STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675774	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Healthcare and Rehabilitation - Greenville	2300 Jack Finney Blvd Greenville, TX 75402

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 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** 34918 Based on observation, interview, and record review, the facility failed to ensure that based on the comprehensive assessment of a resident, the residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for one of 21 residents (Resident #44) reviewed for quality of care. The facility staff failed to ensure Resident #44's splint was placed on his right arm and hand on 06/04/24 and 06/05/24 per physician orders. These failures could place residents at risk of not receiving the care and treatment needed to meet their needs and could result in decreased Range of Motion and worsening of contractures. Findings included: Record review of Resident #44's face sheet dated 06/06/24 reflected a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of aphasia (loss of ability to understand or express speech caused by brain damage), hemiplegia right side (paralysis), and cerebral vascular accident (stroke). Record review of Resident #44's quarterly MDS assessment dated [DATE] reflected a staff assessment for mental status determined the resident was moderately cognitively impaired, he was dependent for his ADL needs and had one side functional limitations in range of motion on both upper and lower limbs. Record review of Resident #44's care plan initiated 11/28/22 reflected, [Resident #44] have right hand that requires splinting related to Cerebral Vascular Accident and contractures .Goal .Maintain current function and prevention of further contractures .Interventions .Right hand splint to be worn daily at 08:00 a.m. and remove splint at 2 p.m. Nursing to apply Right hand splint with wearing schedule daily as tolerated. Record review of Resident #44's Physician order Summary Report dated 06/05/24 reflected, Right hand splint to be worn daily at 8 am and removed splint at 2 pm two times a day with a start date of 01/03/23. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER Legend Healthcare and Rehabilitation - Greenville		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 Jack Finney Blvd Greenville, TX 75402	

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #44's MAR and TAR for June 2024 at 09:45 a.m. reflected RN C had signed the TAR on 06/04/24 which indicated the splint had been placed on at 8 a.m. and off at 2 p.m. and on 06/05/24 it was signed off which indicated the splint had been placed on at 8 a.m. In an observation on 06/04/24 at 10:20 a.m., Resident #44 was observed lying in bed. Resident indicated he was doing okay. Right hand noted to be clenched in a tight fist. No splint in use. Resident was unable to open his right hand. In an observation on 06/04/24 at 12:15 p.m. resident #44 was observed up in a Geri-chair in the dining room. Family members present. No splint on right hand. In an observation on 06/05/24 at 09:30 a.m. Resident #44 was observed in bed. No splint or hand rolls observed on right hand. In an observation on 06/05/24 at 11:10 a.m. Resident #44 remained in bed. No splint in place on resident's right hand. In an observation and interview on 06/05/24 at 11:30 a.m. CNA H entered Resident #44's room to get him up for the day. CNA H stated the CNAs and sometimes therapy are responsible for putting the resident's splint on. She stated she had not put the splint on this morning (06/05/24) because she had just now got his clothes changed. In an interview on 06/05/24 at 11:35 a.m. with RN C, she stated the nurses were responsible for monitoring to ensure the splints were in place for any resident who had orders for splint placement. She stated she thought Resident #44's splint had been placed on the resident. She stated she was not sure why his splint was not on 06/04/24, and again on 06/05/24. She stated she does not check off on the TAR if the splint was not in place and stated the CNAs should be informing her if they had taken it off since he had specific order for it to be in place from 8 am to 2 p.m. In an interview on 06/05/24 at 11:40 a.m. with CNA I, she stated she was assigned to Resident # 44 on 06/04/24. She stated she does not normally work that hall and was not familiar with the resident. She stated she did not put a splint on the resident stating she was not aware he had a splint. She stated an unknown Nurse had told her to put a washcloth in his hand but did not say anything about a splint. She stated she thought the Nurses were responsible for putting on splints. In an interview on 06/05/24 at 11:45 a.m. with ADON A, she stated the nurses were responsible for ensuring splints were in place if they had an order for splint placement. She stated the nurse, or the CNA could put the splints on the resident. She stated the nurse needed to assess the skin at the time of the removal of the splint to ensure no skin issues. She stated failure to ensure placement of splints could result in a decline of mobility and worsening of contractures. On 06/05/24 at 12:50 p.m. Resident # 44 was observed sitting up in Geri-chair in the dining room with family present. Right hand splint was now in place. Interview with resident's Family member, stated the resident did not have his splint on yesterday (06/04/24) when they came at noon. She stated he usually had it on. (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 on 06/05/24 at 02:10 p.m. with the DON, he stated the nurses were responsible for ensuring the splints were in place and should not sign off on the TAR indicating it was in place when it was not. He stated the CNAs had all been trained on splint placement and could put the splints on and take them off, but the nurse needed to ensure the resident was wearing the splint the prescribed amount of time, and if not the reason why. He stated the nurse should also check the skin when the splint is removed. He stated failure to follow the prescribed amount of time or failure to place the splints on a resident could lead to worsening of the contractures and loss of mobility. Review of the facility's undated policy titled, Resident Mobility and Range of Motion, reflected, Resident's will not experience an avoidable reduction in range of motion .Resident with limited range of motion will receive treatment and services to increase and/ or prevent a further decrease in ROM .Residents with limited mobility will receive interventions per the plan of care, which include appropriate services, equipment such as splints and other devices and assistance to maintain or improve mobility unless reduction in mobility is unavoidable .

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for three of five residents (Resident #52, Resident #70, and Resident #85) reviewed for catheter care. 1. The facility failed to ensure CNA D and CNA E maintained the foley catheter drainage bag below Resident #52's bladder during a mechanical lift transfer. 2. The facility failed to ensure RN P maintained Resident #70's foley catheter drainage bag below the bladder level during wound care on 06/03/24. 3. The facility failed to ensure Resident #85's catheter bag did not had contact with the floor. This failure placed residents at risk for not receiving care appropriate to address their incontinence. Findings included: 1. Record review of Resident #52's face sheet dated 06//06/24, reflected a [AGE] year-old male admitted to the facility on [DATE]. Diagnoses included obstructive and reflux uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional), diabetes and obesity. Record review of Resident #52's quarterly MDS assessment dated [DATE] reflected he had a BIMS of 15 which indicted he was cognitively intact, required substantial/maximum assist with toileting and transfers and was frequently incontinent of urine and always incontinent of bowel. Record review of Resident #52's care plan initiated on 04/23/24 reflected, Risk for infection related to foley catheter .Goal .Resident will remain free from signs and symptoms of infection due to catheter .Interventions . Staff will provide catheter care every shift as ordered/indicated . Review of Resident #52's Order Summary report dated 06/06/24, reflected, .Foley catheter care q shift and PRN, Clean with soap and water Keep bag off floor and below bladder level every shift for infection control with a start date of 01/29/24. Observation on 06/06/24 at 09:50 a.m. revealed CNA D and CNA E entered Resident #52's room to get the resident up for the day. CNA D emptied the catheter drainage bag and placed it on the bed while preparing to place the mechanical lift sling under the resident. Both staff positioned the resident on the sling. CNA E picked up the catheter drainage bag and handed it CNA D, who then handed it to Resident #52, and he placed it top of his abdomen. The staff raised the resident from the bed with the catheter drainage bag remaining on the resident's abdomen, above the resident's bladder. Urine was observed flowing back toward the resident's bladder. The staff then positioned him over his wheelchair and lowered him into his chair and then placed the catheter bag onto the side of his wheelchair. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with CNA D on 06/06/24 at 09:55 a.m., he stated she was trained to always keep the catheter drainage bag below the bladder. He stated having it above the bladder could possibility cause the urine to run backwards, which could cause an infection. He stated placing the bag on the bed could cause a risk of cross contamination. In an interview with CNA E on 06/06/24 at 09:58 a.m. she stated they should not have placed the catheter bag in Resident #52's lap. She stated when the resident held out his hand for the bag, they just handed it to him without thinking. She stated she knew the catheter bag and tubing were supposed to be kept below the bladder. She stated failing to do this could cause the urine to back up and might cause an infection. In an interview with the DON on 06/06/24 at 11:30 a.m., he stated any resident with a foley catheter should always have the bag and tubing below the bladder. He stated not keeping the foley catheter bag below the resident's bladder, placed them at risk of a urinary tract infection and cross contamination. He stated to ensure staff were knowledgeable in the care of indwelling catheter the facility does skills competency checks and he stated the ADONs, and Charge Nurses made daily rounds and watched care. He said when staff needed to be re-trained her provided the in-service training. Record review of CNA D's competency check off for catheter care revealed he was proficient in care as of 02/16/24. Record review of CNA E's competency check off for catheter care revealed she was proficient in care as of 02/16/24. 2. A record review of Resident #70's Comprehensive MDS assessment dated [DATE] reflected Resident #70 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses included morbid (severe) obesity due to excess calories, chronic heart failure, and metabolic encephalopathy (a brain disorder caused by a chemical imbalance in the blood due to an illness or organ dysfunction). Resident #70 had a BIMS of 15 which indicated Resident #70's cognition was intact. She had a stage 4 pressure ulcer to the sacrum. She required extensive assistance of two-person physical assistance with personal hygiene and toileting. Record review of Resident #70's care plan initiated on 05/02/24 reflected, [Resident #70] has indwelling foley catheter (a catheter that's inserted into the bladder through the urethra and left in place to drain urine) related to stage 4 wound .Goal . No injury related to catheter and [Resident #70] will remain free from signs and symptoms of infection due to catheter . Review of Resident #70's Order Summary report dated 06/06/24, reflected, Foley catheter care every shift and PRN (as needed), clean with soap and water keep bag off floor and below bladder level with a start date of 04/17/24. Observation on 06/06/24 at 10:33 AM revealed RN P entered Resident #70's room to do wound treatment. RN P unhooked the catheter bag from the bed rail and put it flat on the foot of bed, above the resident's bladder. RN P provided wound care to sacral wound. During the procedure urine was observed flowing back toward the resident's bladder. The staff finished the treatment and then hooked the catheter bag onto the bed rail. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with RN P on 06/06/24 at 10:53 AM she stated she should not have placed the catheter bag on the bed. She stated she knew the catheter bag and tubing were supposed to be kept below the bladder. She stated failing to do this could cause the urine to back up and might cause an infection. 3. Record review of Resident #85's Annual MDS assessment, dated 03/22/2024, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #85 had diagnoses which included: hypertension (high blood pressure), Gastroesophageal Reflux Disease (condition in which stomach acid repeatedly flows back up into the food tube), Anxiety, and Depression (common mental disorder). He was always incontinent of urine and bowel and had a Foley catheter. Resident had BIMS of 9 suggesting Resident #85 had moderate cognitive impairment. Record review of Resident #85's active Physician order dated 7/20/2023 reflected Foley catheter Care every shift and as needed, Clean with soap and water; Keep bag off floor and below bladder level every shift for Infection Control. Record review of Resident #85's comprehensive care plan, dated 04/05/2024, reflected Focus [Resident #85] has indwelling foley catheter. Goals: No injury related to catheter over next 90 days. Interventions: Ensure that catheter is secured to leg and drainage bag is covered. In an Observation and Interview on 06/04/24 at 11:28 AM revealed Resident #85 was in his wheelchair and the catheter bag was in contact with the floor. Resident #85 stated that he had often seen the catheter bag touching the floor many times. Resident #85 then proceeded to pick up the catheter bag tubing and placed it back on the side of his wheelchair. Interview with CNA Q on 06/04/24 at 11:34 AM revealed the catheter bag should not be touching the floor. She stated the CNA or nurses were responsible for emptying the bag. She did not see the catheter bag tubing on the floor until the time of this interview. She stated if the catheter bag was on the floor it could lead to increased risk of infections. In an interview with RN J on 06/5/24 at 2:52 PM revealed the catheter bag tubing should never touch the floor because of increased risk of infection. She stated that she was assigned to the resident and did not see the catheter bag on the floor until the time of this interview. She stated that Resident #85 was not compliant with keeping the catheter tubing off the floor. She stated that Resident #85 had several urine infections in the past and the risk of not keeping the catheter tubing off the floor can lead to increased risk of infection. In an interview with the DON on 6/5/24 at 2:56 PM revealed his expectation was the catheter bag should always be off the ground and below the resident's bladder, per nursing standards. He stated the risk for having a catheter bag in contact with the floor was increased risk for infections. Review of the facility's undated policy titled, Catheter Care, Urinary, reflected, The purpose of this procedure is to prevent catheter-associated urinary tract infections .The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder .Infection control .Use standard precautions when handling or manipulating the drainage system .Be sure the catheter tubing and drainage bag are kept off the floor .

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 42971 Based on interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 2 medication carts (Nurses cart hall 300 and Med Aide Cart Hall 400) of 4 medication carts reviewed for pharmacy services. The facility failed to ensure: 1- RN A, responsible for Nurses Cart hall 300, removed medications in unsecure containers from the Nurses Cart. 2- MA C, responsible for Med Aide Cart hall 400, removed medications in unsecure containers from the Med Aide Cart. These failures could place residents at risk of not having the medication available due to possible drug diversion and at risk of not receiving the intended therapeutic benefit of the medication. Findings Included: 1- Record review and observation on 05/28/24 at 12:48 PM of Nurses Cart Hall 300, with RN A revealed the blister pack for Resident #45's Hydroco/APAP 5 - 325 mg tablet (controlled medication used for pain) had 1 blister seal broken and the pill still inside the broken blister and tapped over. Interview on 05/28/24 at 12:50 PM, RN A stated he was unaware when the blister pack seal was broken, and he was not aware of who might have damaged the blister. He stated the risk would be a potential for drug diversion. He stated the nurses and med aides were responsible to check the medication blister packs for broken seals during the count of narcotics during the change of the shift. He stated the count was done at shift change and the count was correct. He stated he did not see the broken blister during the count. He stated when a broken seal was observed, he would report it to the DON and would discard the pill with another nurse. 2- Record review and observation on 05/28/24 at 1:09 PM of Med Aide Cart Hall 400, with MA C revealed the blister pack for Resident #63's Clonazepam 0.5 mg tablet (controlled medication used for anxiety) had 1 blister seal broken and the pill still inside the broken blister and tapped over. Interview on 05/28/24 at 1:18 PM, MA C stated she was unaware when the blister pack seal was broken, and she was not aware of who might have damaged the blister. She stated the risk would be a potential for drug diversion. She stated the nurses and med aides were responsible to check the medication blister packs for broken seals during the count of narcotics during the change of the shift. She stated she did the count at shift change with the previous shift staff. She stated she did not see the broken blister during the count. She stated if a broken seal was observed, she would report it to the charge nurse. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/30/24 at 8:40 AM, the DON stated she expected if a blister pack medication seal was broken the pill should be discarded. The DON stated it would not be acceptable to keep a pill in a blister pack that was opened. The DON stated the risk would be potential for drug diversion and infection control issue. She stated nurses were responsible for checking the medication blister packs for broken seals during the count on the change of shifts. The DON stated the ADON, and the DON were supposed to check the carts weekly. Record review of the facility's policy Medication Access and Storage revised May 2007, reflected the following: . 13. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction, and reordered from the pharmacy if a current order exists .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 Based on observation, interview, and record review the facility failed to label drugs and biologicals used in the facility in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 (300 hall nurses' medication cart) of 4 medication carts reviewed for pharmacy services in that: The facility failed to ensure the 300 Hall medication cart had: 1- 1 insulin pens with no label and with an expired opened date. 2- 1 insulin pen for Resident #250 with no opened date. These failures could affect residents resulting in diminished effectiveness, and not receiving the therapeutic benefits of the medications. The findings include: 1- Observation on [DATE] at 12:48 PM revealed the 300-hall nurse's medication cart had a pen of Novolin R insulin pen 100 unit/ml, had no label an opened date of [DATE]. The label revealed discard after 28 days. 2- Record review of Resident #250's Comprehensive MDS, dated [DATE], revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses included type 2 diabetes mellitus and elevated blood pressure. She had a BIMS score of 15 indicating her cognition was intact. Record review of Resident #250's physician's orders dated [DATE] revealed an order for Humulin N subcutaneous suspension 100 unit/ml. Inject 30 unit subcutaneously (insertion of medications beneath the skin) at bedtime. Observation on [DATE] at 12:48 PM revealed the 300-hall nurse's medication cart had a vial of Humulin N-100 unit/ml, for Resident #250, that did not have an opened date. Interview on [DATE] at 12:50 PM, RN A stated the insulin pen or vial was supposed to be labeled and have the name of the resident. He stated he did not give any one of the two insulins. He stated the Humulin N insulin belonging to Resident #250 did not have an open date. He stated the purpose of open dates was for expiration purposes because the insulin was only good for 28 days. He stated expired insulin would be ineffective and the insulin with no resident name was supposed to be discarded. Interview on [DATE] at 8:40 AM, the DON stated the insulin flex pens or vial, once opened, needed to be dated because each insulin pen or vial had a 28 or 30 days shelf life and if not thrown out before that time the insulin could lose its effectiveness. The DON stated the Assistant DON and the DON were supposed to do random check of the medication carts for monitoring. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy Medication Access and Storage revised [DATE], reflected the following: . 13. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction, and reordered from the pharmacy if a current order exists .

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F 0806

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48560

Based on observation, interview and record review, the facility failed to ensure each resident received food that accommodated their preferences for four (Resident #66, Resident #250, Resident #73, Resident #1) of 24 residents reviewed for dietary services.

The facility failed to honor Resident #250's preference for no pork.

The facility failed to provide snacks for dialysis for Resident #66 and Resident #73.

The facility failed to provide Resident #1 with food that accommodated his preferences.

This failure could place residents at risk for not having their choices and food preferences accommodated, possible weight loss and a diminished quality of life.

Findings include:

1- Resident #66

Record Review of Resident #66s face sheet revealed she was admitted to facility with initial admitted [DATE]. Her relevant diagnoses include Diabetes Mellitus (increased blood glucose), Hypothyroidism (low thyroid hormone levels), Hypertension (high blood pressure), Dependence on Renal Dialysis (involves relying on a dialysis machine to treat failure of the kidneys).

Record Review of Quarterly MDS assessment dated [DATE] reflected Resident #66 had BIMS of 15 which indicated resident was cognitively intact.

Record Review of Resident #66s care plan revised 8/24/2023 reflected, Focus: [Resident #66] needs dialysis related to Renal Failure . Goal: Will have immediate intervention should any signs and symptoms of complications from dialysis occur through the review date. Interventions: May take snack to dialysis.

In an interview on 05/28/24 at 11:15 AM Resident#66 stated she underwent dialysis three times a week at an outside dialysis facility. She stated she left the nursing facility about 4:00 AM three days a week. She stated the facility did not send anything with her for snacks and did not hold her breakfast. She stated she had to wait for lunch when she returned to the facility. She stated she would like to get a snack from the facility, if available.

2- Resident #250

Record review of Resident #250 Face sheet dated 5/21/2024 revealed Resident#250s initial admitted to the facility was 5/21/2024. Her relevant diagnoses included: Anxiety disorder, Diabetes Mellitus (high blood glucose), Protein calorie Malnutrition (supply of protein, calories or both is inadequate) and hypertension (high blood pressure).

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Healthcare and Rehabilitation - Greenville	2300 Jack Finney Blvd Greenville, TX 75402

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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 0806

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Record Review of Resident #250 physician order dated 5/21/2024 reflected Low Concentrated Sweets diet, Regular texture, Thin liquids consistency, NO PORK.

Record Review of Resident#250 s care plan dated 5/21/2024 reflected, Focus: Has potential nutritional problem. Goal: Will maintain adequate nutritional status as evidenced by maintaining weight with no signs and symptoms of malnutrition through review date. Intervention: Honor resident rights to make personal dietary choices and provide dietary education as needed.

In an Observation and Interview on 05/28/24 at 12:36 PM revealed Resident #250's lunch meal consisted of pizza with pepperoni, bread and steamed green beans. Resident #250 stated she cannot eat pork since it did not agree with her system. She stated that she had told her preference for not being served pork for meals to the facility staff, however Resident #250 was not able to identify which staff she had told. Resident #250 stated that she will not eat the pizza and did not know what alternatives were available.

In an interview on 5/29/24 at 10:53 AM with RN A stated that he was not aware that Resident #250 preferred not eating pork. He stated that Resident #250 was new to the facility, and he was not sure if Resident #250 dietary preference were noted by the Dietary Manager. He stated he will inform the kitchen regarding Resident #250 preferences. RN A stated that Resident preferences for food should be accommodated within a reasonable means and suitable alternatives should be provided. He stated that if Resident's preferences are not met it could lead to decrease quality of life and possible weight loss.

3-Resident #73

Record Review of Resident #73s face sheet revealed she was admitted to the facility with initial admitted [DATE]. Her Relevant diagnoses included: End Stage Renal Disease (permanent stage of chronic kidney disease that occurs when the kidneys can no longer function on their own), Dysphagia (difficulty with swallowing), Diabetes Mellitus (high blood glucose), Essential Hypertension (high blood pressure), Dependence on renal Dialysis (involves relying on a dialysis machine to treat failure of the kidneys).

Record Review of Quarterly MDS assessment dated [DATE] reflected Resident #73 had BIMS of 13 which indicated resident was cognitively intact.

Record Review of Resident#73's care plan revised 1/8/2024 reflected, Focus : [Resident#73] needs hemodialysis related to Renal failure. Goal: Will have no signs and symptoms of complications from dialysis through the review date. Intervention: May send snack with resident to dialysis.

In an interview on 05/28/24 at 1:45 PM with Resident # 73 stated she underwent dialysis three times a week and at an outside dialysis facility. She stated she left the nursing facility about 10:00 a.m. She stated the facility does not provides her snacks for her trips to dialysis. She stated she takes her own snacks that her family brings to her. She stated she would take snacks from the facility if nursing facility provided them.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with LVN H on 5/29/24 at 1:46 PM revealed that both Resident #66 and Resident #73 did not get snacks from the facility before going to dialysis since November 2023. She stated that she had seen Resident #66 and Resident #73 prepare their own snacks or the family provided them with snacks. She stated that Facility provided nighttime snacks, however no snacks were provided specifically for the residents who went to dialysis. LVN H stated that facility should attempt to provide snack choices to dialysis resident and failure to do so may result in decreased quality of life and possible weight loss. In an interview on 5/29/24 at 12:29 PM with Dietary Manager stated she had been the Dietary manager for about a week at the facility. She was not familiar with Kitchen policies. She stated that previous Dietary Manager had stopped the practice of providing alternate menus to the residents since she worked as a [NAME] in the same facility prior to being promoted as a Dietary manager She stated that all residents are provided with snacks, however she did not know if the dialysis resident received a packed snack from the facility before they went to dialysis. She stated that when Residents were gone for a long time , they should be provided with snacks and their food choices should be honored. She also stated that Resident #250 was newer to the facility and the dietary manager was not aware that Resident #250 could not eat pork. She stated she was educated regarding the process of obtaining Resident food preferences on the day of this interview. The Dietary manager stated Residents food preferences and choices should be met by the facility and not doing so can lead to decreased quality of life. In an interview on 5/29/24 at 12:50 PM the Dietitian stated that it was her expectation that Resident food choice, preferences and allergies were met by the facility within reasonable means. The Dietitian stated she thought Resident #66 and Resident #73 were provided a snack for dialysis since it was outlined in their care plan but stated she had not checked whether the facility was providing one. She stated [NAME] resident #250s preference for not having pork should have been honored and a substitute protein alternative should have been offered. The dietitian stated the facility had learned on the day of this interview that the previous dietary manager was not providing residents with preference sheets. She stated failure to honor Resident food choices and preferences can lead to decreased quality of life and possible weight loss. In phone Interview on 5/30/24 at 11:31 AM the Dietitian stated the facility did not have a Resident Dining and food preference policy available for review. 4- Resident #1 Review of Resident #1 Face Sheet dated 03/30/24 revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident's diagnosis included Cerebral Infarction due to unspecified occlusion (also known as a stroke), Hemiplegia and Hemiparesis following cerebral infarction (which occurs after a stroke), and Aphasia following cerebral infarction (a language disorder that can occur after a stroke). Interview with Resident #1 on 05/28/24 at 2:15pm, revealed the food is ok but the portion sizes of the food could be larger. He stated the kitchen does not give 2nd servings when requested. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Dietary Manager on 05/29/24 at 10:55am, revealed the portion sizes are listed on menu tickets. The Dietary Manager stated a resident can change the portion sizes. The Dietary Manager stated monthly menus, without alternatives, are posted at the end of each hall and daily menus are posted in the dining room (with alternatives). The Dietary Manager stated the breakfast daily menu is not listed in the dining room. The Dietary Manager stated CNAs inform residents, who do not come to the dining room for meals, of the menu options. The Dietary Manager stated those residents relay their choice, changes, and request for 2nd servings to the CNAs who inform the kitchen staff. An interview with CNA F on 05/29/24 at 11:20am, revealed residents who eat in their rooms are only informed of the menu if asked. The CNA stated if the resident requested an alternative or 2nd helping, the kitchen was informed right away. The CNA stated 2nd helpings are provided after every resident has been served. An interview with the DON on 05/29/24 at 12:30pm, revealed CNAs received meal tickets from the Dietary Manager and then provided meal tickets to residents who circle their choices. The DON stated the choices contained substitutions as well. Interview with Resident #1 on 05/29/24 at 12:40pm, revealed he has never received a meal ticket outlining meal options and alternatives. Resident #1 stated the only alternative he was aware of is a grilled cheese sandwich. 49640

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48560 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 for the facility's only kitchen 1. The facility failed to ensure food items in the facility refrigerator, freezer and dry storage were dated or labeled. 2. The facility failed to ensure dented cans were stored away from the main dry storage area. 3. The facility failed to ensure Dietary manager checked food temperature before serving during lunch meal service on 5/29/24. These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness if consumed and food contamination. Findings included: Observation in the facility's kitchen on 5/28/24 at 10:54 AM revealed one-gallon Ziplock bag of orange mashed food. Observation in Facility's dry storage on 5/28/2 at 10:44 AM of kitchen dry storage area revealed 3 cans of canned butterbeans and 1 can Chicken Broth were dented and stored within the storage area with other canned goods. Observation of lunch meal service on 5/29/24 at 12:06 PM revealed that Dietary manager went to the dry storage to obtain a big can of chicken noodle soup. She opened the can and poured it in a container. She then placed the soup container on the gas stove to heat it for about 2 minutes. Later, she poured the soup from the container into small bowls, covered it up and placed them on the food cart to be delivered to the residents. The Dietary manager did not check the temperature of the soup before serving it to the residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Dietary Manager on 5/29/24 at 12:29 PM revealed she was not sure what exactly was in the bag stored in the refrigerator and she threw it away on 5/28/24 due to it being unlabeled. She stated that she knew all food items in the kitchen should be labeled and dated . She stated that cooks, Dietary aides, and herself were responsible for dating and labeling all food items. She stated it was important to label and date all food items in the kitchen; so that food can be identified properly, and older items can be used first to decrease the risk of any food borne illness. The Dietary manager stated she saw the dented cans in the dry storage on 5/27/24 and meant to remove them and put them in her office but had not yet gotten around to it yet. The Dietary manager stated dented cans should not be used because they could result in contamination such as metal shavings or rust or have a broken seal that could make residents sick. The Dietary manager also stated that she forgot to measure temperature of the chicken noodle soup before serving it to the residents because they were in the process of serving lunch and she didn't want the residents to wait on it . She stated that she knew that the soup temperature should have been checked before serving it to residents to prevent any food borne illness. In an interview with the Dietitian on 5/29/24 at 12:50 PM she stated that it was her expectation that dented cans cannot be stored with regular canned goods because it may cause food borne illness if used inadvertently. She stated there was a place in the Dietary manager's office to secure dented cans. She stated it was her expectation that all foods in the kitchen should be labeled and dated and not doing so can increase risk of food borne illness for residents. The Dietitian stated that she expected the food service manager to heat canned goods including soup adequately and measure temperature of all foods before serving them to residents. The risk of not obtaining food temperatures before serving it to the residents can lead to food borne illness. In an interview with [NAME] G on 5/29/24 at 1:02 PM revealed that she was aware all foods in the kitchen should be dated and labeled. She stated that she was not aware who left the un-labeled item in the facility refrigerator. She stated that everyone in the kitchen including cooks, aides and dietary manager were responsible for dating and labeling food items. She stated that dented cans needed to be stored separately and was not sure why they were not stored in the Dietary manager's office. She stated that it might have been overlooked and can cause the resident to get sick if served. She stated that cooks usually obtain food temperatures before serving it to the residents. She stated that not obtaining food temperature, or not dating and labeling food items can lead to risk of food borne illness to the resident. In another phone Interview with the Dietitian on 5/30/24 at 11:31 AM stated the facility did not have a Food storage policy that included dating or labeling food items, storage of dented cans; Food temperature safety, however referred to Texas Food Establishment rules (TFER) for guidance. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Food and Drug Administration Food Code, dated 2022, reflected, .3-302.12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food, or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food 3-305.11 Food Storage.(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety Review of Food and Drug Administrative Food Code, dated 2022, reflected, .Chapter 3. Food Condition 3-101.11 Safe, Unadulterated, and Honestly Presented The 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. Review of Food and Drug Administrative Food Code, dated 2022, reflected .5. Develop and Implement Standard Operating Procedures (SOPs) Following standardized, written procedures for performing various tasks ensures that quality, efficiency, and safety criteria are met each time the task is performed Procedures are implemented for measuring temperatures at a given frequency and for taking appropriate corrective actions to prevent hazards associated inadequate cooking.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 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 and to help prevent the development and transmission of communicable diseases and infections for three of sixteen residents (Resident #78, Resident #13 and Resident #51) observed for infection control. 1. The facility failed to ensure that CNA D performed hand hygiene while providing incontinence care to Resident #78 on 06/04/24. 2. The facility failed to ensure that CNA F changed his gloves and performed hand hygiene while providing incontinence care to Resident #13 on 06/04/24. 3. The facility failed to ensure that CNA L changed her gloves and performed hand hygiene while providing incontinence care to Resident #51 on 06/04/24. These failures could place the residents at risk of cross-contamination and development of infection. Findings included: 1. Record review of Resident #78's Face sheet dated 06/06/24 reflected a [AGE] year-old male with an admitted [DATE]. Diagnoses included cerebral infarction (disrupted blood flow to the brain), hemiplegia affecting right side (paralysis) and chronic kidney disease. Record review of Resident #78's quarterly MDS assessment dated [DATE] reflected resident had a BIMS of 2 which indicated he was severely cognitively impaired. He was dependent for ADL care and was frequently incontinent of bladder and bowel. An observation on 06/04/24 at 11:30 a.m. revealed CNA D and CNA E entered Resident #78's room to provide incontinence care. Both staff washed their hands and put on gloves. CNA D unfastened the resident's brief and cleaned down each groin, across the pubic area and retracted the foreskin and cleaned the tip of the penis, wiped down the shaft and changed the wipes with each pass. Both staff assisted the resident onto his side revealing he had a moderate bowel movement. CNA D cleaned the resident from front to back, removed his gloves and put on clean gloves without performing hand hygiene. CNA D placed a clean brief under the resident and both staff repositioned the resident back onto his back and fastened the brief. Both staff then removed their gloves and washed their hands. In an interview with CNA D on 06/04/24 at11:20 a.m. he stated he was supposed to do hand hygiene before, after cleaning the resident, and when he changed his gloves and after completion. He stated he forgot to do hand hygiene when he changed his gloves after cleaning the resident. He stated the risk for failing to do hand hygiene was infection and cross contamination. Record review of CNA D's competency check off for hand hygiene revealed he was proficient in care as of 02/16/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #13's Face sheet dated 06/06/24 reflected a [AGE] year-old female with an admitted [DATE]. Diagnoses included multiple sclerosis (chronic disease of the central nervous system), and overactive bladder. Record review of Resident #13's quarterly MDS assessment, dated 05/07/24, reflected she had a BIMS of 9 which indicated she was moderately cognitively impaired. She was dependent of care for all ADL. She was frequently incontinent of urine and always incontinent of bowel. In an observation on 06/04/24 at 03:20 p.m. CNA F and CNA G were observed entering Resident #13's room to transfer resident with a mechanical lift from her Geri-chair to the bed. Both staff washed their hands and put on gloves. The resident was transferred without incident. CNA F removed his gloves and left the room without performing hand hygiene to retrieve supplies for incontinences care. CNA F returned to the room and put on gloves without performing hand hygiene. CNA F opened the resident's brief and wiped down each groin, across the pubic area and down the middle using a different wipe each time. Both staff rolled the resident onto her side and CNA F removed the soiled brief and placed a clean brief under the resident before cleaning her peri anal area and buttocks. CNA F proceeded to wipe the resident's anal area revealing small bowel movement which fell on to the clean brief. CAN F picked up the bowel movement with a wipe, leaving a smear on the upper portion of the brief, and threw it into the trash can. CNA F continued with peri care and rolled the resident back onto the soiled brief and fastened the brief. Wearing the same gloves, CNA F adjusted the bed, and both staff removed the resident's gown and put a clean gown, covered her up and repositioned her in the bed. Both staff removed their gloves and washed their hands. In an interview on 06/06/24 at 03:40 p.m. with CNA F he stated he was supposed to wash his hands before and after care. He stated he was not aware he had to change his gloves after he finished cleaning the resident and before touching the clean brief or the resident's clean gown. He then stated he could see the risk of infections. He stated he should have washed his hands when he came back into the room with the supplies. In an interview on 06/04/24 at 03:50 p.m. with ADON A she stated staff were supposed to wash hands and change gloves before, after completion of cleaning a resident, and after completion of care. She stated she did the skills checks on her CNAs and any additional training they might need. She stated they were all taught to change their gloves when going from dirty to clean. She stated the risk of failing to perform hand hygiene is increased infections and cross contamination. 3. Record review of Resident #51's Face sheet dated 06/06/24 reflected Resident #51 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses included paraplegia (paralysis that affects legs, but not arms) and chronic respiratory failure Record review of Resident #51's Comprehensive MDS assessment, dated 04/05/24, reflected Resident #51's cognition was severely impaired. The MDS assessment indicated Resident #51 was dependent of care for all ADLs. He requires 2 persons assist with rolling left and right. He was always incontinent of urine and bowel. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/04/24 at 10:13 AM revealed CNA L entered Resident #51's room to provide incontinence care. CNA L had gloves in her hands. She unfastened Resident #51's brief and cleaned down each groin, across the pubic area and retracted the foreskin and cleaned the tip of the penis and wiped down the shaft. She removed her gloves and put on clean gloves without performing hand hygiene. She wiped the resident's buttock area with peri-wipes, front to back. She then removed the soiled brief and with soiled gloves, placed the clean brief under the resident. LVN N entered the room, and she helped CNA L to roll Resident #51 on his back onto the clean brief. LVN N left the room to bring clean linen. CNA L fastened the resident's brief. LVN N entered the room with clean linens, and CNA L covered Resident #51 with the blanket. Both staff removed their gloves and washed their hands. In an interview on 06/04/24 at 10:45 AM, CNA L stated she was supposed to do hand hygiene before, after, and in the middle of the procedure of incontinent care. She stated she should change her gloves and perform hand hygiene when she went from dirty to clean. She stated she was nervous and forgot to change gloves and perform hand hygiene. CNA L stated failing to provide proper care exposed the resident to infections. Record review of CNA L's competency check off for hand hygiene revealed she was proficient in care as of 08/28/23. In an interview on 06/06/24 at 11:11 a.m. with the DON he stated hand Hygiene was to be done before incontinence care, staff were to change gloves and perform hand hygiene after cleaning the resident and before putting on a clean brief and clean clothing. He stated the ADONs did skill checks on the staff, and he expected the ADON's and Charge nurses to make rounds and observe care provided by the staff. He stated if the ADON's or Charge nurses determine additional training was needed then he provided the training through in-services. He stated the failure to follow the procedure was risk of infection and cross contamination. Record review of CNA F's skill checks reflected both staff were skills checked on 06/04/24 and were competent in hand hygiene and perineal care. In a follow up interview with ADON A on 06/06/24 at 02:00 p.m. she stated she had been unable to locate CNA's F and G previous skills checks. She stated she knew the previous DON had performed those skills checks because they had a clinic where all the staff were skills checked with a mannequin, but stated she could not locate the documents. She stated she re-educated both staff and checked their competency on 06/04/24. Record review of the facility's undated policy titled, Handwashing/Hand Hygiene, reflected, The Facility considers hand hygiene the primary means to prevent the spread of infections All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection .Wash hands with soap and water .when hands are visibly soiled .Use an alcohol-based hand rub .Before and after direct contact with residents .Before moving from a contaminated body site to a clean body site during resident care .After removing gloves .Hand hygiene is the final step after removing and disposing of personal protective equipment .The use of gloves does not replace hand washing/hand hygiene .