observation on 10/01/24 at 03:20 PM CNA A performed incontinent care for Resident #18. CNA A washed her hands and put on a pair of new gloves then closed the door. CNA A undid Resident #18's brief and performed peri-care to the resident's penis and scrotum area. CNA A then turned the resident on his right side and wiped the resident's rectal area. Resident #18 was noted to have a bowel movement. After CNA A wiped the bowel movement from the resident's rectal area, she then proceeded to touch the resident's arms and hands to reposition him while wearing the same gloves that she had wiped the resident's bowel movement. While still wearing the same gloves CNA A took a clean brief and fastened to Resident #18. While still wearing the same gloves CNA A removed the linen from the bed and then removed her gloves. CNA A then put on a pair of new gloves without first washing or sanitizing her hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/02/24 at 02:44 PM CNA A said she was supposed to wash her hands in between glove changes to prevent the spread of infections. CNA A said she was supposed to change her gloves after they became contaminated to prevent the spread of germs. CNA A said she should have changed her gloves before she placed the new brief on Resident #18 since she had just wiped the resident's bowel movement. CNA A said she should have washed her hands in between glove changes since not doing that could lead to cross contamination. CNA A said she had received training on when to change her gloves and wash her hands and that she knew that but had gotten nervous when being observed and forgotten her steps. CNA A said if she did not change her gloves and wash her hands at the appropriate times then that could possibly lead to infections. During an interview on 10/03/24 at 04:12 PM the DON was made aware of the observation of incontinent care performed by CNA A on Resident #18. The DON said the CNA should have changed her gloves before she touched the new brief and the resident. The DON said CNA A should have also washed or sanitized her hands when she changed her gloves. The DON said if the CNA did not change her gloves and washed or sanitized her hands that could lead to cross contamination and the spread of germs. The DON said the failure probably occurred because CNA A got nervous. The DON said the CNAs received training and competency checks. The DON said CNA A had recently received a competency check and had done fine. The DON said she monitored the CNAs by conducting competency checks which were done by the ADON. The DON said they would have to conduct more training. During an interview on 10/03/24 at 04:16 PM the ADON was made aware of the observation of incontinent care performed by CNA A. The ADON said the CNA should have changed her gloves after she performed the peri-care and also should have washed her hands in between glove change. The ADON said she had conducted competency checks to include CNA A and she had passed. The ADON said they would have to conduct more training. During an interview on 10/03/24 at 05:32 PM the Administrator was made aware of the incontinent care performed by CNA A on Resident #18. The Administrator said the CNA should have changed her gloves once they became contaminated to prevent the spread of germs. The Administrator said CNA A should have washed or sanitized her hands in between glove changes. The Administrator said if the CNA did not change her gloves or washed her hands in between glove changes that could lead to cross contamination. The Administrator said the failure probably occurred because the CNA got nervous since the CNA knew the correct procedures. Resident #20 Record review of Resident #20's Admission record dated 10/02/2024 indicated the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. The admission record revealed the resident has diagnoses that include muscle weakness, reduced mobility, type 2 diabetes mellitus, morbid obesity, and cellulitis. Record review of Resident #20's care plan revealed a focus of I have an ADL self-care performance deficit r/t (Related to) disease processes. Impaired balance, Limited Mobility. Interventions include The resident is dependent on staff for assistance with toileting. Record review of Resident #20's MDS revealed BIMS score = 15 indicating resident was cognitively intact. Bladder and bowel: Bowel continence = Frequently incontinent (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/01/24 at 11:32 AM revealed CNA B performing incontinent care for Resident #20. CNA B donned a gown and gloves prior to entering the resident's room. CNA B unlatched the resident's brief and began wiping the resident's bottom removing bowel movement. CNA B with the same gloves removed the old draw sheet under the resident, placed a new draw sheet then placed a new brief under the resident. Resident #41 Record review of Resident #41's Admission record dated 10/02/2024 indicated the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. The admission record revealed the resident has diagnosed that includes end stage renal disease, Type 2 diabetes mellitus, muscle weakness, and heart failure. Record review of Resident #41's care plan revealed a focus of The resident has frequent bladder incontinence and is at risk for skin breakdown r/t incontinence of urine. Goal includes The resident will remain free from skin breakdown due to incontinence and brief use through the review date. Record review of Resident #41's MDS revealed BIMS score = 15 indicating resident is cognitively intact. Bladder and bowel: urinary continence = frequently incontinent, Bowel continence = Frequently incontinent. Observation on 10/02/24 at 09:45 AM revealed CNA B performing incontinent care for Resident #41. Resident #41 stood up for CNA B. CNA B removed the resident's brief, wiped the resident's bottom removing bowel movement, without changing gloves CNA B placed barrier cream to the resident's bottom, with the same gloves CNA B placed the new brief on the resident and helped pull the resident's pants up. Interview with CNA B on 10/02/24 at 02:01 PM regarding not changing gloves during incontinent care. CNA B states she only ever changes her gloves if they were visibly soiled. CNA B stated she did not think what she was doing was wrong. CNA B acknowledged after explanation of cross contamination that not changing gloves between dirty and clean practices could cause cross contamination. CNA B states she was not sure what the facility policy stated. Record review of the facility's nursing services competency evaluation dated 09/24/2024 indicated in part: Peri/Incontinent care. Wash hands, Apply disposable gloves. Remove soiled clothing or brief, remove gloves clean hands (may use gel) apply new gloves. Clean starting at waist band from center of abdomen and clean outwards from middle to side. Clean the inner thighs from inner to outer area of legs. Use separate section of cloth/wipe for each individual stroke, remove gloves, place soiled items in plastic bag clean hands (may use gel) and apply clean gloves. Record review of the facility's policy titled Hand hygiene dated 10/24/2022 indicated in part: Hand hygiene is used to prevent the spread of pathogens in healthcare settings. Hand hygiene is a general term that describes hand washing using soap and water or the use of an alcohol-based hand rub (ABHR) to destroy harmful pathogens, such as bacteria or viruses, on the hands. You should always perform hand hygiene: Before applying and after removing personal protective equipment (e.g. gloves). (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 the facility's policy titled Infection Control and dated 10/25/2022 indicated in part: This communities' infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. This communities' infection control policies and practices apply equally to all personnel, consultants, contractors, residents, visitors, volunteers, works and the public alike, regardless of race, color, creed, national origin, religion, age, sex, handicap, marital or veteran status or payor source. The objective of our infection control policies and practices are to: prevent, detect, investigate and control infections in the community. Maintain a safe, sanitary and comfortable environment for personnel, residents, visitors and the public. All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter including where and how to find and use pertinent procedures and equipment related to infection control. The depth of employee training shall be appropriate to the degree of direct resident contact and job responsibilities.