STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675790	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garland Nursing and Rehabilitation	321 N Shiloh Rd Garland, TX 75042

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0558

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Reasonably accommodate the needs and preferences of each resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50444

Based on observations, interviews, and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 5 (Resident #58, #56, #54, #61, and #120) of 18 residents reviewed for Reasonable Accommodation of Needs.

The facility failed to ensure the call light was in reach and accessible for Residents #58, #56, #54, #61, and #120.

This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.

The findings included:

Resident #58

Record review of Resident 58's Face Sheet, dated 03/18/2025, reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #58 had diagnoses which included unspecified dementia (mental decline that interferes with daily life) and repeated falls.

Record review of Resident #58's Quarterly MDS (assessment used to determine functional capabilities and health needs) Assessment, dated 02/13/2025, reflected the resident had severe impairment in cognition with a BIMS (screening tool used to assess cognitive status) score of 04. Section GG indicated the resident required substantial assistance with self-care.

Record review of Resident #58's Comprehensive Care Plan, dated 02/27/2025, reflected the resident has a history of falls and is at risk for increased falls and or fractures AEB cognitive impairment, physical impairment, unsteady gait and one intervention was encourage the use of call light.

An observation and interview on 03/16/2025 at 08:48 AM revealed Resident #58 sitting on the side of her bed. The call light was clipped to the light over the resident's bed and was not within the resident's reach. Resident #58 did not respond when asked if she could reach her call light. CNA F came into the resident's room and stated she would move the call light so the resident could reach it.

Resident #56

(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: 675790	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2025
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident 56's Face Sheet, dated 03/18/2025, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #56 had diagnoses which included the need for assistance with personal care and other abnormalities of gait and mobility. Record review of Resident #56's Quarterly MDS Assessment, dated 02/13/2025, indicated the resident had moderate impairment in cognition with a BIMS score of 12. Section GG indicated the resident required moderate assistance with mobility. Record review of Resident #56's Comprehensive Care Plan, dated 01/09/2025, reflected the resident was at risk for falls d/t unsteady gait and at risk for increased falls and/or fractures and one intervention was to keep call light in reach at all times. During an observation and interview on 03/16/25 at 08:50 AM, Resident #56 was sitting on his bed. Resident #56 did not have a roommate. The two call lights in the room were attached to the bedrail of the unoccupied bed. Resident #56 stated he did not know where his call light was, but he did not use it much. Resident #54 Record review of Resident #54's Face Sheet, dated 03/18/2025, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #54 had diagnoses which included Alzheimer's disease (a progressive brain disorder that affects the ability to think and remember things) and muscle wasting and atrophy. Record review of Resident #54's Quarterly MDS Assessment, dated 01/27/2025, indicated the resident had severe impairment in cognition with a BIMS score of 03. Section O indicated the resident received physical therapy and occupation therapy services. Record review of Resident #54's Comprehensive Care Plan, dated 02/27/2025, reflected the resident was at risk for fall r/t lack of coordination, unsteady gait. One intervention was to keep call light within reach. During an observation and interview on 03/16/25 at 9:06 AM, Resident #54 was sitting in a recliner in her room. Resident #54's call light and her roommate's call light were both attached to the roommate's bedrail. The recliner was placed between the two beds. Resident #54 was unable to answer questions because of her cognitive status. Resident #61 Record review of Resident #61's Face Sheet, dated 03/18/2025, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #61 had diagnoses which included cerebral infarction (stroke) and other seizures (abnormal electrical activity in the brain). Record review of Resident #61's Quarterly MDS Assessment, dated 12/23/2024, indicated the resident had severe impairment in cognition with a BIMS score of 06. Section O indicated the resident received physical therapy and occupation therapy services. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #61's Comprehensive Care Plan, dated 02/27/2025, reflected the resident had a history of falls. Some interventions included keep call light within reach and encourage use of call light. During an observation and interview on 03/16/2025 at 9:12 AM, Resident #61 was lying in bed. Resident #61's call light was on the floor under her wheelchair. There was a nightstand between the bed and the wheelchair. Resident #61 stated it was fine and she could get to her call light if she needed it. Resident #120 Record review of Resident #120's Face Sheet, dated 03/17/25, reflected he was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included heart failure, shortness of breath, and mini strokes. Record review of Resident #120's Quarterly Minimum Data Set (MDS) assessment, dated 02/11/25, reflected he had a BIMS score of 8 (moderate impairment). For ADL care it reflected for transfers, toileting, and bathing the resident required extensive assistance. Record review of Resident #120's Quarterly Care Plan, dated 02/24/25, reflected the resident was a risk for falls and an intervention was to encourage the resident to use the call light. In an observation and interview on 03/16/25 at 09:00 AM, CNA J observed Resident #120's call light on the floor, out of reach for the resident's use. The CNA picked up the resident's call light off the floor and clipped it to his bed. She stated the call light needed to be in reach of the resident so he could alert staff if he needed assistance. During an interview on 03/16/25 at 09:18 AM, CNA F stated the residents were assigned to her. She stated it was important for all the residents to have their call lights within reach. She stated the residents needed to be able to call staff for assistance. She stated they might be sick or need help. She stated if the residents had to use their voice to call out for help, staff might not hear them. CNA F stated she would move the call lights so the residents could reach them. During an interview on 03/16/25 at 09:23 AM, LVN H stated it was important for residents to be able to reach their call lights to alert staff if they needed assistance. LVN H stated if a resident fell or had an emergency, the call light should be placed where the resident could reach it. During an interview on 03/17/24 at 08:47 AM, the DON stated some residents don't know what to do with the call light. She stated staff may forget to go back to the residents' rooms and make sure the residents have not moved their call lights. The DON stated the residents on the unit wander in and out of the rooms. She stated when a resident goes back to their room to lay down, staff need to go to the room and make sure the call light was in reach. She stated it was important to have a call light so the residents can call for help. She stated residents on the unit rarely use the call light, but it is their method of calling for help when they were in their room. She stated staff would be in-serviced about this. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/18/25 at 10:10 AM, the ADON stated most of the residents in the locked unit pull their call light and disconnect it from the wall. She stated staff try to keep the call lights in the residents' reach as much as possible. The ADON stated some residents use their call light and some do not. She stated the use of a call light was different on the unit but it should be there if the resident needed it, especially when the resident was in the room. She stated everyone was responsible for ensuring the residents could reach their call light. She stated that included administration, therapy services, nursing staff, and any other member of staff. She stated if a resident could not reach their call light, they might not receive help when they need it. The facility's policy Answering the Call Light, revised March 2021, 2024, reflected 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review, the facility failed to treat each resident with respect, dignity, and care in a manner and environment that promoted maintenance or enhancement of his or her quality of life for one (Resident #50) of nine residents reviewed for Privacy. The facility failed to ensure RN B assessed and flushed Resident #50's midline catheter (a device inserted in the veins used for treatment) inside the resident's room on 03/17/2025. This failure could place the residents at risk of not having their personal privacy maintained during medical treatment. Findings included: Record review of Resident #50's Face Sheet, dated 03/17/2025, reflected a [AGE] year-old female resident admitted to the facility on [DATE]. The resident was diagnosed with urinary tract infection on 01/27/2025. Record review of Resident #50's Quarterly MDS Assessment, dated 12/12/2024, reflected the resident was unable to complete the interview to determine the BIMS score. Record review of Resident #50's Physician Order, dated 03/16/2025, reflected ERTAPENEM 1 GM /100 mL NS . ACTIVATE, MIX, & INFUSE 1 BAG INTRAVENOUSLY AT A RATE OF 200 ML/HR EVERY 24 HOURS FOR 14 DAYS for urinary tract infection. Record review of Resident#50's Physician Order, dated 03/17/2025, reflected Midline on right arm for IV (intravenous: administering fluids or medications directly into a vein) antibiotics. Observation and interview on 03/17/2025 at 12:01 PM revealed Resident #50 was in the hallway with RN B. Resident #50 was observed with midline to the left upper arm with scant bleeding. RN B said she was assessing the resident's IV site if it was infiltrated or dislodged because there was blood surrounding the IV site. She said she would try to flush it to see what was going on with the resident's IV and see if she needed to transfer her IV. RN B took the IV flush syringe from the top of her cart and started to flush the resident's IV. Observation on 03/17/2025 at 12:04 PM revealed the DON told RN B that she should assess and flush the IV site inside the resident's room to provide privacy. In an interview on 03/17/2025 at 12:07, the DON stated she did not see RN B flushing Resident #50's IV. She said if she did, RN B was not providing privacy to the resident. She said even if she was just assessing the IV site, the assessment should be done inside the resident's room with door closed or the privacy curtain pulled. She said all treatments should be done inside the room to provide privacy and dignity and to avoid embarrassment. The DON said the expectation was for the staff to make sure that when they were providing any kind of treatment, they should do it inside the residents' room with the door closed or with the privacy curtain were pulled. She concluded that she would continually remind the staff the importance of providing privacy and dignity through an in-service. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/17/2025 at 12:43 PM, RN B stated she should have assessed and flushed Resident #50's IV site inside her room to provide privacy and dignity. She said the IV was inserted early that morning and the order for the antibiotics wereas given the day before. She said she should have ushered the resident to her room and did the assessment and the flushing in the privacy of the resident's room. She said the DON already did a one-on-one in-service about dignity and privacy. In an interview on 03/18/2025 at 7:23 AM, the Administrator stated the expectation was for the staff to make sure that the residents were provided privacy during any treatment to prevent embarrassment. He said he would collaborate with the DON and the ADON to do an in-service about providing dignity and privacy. In an interview on 03/18/2025 at 10:07 AM, the ADON stated all treatments should be done in the privacy of the residents' room to promote dignity and privacy. She said allevery care done by the staff should be behind the door so other staff, other residents, or even the visitors would not see or speculate the medical condition of the residents. She said it did not matter if the residents care or not, the treatment should be done inside the room and not on the hallway. She said the expectation was for the staff to be mindful when they were providing any treatment. She said she would coordinate with the DON to do an in-service about privacy during treatment. In an interview on 03/18/2025 at 10:33 AM, Resident #50 stated she had an IV because she had UTI . She said a staff member inserted the IV early that morning so she could start the antibiotics. She said she was with RN B in the hallway because RN B was trying to figure out what was going on with her IV. She said she did not mind but if it should be done inside the room, then it should be done inside the room. Record review of the facility's policy, Dignity 2001 MED-PASS revised February 2021 revealed Policy Statement: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem . Policy Interpretation and Implementation . 11. Staff promote, maintain, and protect resident privacy, including bodily privacy during . treatment procedures.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observations, interviews, and record review the facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for 9 of 12 resident rooms (Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, #8, and #9) reviewed for environment. The facility failed to ensure Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, #8, and #9 were thoroughly cleaned and sanitized. This deficient practice could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life. Findings included: An observation on 03/16/25 at 11:05 Am of resident room [ROOM NUMBER] reflected the air vent along the wall of the room had thick black and brown dirt along and between the vents. The bathroom sink faucet had thick white stains along the base of the faucet. The soap dispenser had a reddish stain on the base of it. An observation on 03/16/25 at 11:12 Am of resident room [ROOM NUMBER] reflected the air vent along the wall of the room had thick black and brown dirt along and between the vents. The bathroom sink faucet had thick white stains along the base of the faucet. The soap dispenser had a reddish stain on the base of it and behind the room door was a large hole on the wall. An observation on 03/16/25 at 11:23 Am of resident room [ROOM NUMBER] reflected the air vent along the wall of the room had thick black and brown dirt along and between the vents. The bathroom sink faucet had thick white stains along the base of the faucet. The soap dispenser had a reddish stain on the base of it. The mini fridge in the room had brown and red stains inside the bottom of it. An observation on 03/16/25 at 11:28 Am of resident room [ROOM NUMBER] reflected the air vent along the wall of the room had thick black and brown dirt along and between the vents. The window ledge had dirt particles along the windowsill. The mini fridge in the room had brown and red stains inside the bottom of it. An observation on 03/16/25 at 11:31 Am of resident room [ROOM NUMBER] reflected the air vent along the wall of the room had thick black and brown dirt along and between the vents. An observation on 03/16/25 at 11:34 Am of resident room [ROOM NUMBER] reflected the air vent along the wall of the room had thick black and brown dirt along and between the vents. An observation on 03/16/25 at 11:39 Am of resident room [ROOM NUMBER] reflected the air vent along the wall of the room had thick black and brown dirt along and between the vents. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 03/16/25 at 11:42 Am of resident room [ROOM NUMBER] reflected the air vent along the wall of the room had thick black and brown dirt along and between the vents. An observation on 03/17/25 at 12:24 Am of resident room [ROOM NUMBER] reflected behind a resident's bed, large amounts of drywall debris between the bed and wall. During a Resident Council meeting on 03/17/5 at 11:00 AM, Resident #50 stated her room did not get cleaned every day. She stated when she dropped items on her floor, she had seen the same items on the room floor the next day because her room was not cleaned. In an interview on 03/17/25 at 12:35 PM, Housekeeper C stated she had been at the facility a year. She stated they were responsible for cleaning the vents, windows, bathroom, dust, and the mini fridges. She stated she cleaned different halls daily. She was shown pictures of the concerns observed in room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, #8, and #9 and she stated they were responsible for ensuring the concerns observed were cleaned. She stated the risk of not ensuring the rooms were thoroughly cleaned could impact the health of the residents. In an interview on 03/17/25 at 12:46 PM, Housekeeper K stated she had been at the facility since August 2024. She stated they were responsible for cleaning the floors, sweep and mop, vents, windows, bathroom, dust, but the housekeeping manager cleaned the mini fridges. She stated she was responsible for cleaning the 600 hall. She was shown pictures of the concerns observed for room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, #8, and #9. She stated they were responsible for ensuring the concerns observed were cleaned. She stated the risk of not ensuring the rooms were thoroughly cleaned they could get sick and the items in the mini fridge should be thrown out. In an interview on 03/18/25 at 09:52 AM, the Housekeeping Supervisor, stated she had been at the facility for 2 years. She stated housekeeping were supposed to clean the bathrooms, clean the floors, wipe down furniture, take out trash, clean air vents, but she did not know who was responsible for cleaning the mini fridge in the resident rooms. She was shown pictures of the concerns observed in room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, #8, and #9. She stated leadership was supposed to check for any issues with resident rooms during their morning rounds. She stated the risk of not cleaning the rooms thoroughly was this was their home, and it was not homelike. In an interview on 03/18/25 at 10:30 AM, the Administrator was shown pictures of the concerns observed in Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, #8, and #9. He stated it appeared housekeeping was not doing a thorough job cleaning the resident rooms, the housekeeping supervisor was not following up and checking housekeeping work, and leadership were not checking for room cleanliness during their daily rounds. He stated he had just hired a maintenance person, to repair issues such as the hole in the resident's wall. He stated the risk of not addressing these concerns could impact infection control. Record review of the facility's policy on Homelike Environment (February 2021) reflected Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible . 2. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. clean, sanitary, and orderly environment

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on interviews, and record review, the facility failed to ensure assessments accurately reflected the resident's status for one (Resident #43) of eight residents reviewed for Accuracy of Assessments. The facility failed to ensure Resident #43's Quarterly MDS assessment dated [DATE] accurately reflected that the resident had an external catheter (non-invasive device used to manage urinary incontinence such as Purewick). This failure could place the resident at risk for not receiving care and services to meet their needs, diminished function of health, and regression in their overall health. Findings included: Review of Resident #43's Face Sheet, dated 03/16/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with neuromuscular dysfunction of bladder (the muscles and nerves that control the bladder do not work properly due to illness). Review of Resident #43's Quarterly MDS Assessment, dated 01/17/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment did not indicate that the resident was using an external catheter. Review of Resident #43's Comprehensive Care Plan, dated 02/27/2025, reflected the resident was frequently incontinent and used Purewick (non-invasive urinary drainage device that uses suction to collect urine from the body) while in bed and one of the approaches was to check the output every shift. Review of Resident #43's Physician Order, dated 09/29/2023, reflected Purewick: Output every shift. Observation and interview on 03/16/2025 at 8:57 AM revealed Resident #43 was in her bed, awake. It was observed that the resident had a Purewick system at her bedside. The resident said she used it when she was in bed but would take it off when she went out of her room. She said she had been using a Purewick for two years. In an interview on 03/17/2025 at 6:40 AM, LVN A stated Resident #43 had been using Purewick ever since she started working in the facility two years ago. She said nurses and CNAs monitored the output every shift. She said the resident had it every time she was in bed. In an interview on 03/17/2025 at 12:14 PM, the DON stated she was not familiar with the MDS. She said if the resident was using an external catheter, then the resident's MDS should reflect it. She said the MDS Nurse was responsible for doing the MDS and if the assessment in the MDS was not accurate, the care needed by the resident would not be metD (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/17/2025 at 1:01 PM, the MDS Nurse stated the purpose of the MDS was to collect and record pertinent data about the resident. The data collected were the resident's demographics, cognition, behavior, functional abilities, diagnosis, and if the resident was using any kind of treatment. She said the MDS was used to do a basic assessment of the resident that could be from the documentation of the nurses or through a face-to-face. She turned on her computer and went to Resident #43's profile. She said the resident had a diagnosis of neuromuscular dysfunction of bladder, had an order to monitor the output collected in the Purewick, had a care plan for the Purewick, but it was not coded for an external catheter. She said it was an oversight on her part and missed the resident was using Purewick as a form of an external catheter. She said she would audit the MDS' of the residents and would make sure that everything was coded appropriately. She said if the residents were not properly assessed, the needs would not be met, and there could be confusion in the provision of care and in doing the care plan. In an interview on 03/18/2025 at 7:53 AM, the Administrator stated the MDS was done to reflect the current condition of the resident. He said if there was no accurate assessment, there could be a misunderstanding about the care needed. He said he would coordinate with the DON and the MDS Nurses to evaluate and resolve the issue. Record review of the facility policy, Certifying Accuracy of the Resident Assessment 2001 MED-PASS, Inc. (Revised November 2019) revealed Policy Interpretation and Implementation . 3. The information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment. Different items on the MDS may have different observation periods . 4. The Resident Assessment Coordinator is responsible for ensuring that an MDS assessment has been completed for each resident.

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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** 47743 Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for a resident for two (Resident #11 and Resident #50) of eight residents reviewed for Care Plans. 1. The facility failed to ensure Resident #50 smoking cigarettes at the facility was care planned. 2. The facility failed to ensure Resident #11's breathing treatments were care planned. These failures could place the residents at risk of not receiving the necessary care and services needed. Findings included: 1. Record review of Resident #50's Face Sheet, dated 03/17/25, reflected she was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included heart failure, absence of left leg and right leg below the knees, and history of falls. Record review of Resident #50's Quarterly Minimum Data Set (MDS) assessment, dated 12/12/24, reflected she had no BIMS score recorded. The resident had an active diagnosis of Chronic Obstructive Pulmonary Disease (inflammation of airways). Record review of Resident #50's Quarterly Care Plan, dated 02/27/25, did not reflect a care plan for the resident being a smoker. Record review of the facility's list of smokers provided on 03/17/25, revealed Resident #50 was a smoker. In an interview on 03/17/25 at 12:00 PM, the Social Worker stated she was responsible for completing smoking assessments and ensuring Resident #50 was care planned for smoking. She stated she gets a list from the nursing staff; she completed the quarterly assessments and ensured residents who smoke were care planned. She stated the risk of not care planning the resident being a smoker, could impact the care of the resident. She stated she did not know how she overlooked the resident. In an interview on 03/17/25 at 01:02 PM, the MDS Nurse stated she had been at the facility since 2018. She stated she input the information for care plans and sometimes the DON. She stated the residents care should be care planned because it drove the care of the resident and if not care planned, they might not receive the care. She stated Resident #50 should have been care planned for smoking to ensure that she was a safe smoker. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #11's Face Sheet, dated 03/16/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with acute respiratory failure with hypoxia (insufficient amount of oxygen in the body). Record review of Resident #11's Quarterly MDS Assessment, dated 01/30/2025, reflected the resident had severe impairment in cognition with a BIMS score of 00 (resident required significant assistance and support in daily life). The Comprehensive MDS Assessment indicated the resident had respiratory failure. Record review of Resident #11's Comprehensive Care Plan, dated 02/27/2025, reflected Resident #11's care plan for respiratory failure did not include his breathing treatment. Record review of Resident #11's Physician Order, dated 10/23/2024, reflected Budesonide 0.25 MG/2ML Suspension. INHALE THE CONTENTS OF 1 VIAL VIA NEBULIZER TWICE DAILY for acute respiratory failure with hypoxia. Observation and interview on 03/16/2025 at 9:12 AM revealed LVN A was about to do Resident #11's breathing treatment. She opened the resident's drawer and took the resident's breathing mask, put the solution in it, and placed it on the resident's nose. She said the resident had an order for a breathing treatment two times a day. In an interview on 03/17/2025 at 11:47 AM, the ADON stated every resident must have a comprehensive care plan, so the staff were in sync with the care of the residents. She said without the care plan, appropriate and needed interventions might not be provided. She said the expectation was all the issues of the residents were care planned. She said if the resident had a breathing treatment, the care plan should reflect that the resident was receiving a breathing treatment. She said she would coordinate with the DON and the MDS Nurse on how to make sure the residents were care planned accordingly. Observation and interview on 03/17/2025 at 12:14 PM, the DON stated every resident needed a detailed care plan to ensure the residents received the care needed. The DON said the care plan should be in place so the staff providing care would be on the same page and without the care plan, there could be confusion with the care needed by the residents. The DON said the care plan should reflect the resident's problem lists, the goals, and the interventions. The DON logged on to her computer and saw the resident had an order for a breathing treatment. She then checked the resident's care plan and saw Resident #11 did not have a care plan for the breathing treatment. The DON started to make a care plan for the resident's breathing treatment. She said the MDS Nurse and herself were responsible in doing the care plans of the resident. She said the expectation was every resident had detailed care plans. She said she would coordinate with the MDS Nurse to audit the care plans of the residents. Observation and interview on 03/17/2025 at 1:01 PM, the MDS Nurse stated care plans were done so the staff would know the care and services needed by the residents. She said if a resident had a breathing treatment, then the care plan should reflect that the resident was receiving a breathing treatment. She logged on to her computer and saw the resident had an order for a breathing treatment, twice a day. She then checked the resident's care plan and saw that the DON made a care plan for the resident's breathing treatmnet earlier that day. She said she would audit the care plans of the residents and would edit them if needed. She said she was responsible for the care , and it was an oversight on her part. (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 03/18/2025 at 7:53 AM, the Administrator stated all the care, services, and treatment done for the resident should be reflected in their care plans to make sure the staff would not know and understand what kind of care to provide. The Administrator concluded that the expectation was for the staff to ensure that the residents' care plans were complete and individualized. He said he would coordinate with the DON and the MDS Nurse to make sure all the residents were care planned accordingly. Record review of the facility's policy, Comprehensive Care Plans . Operations revised 1-26-2024 revealed Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident . to meet a resident's medical, nursing, mental and psychosocial needs . Policy Explanation and Compliance Guidelines . 3. The comprehensive care plan will describe . f. Resident specific interventions that reflect the resident's needs and preferences.

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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** 45055 Based on observations, interviews, and record reviews, the facility failed to ensure that residents' environment remained free of accident hazards as was possible for 3 of 6 residents (Resident #17, #26, and #34) reviewed for accident prevention. The facility failed to ensure Resident #17, and Resident #26 had physician orders for the use of a scoop mattress for fall prevention. The facility failed to ensure Resident #34 had a fall mat placed alongside her bed for fall prevention. These failures could prevent the resident from having an environment that was free and clear of accidents and hazards. Findings included: 1. Record review of Resident #17's Face Sheet, dated 03/17/25, reflected she was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included unsteadiness on feet, dementia (cognitive decline), and history of falling. Record review of Resident #17's Quarterly Minimum Data Set (MDS) assessment, dated 03/14/25, reflected she had a BIMS score of 12 (moderate impairment). For ADL care it reflected for transfers, toileting, and bathing the resident required extensive assistance. Record review of Resident #17's Quarterly Care Plan, dated 01/12/25, reflected the resident was at risk for falls and an intervention was to provide a scoop mattress. Record review of Resident #17's physician orders, dated 03/16/25, reflected no physician orders for the scoop mattress. An observation on 03/16/25 at 09:25 AM, revealed Resident #17 had a scoop mattress on her bed. 2. Record review of Resident #26's Face Sheet, dated 03/16/25, reflected he was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included cerebral infarction (stroke) and absence of left leg, below the knee. Record review of Resident #26's Quarterly Minimum Data Set (MDS) assessment, dated 02/05/25, reflected he had a BIMS score of 15 (intact cognitive response). For ADL care it reflected for transfers, toileting, and bathing the resident required extensive assistance. Record review of Resident #26's Quarterly Care Plan, dated 01/30/25, did not reflect the resident was a fall risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #26's physician orders, dated 03/16/25, reflected no physician orders for the scoop mattress. An observation on 03/16/25 at 11:47 AM, revealed Resident #26 had a scoop mattress on her bed. 3. Record review of Resident #34's Face Sheet, dated 03/17/25, reflected she was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included unsteadiness on feet, disorders of bone density and structure (weak bones), and history of falling. Record review of Resident #34's Quarterly Minimum Data Set (MDS) assessment, dated 12/16/24, reflected she had a BIMS score of 99 (unable to complete the interview). For ADL care it reflected for transfers, toileting, and bathing the resident required total assistance. Record review of Resident #34's Quarterly Care Plan, dated 01/12/25, reflected the resident was at risk for falls and an intervention was to provide a fall mat alongside the resident's bed. In an interview oin 03/16/25 at 02:15 PM, the DON was advised of Resident #17 and Resident #26 having scoop mattresses. She stated Resident #17 was care planned for a scoop mattress because she was a fall risk but Resident #26 should not have a scoop mattress. She stated Resident #26 would be provided a different mattress and she would obtain physician orders for Resident #17. She would not provide risk of residents having scoop mattresses without physician orders. In an observation and interview on 03/17/25 at 09:55 AM, RN F stated Resident #34 had a history of falls and she had recently had an injury of unknown origin. She stated her bed should be lowered and a fall mat placed alongside her bed. RN F observed no fall mat alongside the resident's bed. She stated they had failed to place the fall mat next to the resident's bed after she had returned from the hospital. She stated the risk of the fall mat not being placed alongside the resident's bed could result in her falling out of bed and injuring herself. She stated the nurses were responsible for checking for this. In an interview on 03/18/25 at 10:10 AM, the ADON was advised Resident #34 was observed without a floor mat placed alongside her bed and she stated the nurses and CNAs were supposed to monitor her to ensure the fall mat was alongside her bed. She stated the risk of the fall mat not being placed alongside the bed could result in an injury. The facility's policy Fall Prevention Program (11/24) reflected Policy:Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for five (Resident #10, #11, #32, #49, and #120) of ten residents reviewed for Respiratory Care. 1. The facility failed to ensure Resident #120's nasal canula (flexible tube used to deliver oxygen to the nose through two prongs), for the oxygen machine was placed in a sanitary bag to avoid contamination while not in use on 3/16/2025. 2. The facility failed to ensure Resident #10's humidifier bottle (a medical device designed to increase the moisture level in supplemental oxygen) had water in it on 03/16/2025. 3. The facility failed to ensure Resident #11's breathing mask for his nebulizer (a medical device that turns liquid medicine into mist that could be inhaled through a face mask) was properly stored when not in use on 03/16/2025. 4. The facility failed to ensure Resident #49's breathing mask and nasal cannula were properly stored when not in use on 03/16/2025. 5. The facility failed to ensure Resident #32's breathing mask for her nebulizer was properly stored when not in use on 03/16/2025. These failures could place residents at risk for respiratory infection and not having their respiratory needs met. Findings included: 1. Record review of Resident #120's Face Sheet, dated 03/17/25, reflected he was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included heart failure, shortness of breath, and mini strokes. Record review of Resident #120's Quarterly Minimum Data Set (MDS) assessment, dated 02/11/25, reflected he had a BIMS score of 8 (moderate impairment). The resident had an active diagnosis of respiratory failure. Record review of Resident #120's Quarterly Care Plan, dated 02/24/25, reflected the resident experienced shortness of breath and an intervention was the use of oxygen therapy. Record review of Resident #120's Physician orders, dated 03/16/25, reflected oxygen at 2 liters via nasal canula to keep oxygen saturation above 94% as needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and observation on 03/16/25 at 09:00 AM, RN I observed Resident #120's nasal cannula hanging on the oxygen concentrator unbagged. She stated the resident's nasal canula should be bagged when it was not in use. She stated the risk of the resident's nasal canula not being bagged could result in an infection. 2. Record review of Resident #10's Face Sheet, dated 03/16/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with respiratory failure with hypoxia (insufficient amount of oxygen in the body). Record review of Resident #10's Comprehensive MDS Assessment, dated 02/02/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had respiratory failure. Record review of Resident #10's Comprehensive Care Plan, dated 02/27/2025, reflected the resident had episodes of shortness of breath and one of the approaches was to apply O2 as ordered. Record review of Resident #10's Physician Orders, dated 05/16/2024, reflected Monitor Oxygen Humidification Bottle every shift. Replace or Refill as required every shift. Observation and interview on 03/16/2025 at 8:57 AM, Resident #10 was in her bed, awake. It was observed that the resident was using oxygen at 2 liters per minute. She said she had been using since last year. She said she thought her bottle was already dry because her nose was already dry. It was observed that a prefilled humidifier bottle was attached to her oxygen concentrator and was already empty. She said she could not remember when the last time the humidifier bottle was changed. 3. Record review of Resident #11's Face Sheet, dated 03/16/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with acute respiratory failure with hypoxia. Record review of Resident #11's Quarterly MDS Assessment, dated 01/30/2025, reflected the resident had severe impairment in cognition with a BIMS score of 00 (resident required significant assistance and support in daily life). The Comprehensive MDS Assessment indicated the resident had respiratory failure. Record review of Resident #11's Comprehensive Care Plan, dated 02/27/2025, reflected Resident #11's care plan for respiratory failure did not include his breathing treatment. Record review of Resident #11's Physician Order, dated 10/23/2024, reflected Budesonide 0.25 MG/2ML Suspension. INHALE THE CONTENTS OF 1 VIAL VIA NEBULIZER TWICE DAILY for acute respiratory failure with hypoxia. Observation on 03/16/2025 at 9:12 A revealed LVN A was about to do Resident #11's breathing treatment. She opened the resident's drawer and took out the resident's breathing mask. The breathing mask was not bagged. She cleaned the breathing mask before administering the breathing treatment. 4. Record review of Resident #49's Face Sheet, dated 03/16/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #49's Comprehensive MDS Assessment, dated 02/26/2025, reflected the resident was cognitively intact with a BIMS score of 14. The Comprehensive MDS Assessment indicated the resident had chronic obstructive disease and was on oxygen therapy. Record review of Resident #49's Comprehensive Care Plan, dated 01/10/2025, reflected the resident had episodes of shortness of breath and one of the approaches was to administer medications as ordered. Record review of Resident #49's Physician Orders, dated 03/10/2025, reflected Nasal Cannula (Continuous): O2 @ (2)L/Min every shift. Record review of Resident #49's Physician Orders, dated 09/13/2024, reflected Albuterol Sulfate (2.5 MG/3ML) 0.083% Nebulization solution. INHALE THE CONTENTS OF 1 VIAL VIA NEBULIZER EVERY 6 HOURS AS NEEDED for asthma (narrowing of the airways). Observation on 03/16/2025 at 8:48 AM revealed the resident was not inside her room. It was observed that the resident's breathing mask was on her chair beside the resident's bed and her nasal cannula was on the floor. Both were not bagged. Observation and interview on 03/16/2025 at 9:15 AM, LVN A stated the nasal cannula, and the breathing masks should be bagged whenever the residents were not using them to prevent cross contamination and respiratory infection. She went inside Resident #49's room and saw the breathing mask and the nasal cannula were not bagged. She said she would get a new nasal cannula and breathing mask for Resident #49. She said she did not administer Resident #49's breathing treatment but she should have checked during her morning round if it was stored properly. She said Resident #49 also had an order for continuous oxygen and would use the portable oxygen tank if she went out of her room. She said she did not notice, as well, that the nasal cannula was on the floor. LVN A then went to Resident #10's room and saw the humidifier bottle was empty. She said the oxygen concentrator had a humidifier to keep the nose of the resident moist and to prevent irritation. She said she did not notice during her morning round that Resident #11's humidifier bottle was empty or running low. She said she will get a new pre-filled humidifier bottle for resident #11. LVN A said she administered Resident #11's breathing treatment and when she took it from Resident #11's drawer, it was not inside a bag. She said she would also get a new breathing mask for Resident #11. In an interview on 03/17/2025 at 11:47 AM, the ADON stated the nasal cannula, and the breathing mask should be stored properly inside a plastic bag if the residents were not using them. She said the staff were responsible for ensuring the nasal cannula and the breathing masks were clean every time the residents would use them. She said the expectation was for all nasal cannulas and the breathing masks to be stored properly. She said another expectation was for the staff to check if the pre-filled humidifier bottle was running low or was empty. She said if it was running low, the staff should be ready to change it. She said she would coordinate with the DON to initiate an in-service about respiratory care. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/17/2025 at 12:14 PM, the DON stated the breathing mask and the nasal cannula were supposed to be in a bag when the residents were not using them to prevent cross contamination and worsening of respiratory issues the resident might already have had. She said the oxygen concentrator should always have water in it to prevent dryness and irritation of the nasal passageway. She said the expectation was for the staff to be mindful and make sure the breathing masks and the nasal cannulas were bagged and that there was water in the humidifier bottle. She said she would conduct an in-service about respiratory care. In an interview on 03/18/2025 at 7:53 AM, the Administrator stated everything that the residents were using should be kept clean to prevent infection. He said he would coordinate with the DON to educate and re-educate the nursing staff to bag the nasal cannulas and breathing masks if not in use and to make sure there was water in the oxygen concentrator. He said the DON will in-service the staff about the respiratory care issue. 5. Record review of Resident #32's Face Sheet, dated 03/16/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with post COVID-19 (an acute disease caused by a virus) condition. Record review of Resident #32's Comprehensive MDS Assessment, dated 02/02/2025, reflected the resident had severe impairment in cognition with a BIMS score of 03. Record review of Resident #32's Comprehensive Care Plan, dated 01/27/2025, reflected the resident had episodes of shortness of breath and one of the approaches was to apply O2 as ordered. Record review of Resident #32's Physician Orders, dated 04/26/2023, reflected Ipratropium-Albuterol 0.5-2.5 (3) MG/3ML Solution. INHALE THE CONTENTS OF 1 VIAL VIA NEBULIZER EVERY 4 HOURS AS NEEDED FOR COUGH AND WHEEZING for Post COVID-19 condition. Observation and interview on 03/16/2025 at 9:18 AM revealed Resident #32 was in her bed, awake. It was observed that the resident had a nebulizer machine with a breathing mask attached to it on top of her side table. The breathing mask was not bagged. When asked how long she had been using the breathing mask, the resident shrugged her shoulders. Observation on 03/18/2025 at 8:17 AM revealed Resident #32's breathing mask was still on top of the resident's side table, unbagged. In an interview on 03/18/2025 at 8:47 AM, RN C stated Resident #32 had an order for a breathing treatment as needed. He said he was not aware when was the last time the resident used the breathing mask. He said if the breathing mask was not in use, it should be bagged to prevent it from getting dirty. He said he would clean the breathing mask and would put it in a plastic bag. Record review of the facility policy Oxygen Administration reviewed February 2025 revealed Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice . Policy Explanation and Compliance Guidelines . 5. Other infection control measures include . f. Keep delivery devices covered in a plastic bag when not in use.

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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. 47743 Based on observations, interviews, and record review, the facility failed to ensure that one (Probiotic) of one medication reviewed for Medication Storage was stored properly. The facility failed to ensure that the Probiotics with an instruction to refrigerate after opening was stored in the refrigerator. These failures could place the residents at risk of not receiving the full benefit of the medications or supplement. Findings included: Observation and interview on 03/17/2025 at 1:43 PM revealed during inspection of hall 500 nurse's cart, there was an over-the-counter probiotics with an instruction at the back, Refrigerate after opening. LVN A took the bottle and read the instruction at the back. She stated she was not aware that some probiotics had to be refrigerated. She said there was a reason why some probiotics needed to be stored in a cool place and she believed it had something to do with the effectivity of the probiotics. She said she did not use it during medication administration earlier. LVN A took the bottle of probiotics and said she was going to show it to the DON. In an interview on 03/18/2025 at 7:23 AM, the Administrator stated the expectation was if the probiotics had an instruction to be refrigerated, the staff should store it inside the refrigerator when they were done administering them. He said he believed it had something to do with the effectiveness of the probiotics. He said he would collaborate with the DON on how to prevent the issue from happening again. In an interview on 03/18/2025 at 8:14 AM, the ADON stated the probiotics that needed to be refrigerated should not be stored in the cart because it would just render the probiotics ineffective, and the residents would not get the full benefit of the supplement. She said the expectation was to refrigerate the medications and supplements that needed to be refrigerated. She said she would also audit the carts to determine if there were other medications or supplements that needed to be stored inside the refrigerator. In an interview on 03/18/2025 at 9:07 AM, the DON stated she was made aware about the unrefrigerated probiotics by LVN A. She said some probiotics needed to be refrigerated to maintain its potency. She said if not refrigerated the probiotics could lose their effectiveness. She said the expectation was for the staff to be mindful of what medications or supplements needed to be stored inside the refrigerator. She said the nurses and the medication aides were responsible for making sure the medications and supplements that needed to be refrigerated after opening were stored in the refrigerator when they were done using it. She said she would do an in-service regarding medication storage. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Garland Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 321 N Shiloh Rd Garland, TX 75042	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy Medication Storage in the Facility Policies and Procedures revised January 2018 revealed Temperature . C. medications requiring refrigeration are kept in a refrigerator.

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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. 45055 Based on observations, interviews, and record review the facility failed to store, prepare, distributed, and serve food in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food and nutrition services. 1. The facility failed to ensure the ice scoop for the ice machine in the facility kitchen was cleaned and exposed to air-borne contaminants. 2. The facility failed to ensure the ice machine was thoroughly cleaned. 3. The facility failed to ensure the kitchen floor and walls were cleaned. 4. The facility failed to ensure kitchen cooking equipment was cleaned. 5. The facility failed to place a cover on top of the tea dispenser to avoid air borne contaminants. 6. The facility failed to ensure food in the refrigerator was labeled and dated. 7. The facility failed to ensure foods in the freezer was sealed from air-borne contaminants. These failures could place residents at risk for cross contamination and other air-borne illnesses. Findings included: Observations on 03/16/25 from 8:44 AM to 9:01 AM in the facility's only kitchen revealed: The ice machine, located in a hallway outside the kitchen, had an ice scoop stored in a black holder, and the lid was not covering the ice scoop from air-borne contaminants. The ice scoop also had ice sitting in it, while in the scoop holder. The ice machine, located in the hallway outside the kitchen had a dirty filter and the inside wall of the machine had light brownish stains. The kitchen floor had built up dirt stains along the walls and the walls had dried brownish stains sprayed on it. One large microwave, located in the kitchen area, had dried up food stains along the inner walls of the microwave. One large table containing the drink dispensers had dark stains under a small machine, near one of the drink dispenser containers. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Two containers containing flour and sugar had white and reddish stains along the lids of the containers. One long tube of ground beef, located in the refrigerator was not dated with the date the item was stored. One large box of frozen roll dough was sitting in a plastic bag unsealed from air-borne contaminants. One large box of frozen vegetable blend was sitting in a plastic bag unsealed from air-borne contaminants. Observations on 03/17/25 at 11:00 AM in the facility's only kitchen revealed: One large tea dispenser, located in the kitchen area, had tea in it and it did not have a lid placed on the top dispenser to avoid air-borne contaminants. In an interview and observation on 03/17/25 at 10:15 AM, the Dietary Manager was shown pictures and observed the concerns discovered in the kitchen. She stated she had a cleaning schedule for her team, and she followed up with them to ensure that the tasks were completed. She stated they had not had time to complete a deep cleaning because of their staffing challenges. She stated they attempted to clean the kitchen and equipment at least once a month. She stated she would remind staff to ensure they completely seal the foods observed in the freezer. She stated her staff often get in a hurry and forget to completely seal the items in the bags. She stated everyone was responsible for ensuring all food were labeled and dated once it was received from the vendor. She stated they cleaned the ice machine once a month. She observed the tea dispenser not being covered after the tea was prepared and she stated that it should have been covered. She stated the risk of not addressing these concerns could result in air-borne and food contamination. In an interview on 03/18/25 at 10:30 AM, the Administrator was shown pictures of the concerns observed in the facility kitchen. He stated they needed to do a more thorough job cleaning in the kitchen area and ensured that foods were stored correctly. He stated the risk of not addressing these concerns could result in an infection. Record review of the facility's policy on Kitchen Sanitation and Cleaning Schedules (undated), revealed All surfaces, including floors, walls, storage shelves, prep tables, trash cans, and all food contact surfaces must be routinely cleaned and sanitized. Ceilings, vents, light fixtures, pipes, and any other potentially contaminated surface will be cleaned as needed. All equipment must be thoroughly washed and sanitized between uses, in different food preparation tasks and anytime contamination occurs or is suspected. Food Storage and Sanitation Do not store scoops in the ice machine or food bins. Clean bins when empty. Store scoops in a sanitary manner to prevent contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, Food shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.

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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 50444

Based on observations, interviews, and record review the facility failed to establish and maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two of twelve (Resident #42 and Resident #15) residents reviewed for infection control.

1. The facility failed to ensure CNA D did not use gloves taken from the pocket of her scrub top while providing incontinence care to Resident #42 on 03/17/2025.

2. The facility failed to ensure CNA F changed her gloves and performed hand hygiene while providing incontinence care to Resident #15 on 03/17/2025.

This failure could place residents at risk of cross-contamination and development of infections.

The findings included:

1. Record review of Resident #42's Face Sheet, dated 03/18/2025, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #92 had diagnoses which included cognitive communication deficit and the need for assistance with personal care.

Record review of Resident #42's Quarterly MDS (assessment used to determine functional capabilities and health needs) Assessment, dated 01/25/2025, indicated the resident had severely impaired cognition with a BIMS (screening tool used to assess cognitive status) score of 5. Section G reflected Resident #42 required extensive assistance with toileting.

Record review of Resident #42's Comprehensive Care Plan, dated 01/20/2025, reflected the resident was incontinent of bowel and bladder and at risk for skin breakdown. One intervention was to check for incontinence every 2 hours and as needed.

On 03/17/2025 at 09:24 AM, CNA D and CNA E were observed providing incontinence care for Resident #42. CNA D and CNA E were wearing gloves. CNA D pulled the privacy curtain around Resident #42's bed and told the resident she was going to change his brief. CNA E pulled down the sheet and blanket to uncover Resident #42 and unfastened the tabs on each side of the brief. CNA D pulled the brief down and used wipes to clean the front of the resident. CNA D dropped the wipes into a trash bag on the floor next to her. CNA E assisted CNA D to turn Resident #42 on his left side and CNA D removed the soiled brief. CNA D cleaned the residents bottom and dropped the soiled brief and wipes into the trash bag on the floor next to her. CNA D removed her gloves and washed her hands in the resident's restroom. CNA D pulled a pair of gloves from the pocket of her scrub top and put them on. CNA E assisted CNA D to roll the resident to his right side and CNA D placed the clean brief under the resident. CNA E straightened the resident's brief and assisted the resident to roll to his back. CNA E secured the tabs and pulled up the blanket to cover the resident. CNA D and CNA E removed their gloves and washed their hands in the resident's restroom.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/17/2025 at 11:55 AM, CNA D stated she was a new CNA and had been at the facility about a month. CNA D stated she did not have access to gloves in the resident's room because the boxes of gloves were stored on a cart in the hall. CNA D stated she took the gloves she needed from the supply cart in the hall and put them in her pocket before going into the resident's room. CNA D agreed carrying clean gloves in the pocket of her scrub top posed a risk for cross-contamination. CNA D stated during her training there were boxes of gloves in the rooms to use during resident care. CNA D stated she would find out what the expectation was for taking gloves into the resident's room. During an interview on 03/18/25 at 08:55 AM, the DON stated CNA D should have placed the gloves in a clean bag to take into the resident's room. The DON stated CNA D should not have placed the gloves in the pocket of her scrub top to carry into the resident's room. The DON stated that was cross contamination. The DON stated the facility would provide in-service training to staff. During an interview on 03/18/2025 at 10:00 AM, the ADON stated CNA D should not have placed gloves in the pocket of her scrub top to use for providing resident care. The ADON stated that was cross contamination. The ADON stated CNA D should have placed the gloves in a clean bag to carry into the resident's room. The ADON stated the facility would provide in-service training to staff. 2. Record review of Resident #15's Face Sheet, dated 03/18/2025, reflected the resident was an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #15 had diagnoses which included Alzheimer's disease (a progressive brain disorder that affects the ability to think and remember things) and the need for assistance with personal care. Record review of Resident #15's Quarterly MDS (assessment used to determine functional capabilities and health needs) Assessment, dated 01/07/2025, indicated a BIMS (screening tool used to assess cognitive status) test was not conducted because the resident was never or rarely understood. The staff assessment indicated the resident had severely impaired cognitive skills for daily decision making. Section G reflected Resident #15 required extensive assistance with toileting. Record review of Resident #15's Comprehensive Care Plan, dated 01/21/2025, reflected the resident was incontinent of bowel and bladder related to cognitive impairment. One intervention was to monitor for incontinence every two hours or as needed and change the resident promptly. On 03/17/2025 at 10:40 AM, CNA F and CNA G were observed providing incontinence care for Resident #15. CNA F pulled the curtain around the bed to provide privacy and told the resident she was going to change his brief. CNA F and G washed their hands in the resident's restroom and put on clean gloves. The incontinence care supplies were on a towel that was draped over the resident's bedside table. CNA F pulled down the brief, cleaned the front of the resident, and dropped the wipes into the wastebasket next to her. CNA F changed gloves without using hand sanitizer or washing her hands. CNA G assisted CNA F to turn the resident to his left side and CNA F cleaned the resident's bottom. CNA F removed the soiled brief and dropped it into the wastebasket next to her. CNA F changed gloves without washing her hands or using hand sanitizer. CNA G assisted CNA F to turn Resident #15 to his left side and CNA F placed a clean brief under the resident. CNA F applied barrier cream to his bottom and CNA G assisted with rolling Resident #15 to his back. CNA G secured the tabs on each side of the brief and pulled up the blanket to cover Resident #15. CNA F and CNA G washed their hands in the resident's restroom after providing care. (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 3/17/25 at 10:53 AM, CNA F stated she should have taken a bottle of hand sanitizer into the room when she provided incontinence care for Resident #15. CNA F stated the facility recently had training about hand washing or using hand sanitizer when providing resident care. CNA F stated it was important to use hand sanitizer or wash your hands after removing dirty gloves to prevent infection. During an interview on 03/17/25 at 12:05 PM, LVN H stated the facility provided in-service training on handwashing frequently. LVN H stated staff were provided with small bottles of hand sanitizer to carry around with them. He stated CNA F should have washed her hands or used hand sanitizer when she took off her dirty gloves and before she put on clean gloves. LVN H stated it was important, so staff did not transmit infection. During an interview on 03/18/25 at 08:55 AM, the DON stated CNA F should have used hand sanitizer or washed her hands each time she removed soiled gloves. The DON stated during training she told staff to provide resident care correctly every time, even when no one was watching. She stated CNA F's failure to use hand sanitizer or wash her hands when providing care caused cross contamination and increased the risk of infection. She stated the facility would provide an in-service training to staff members. During an interview on 03/18/25 at 10:10 AM, the ADON stated her expectation of staff was to use hand sanitizer or wash their hands between glove changes to reduce infection. She stated CNA F should have washed her hands or used hand sanitizer when she changed gloves during incontinence care for Resident #15. The ADON stated staff would receive in-service training. Review of the facility's policy Handwashing/Hand Hygiene, revised 01/20/23, reflected 1. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . 5. Hand hygiene must be performed prior to donning (putting on) and after doffing (removing) gloves.