STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675799	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brenham Nursing and Rehabilitation Center	400 E Sayles St Brenham, TX 77833

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 49097 Based on observation, interview and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 5 of 7 residents (Resident #9, Resident #49, Resident #61, Resident #98 and Resident #106) reviewed for resident rights . 1. The facility failed to ensure Resident #49, Resident #61, Resident #98 and Resident #106's were served their lunch tray at the same time as other residents at the same table for lunch on 11/19/2024 and 11/20/2024 . 2. The facility failed ensure CNA P spoke respectfully to Resident #9 when the resident attempted a self-transfer. These failures could place residents at risk of poor self-esteem and unmet needs and risk of skin breakdown. Findings include: 1. Record review of Resident #9's face sheet, dated 11/20/2024 , reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #9 had diagnoses which included muscle wasting and atrophy (loss of skeletal muscle mass), major depressive disorder (mental health disorder), aphasia (damage to the brain) following cerebral infarction (a condition that that impacts the ability to speak, write and understand language after a stroke) and unsteadiness on feet. Record review of Resident #9's quarterly MDS Assessment, dated 09/27/2024, reflected a BIMS of 06 which indicates severe cognitive impairment. Section GG (Functional Abilities and Goals) reflected she was dependent for chair/bed-to-chair transfers. Record review of Resident #9's quarterly care plan, dated 02/01/24 , reflected she was at high risk for falls related to poor balance, unsteady gait, and poor safety awareness with an intervention of using a mechanical lift for transfers, provided signs in room to remind resident to use call light, and continue to interventions on at-risk plan . (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 11/19/24 at 11:29 AM revealed Resident #9 transferred herself to the toilet assisted by her family member . An observation on 11/20/24 at 3:30 PM revealed Resident #9 smelling of urine. There was water on the floor and the resident was attempting to transfer herself. The State Surveyor went to notify CNA P. The State Surveyor and CNA P walked into the room and CNA P said to the resident in a condescending tone oh no, sit down, you know you're not supposed to do that. CNA P proceeded to help Resident #9 sit in the wheelchair. The resident was faced away from the door, still undressed, shaking her head in her hands. CNA P walked back out and grabbed CNA Q who both assisted her into bed without a mechanical life . After the resident care was completed Resident #9 had a distressed look on her face and was crying in bed. In an interview with Resident #9 on 11/20/2024 at 3:50 PM, she stated her feelings were hurt when they told her to sit down. She did not respond to more questions . In an interview with Resident #9's RP on 11/20/24 at 04:08 PM, she stated she was worried about the resident. She was not supposed to be in the bathroom, but insisted, so she helped her. The facility denied the resident a pad alarm because it was considered a restraint. Resident #9 was not depressed when she was admitted to the facility and was able to voice her needs. RP stated her mood and condition had declined since she moved into the facility. She did not leave her room. She would glare at the staff. She cried and stated they were rough with her Resident #9 would not name any specific staff. RP stated that she had no concerns about the way staff treated the resident. She was concerned about the lack of supervision. The RP stated she asked the facility to get her out of bed and dressed for breakfast. RP stated Resident #9 would not leave her room until she was dressed. The RP stated she asked for increased monitoring by the CNAs, but they started monitoring at the end of the hall every time she visited. Interview with LVN R on 11/20/24 at 04:15 PM, LVN R said she was the only daytime charge nurse on the hall. She did not tolerate any disrespect geared at the residents. She stated there were no reports of CNA P speaking disrespectfully to Resident #9. She stated it would be hard to identify people who were non-verbal who felt uncomfortable around the caregiver. She stated signs demeanor change would be their posture changed when they saw that person. She stated if a resident reported a CNA who disrespected them, she would report it. Interview with the Administrator on 11/21/24 at 3:30 PM, he stated he expected staff to treat the residents with respect and dignity. He did not believe Resident #9 was more vulnerable because of her low BIMS score than the rest of the population. He did not believe the CNA abused Resident #9. He believed CNA P reacted in the moment, and there was no negative or harmful intention in her action. He reported there was no change in Resident #9's demeanor and the resident were upset due to a lack of family at the holiday event in the evening . Record review of records indicated there was no at-risk plan available for the resident #9's chart. A record review of the facility's grievance log for September of 2024 reflected an entry on 09/30/2024, which documented the resident's RP grievance about checking and changing Resident #9. That issue was marked to be resolved the same day by the DON. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #49's face sheet, dated 11/20/2024, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident's diagnoses included dementia (memory, thinking difficulty), muscle wasting, lack of coordination, repeated falls, unsteadiness on feet, anemia (not enough healthy red blood cells), hypertension (high blood pressure), muscle weakness, age related osteoporosis (skeletal disorder), cognitive communication deficit (problems with communication), altered mental state, heart failure and protein-calorie malnutrition. Record review of Resident #49's Quarterly MDS, dated [DATE], reflected Resident #49 had a BIMs score of 2, which meant the resident was severely impaired. Record review of Resident #49's comprehensive care plan, dated 11/06/2024, reflected the resident sometimes was able to make needs known and understood others. 3. Record review of Resident #61's face sheet, dated 11/20/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident's diagnoses included abnormal posture, unsteadiness on feet, type 2 diabetes mellitus without complications (high blood sugar), anxiety, protein- calorie malnutrition, pain in left shoulder, major depressive order, impulsiveness, malaise (feeling of general discomfort), abnormalities of gait and mobility, muscle wasting, and profound intellectual disability . Record review of Resident #61's Quarterly MDS, dated [DATE], reflected Resident #61's BIMs score was 99, which meant the resident was unable to complete the interview. Record review of Resident #61's comprehensive care plan, dated 10/29/2024, reflected the resident rarely was able to make needs known and sometimes understood others. 4. Record review of Resident #98's face sheet, dated 11/20/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident's diagnoses included dementia (memory, thinking difficulty), muscle wasting, lack of coordination, repeated falls, unsteadiness on feet, depression, hypertension (high blood pressure), insomnia (difficulty sleeping), chronic kidney disease, dysuria (painful or uncomfortable urination), delirium due to physiological condition, and abnormalities of gait and mobility . Record review of Resident #98's Quarterly MDS, dated [DATE], reflected Resident #98's BIMs score was 2, which meant the resident was severely impaired. Record review of Resident #98's comprehensive care plan, dated 11/19/2024, reflected the resident had severe impaired cognation. 5. Record review of Resident #106's face sheet, dated 11/20/2024, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident's diagnoses included dementia (memory, thinking difficulty), cognitive communication deficit (problems with communication), impulsiveness, type 2 diabetes mellitus without complications (high blood sugar), weakness, difficulty walking, repeated falls, need for assistance with personal care, insomnia (difficulty sleeping), malaise (feeling of general discomfort) and hypertension (high blood pressure). Record review of Resident #106's Quarterly MDS, dated [DATE], reflected Resident #106's BIMs score was 4, which meant the resident was severely impaired. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #106's comprehensive care plan, dated 11/20/2024, reflected the resident had severe impaired cognitive function. Observation of dining services at lunch on 11/19/2024 at 12:00 PM revealed Resident #61 did not get their meal trays with their tablemate. Residents #61 did not get their meal tray until 6 minutes after their tablemate and staff were passing meal trays to other tables. Observation of dining services at lunch on 11/19/2024 at 12:05 PM revealed Resident #106 did not get her meal tray at the same time as her tablemates. Resident #106 did not get her meal tray until 10 minutes after her tablemates and staff were passing meal trays to other tables. Observation of dining services at lunch on 11/20/2024 at 12:17 PM revealed Residents #49 and #98 did not get their meal trays with their tablemate. Residents #49 and #98 did not get their meal tray until 7 minutes after their tablemate and staff were passing meal trays to other tables. An interview with Resident #106 on 11/19/2024 at 12:07 PM revealed she did not know where her meal tray was, and she said she was starving. She said she was so hungry she did not want to watch her tablemates eat. She said she felt like the staff wanted her to beg for food and she was not going to beg. She said it was not right for her to be so hungry and must watch other people eat and smell the food and not given anything to eat. An interview with Resident #61 on 11/20/2024 at 12:04 PM revealed she did not want to talk to the State Surveyor. An interview with Resident #49 on 11/20/2024 at 12:20pm revealed that she had to wait for her tray all the time. She said that she just wanted her food. An interview with Resident #98 on 11/20/2024 at 12:22 PM revealed the resident did not want to talk to the State Surveyor and just looked at the surveyor. An interview with the DON on 11/21/2024 at 11:16 AM revealed she was trained on resident rights. She said she was not sure what the policy was for meal tray pass. She stated she expected the staff to pass the trays by table. She said all staff in the dining room were responsible for ensuring all residents had their meal tray at the same table before moving on. She said if all residents did not get their meal tray at the same table residents may try to eat of someone else's plate. She said everyone was responsible for monitoring residents all got their trays together. She said everyone should be vigilant when passing by the tables. She said she did not know why the residents did not get their meal tray at the same time. An interview with CNA J on 11/21/2024 at 12:54 PM revealed she was trained on resident rights. She said staff were to pass meal trays to residents at the same table. She said all staff were responsible for ensuring all the residents at a table had their meal trays before moving on. She said it had never happened where a resident had to wait. She said all staff in the dining room were responsible for monitoring to ensure all residents had their meal tray with their tablemates. She said staff would walk around and ensure residents had fluids when they would monitor also. She said she did not know why the residents did not get their meal tray with their tablemates. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with LVN B on 11/21/2024 at 2:05 PM revealed she was trained on resident rights. She said the policy was for the nurse to check the meal trays and for the CNAs to give the trays by table. She said all staff were responsible for ensuring residents at the same table had their meal tray before moving on. She said it was a dignity issue and the resident did not want to watch others eat. She said all staff monitored to ensure the residents all had their meal tray at the same time by walking around and observing. She said she did not know why the residents did not get their meal tray at the same time as their table mates. An interview with the Administrator on 11/21/2024 at 3:26 PM revealed the policy was to pass meal trays by tables so all the resident at the same table could eat together. He said the nurse was responsible for ensuring the residents had their food at the same table. He stated if residents did not get their meal tray together it would leave residents waiting for their food. He said the charge nurse was responsible for monitoring to ensure all residents at the same table had their meal tray before moving on. He said the monitoring was done by observation. He stated the residents did not get their meal tray with their table mates because the nurse pulled the meal tickets was disorganized. Record review of the facility's policy entitled Promoting/Maintaining Resident Dignity, implemented 1/13/23, reflected the following: 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights . 10. Speak Respectfully to the residents. Record review of the Meal Service Policy, dated 10/01/2028, reflected all residents at one table will be served at the same time prior to serving residents at other tables .

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49097 Based on observation, interview and record review the facility failed to ensure residents had a right to personal privacy and confidentiality of his or her personal and medical records for 3 of 15 residents (Resident #26, Resident #58, and Resident # 69) residents reviewed for personal privacy. The facility failed to knock (CNA I) on Resident #26, #58, and #69's room when going into the residents' rooms. The deficient practice could place residents at risk of feeling like their privacy was being invaded or the facility was not their home. Findings include: 1. Record review of Resident #26 face sheet, dated 11/21/2024, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #26 had diagnoses which included type 2 diabetes mellitus with hyperglycemia (high blood sugar), depressive disorder, morbid obesity, vitamin deficiency, major depressive disorder, muscle wasting, muscle weakness, overactive bladder, difficulty walking, lack of coordination, abnormal posture, cognitive communication deficit (problems with communication), and malaise (feeling of general discomfort). Record review of Resident #26's Quarterly MDS, dated [DATE], revealed Resident #26's BIMs score was 14, which meant the resident was cognitively intact . 2. Record review of Resident #58 face sheet, dated 11/21/2024, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #58 had diagnoses which included atrial fibrillation (abnormal heart rhythm), hypertension (high blood pressure), protein-calorie malnutrition, cognitive communication deficit (problems with communication), muscle wasting, contracture left hip and knee (permanently bent), contracture right hip and knee (permanently bent), contracture left hand and elbow (permanently bent), contracture right hand and elbow (permanently bent), abnormal posture, unsteadiness on feet, elevated white blood cell count and edema (swelling). Record review of Resident #58's Quarterly MDS, dated [DATE], revealed Resident #58's BIMs score was 12, which meant the resident was moderately cognitively impaired . 3. Record review of Resident #69 face sheet, dated 11/21/2024, revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #69 had diagnoses which included dementia (memory, thinking, difficulty), hypertension (high blood pressure), major depressive disorder (mental disorder), cognitive communication deficit (problems with communication), cough, diarrhea, muscle wasting, anemia (not enough healthy red blood cells), dry eye, repeated falls, and hypertensive heart disease without heart failure (damage to heart due to chronic high blood pressure). Record review of Resident #69's Quarterly MDS, dated [DATE], revealed Resident #69's BIMs score was 15, which meant the resident was cognitively intact. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/19/2024 at 9:43 AM revealed CNA I opened the door and walked into the room of Resident #26 without knocking. Observation on 11/19/2024 at 2:20 PM revealed CNA I walked into Resident #58 and Resident #69's room without knocking. An interview with Resident #26 on 11/19/2024 at 9:43 AM revealed staff normally knocked. She said there were times when staff did not knock. She also stated she would like for staff to knock . She stated that sometimes it bothered her when staff did not knock. An interview with Resident #69 on 11/21/2024 at 12:21 PM revealed the resident did not want to answer the State Surveyor's questions. An interview with Resident #58 on 11/19/2024 at 12:57 PM revealed the resident did not want to answer the State Surveyor. An interview with CNA I on 11/20/2024 at 2:56 PM revealed she was trained on resident rights. She stated staff were to knock on the resident's door and wait for them to respond before entering . She said staff were to knock every time they were going to go into a resident's room. She said if staff were not knocking then the resident may feel like their privacy was being invaded. She stated if she did not knock on the resident's doors it was because she had already been in the room. She also stated she was supposed to knock even if she had been in the room. An interview with the DON on 1/21/2024 at 11:08 AM revealed she was trained on resident rights. She stated she would have to look at the policy for knocking but her expectation was all staff to knock before entering. She said staff should always knock before entering the resident's room. She said she was not the resident so not sure how it makes them feel. When asked how it might make the resident feel with staff not knocking, she said she was unaware that staff were not knocking on the residents doors. An interview with the Administrator on 11/21/2024 at 3:24 PM revealed he was trained on resident rights. He stated he did not know what the policy stated about knocking but the facility asked staff to knock and wait for a response. He said staff should always knock if they were entering a resident's room. He said every resident was different, but it could make the resident uncomfortable. He said he did not know why staff were not knocking. Record Review of the facility's, undated, Incontinent Care Checklist revealed Knock on the door. This was the only policy provided for knocking . Resident Rights was requested from the administrator on 11/20/2024 at 1:52pm and was not provided before exit.

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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. 50472 Based on observation, interview and record review the facility failed to provide a safe, clean, comfortable, and homelike environment which allowed the resident to use his or her personal belonging to the extent possible for 3 of 10 reviewed on the 100 hall for resident rights. 1. The facility failed to ensure Resident #27, Resident #83, Resident #52 did not have visible dirt behind the beds, in the main walking area and on the furniture. 2. The facility failed to ensure Resident #83 and Resident #52's floors were not sticky while walking . These deficient practices place residents at risk of reduced functional use of the room, decreased resident's satisfaction with their environment and a lack of a homelike environment. Findings Include: An observation on 11/21/24 at 9:30 AM revealed Resident #83's RP spoke to the housekeeping aid. The RP was visibly upset the resident's room had not been swept . An observation on 11/19/24 at 10:17 AM revealed Resident #83 had a large and small broom and dust pans in the room. There were visible crumbs and dirt on the floor, on the chair, and behind the bed. The States Surveyors' feet were sticking to the floor. An observation on 11/19/24 at 10:28 AM revealed the State Surveyor's feet were sticking to the floor in Resident #52's room. An observation on 11/19/24 at 10:11 AM revealed crumbs on the bed and Resident #27's chest. There was visible dirt behind the bathroom door and behind the bed . Interview with Resident #27 on 11/19/24, he stated that the CNA's come by quickly and do not help him clean up after meals. He stated that housekeeping cleaned the room. He cannot look to see if they did a good job. Interview with the RP for Resident #83 on 11/19/24 at 10:17 AM, stated there were issues with room cleanliness, especially on the floor. It was constantly dirty . She stated Resident 83 had Parkinson's disease and dropped things on the floor because of her tremors. When she picked items up off the floor, they had dirt on them. She had filed a grievance with the facility. The RP stated she stopped cleaning because she knew the state survey team was going to come soon. She began to sweep the floors while the interview was being conducted. Interview with Resident #83 at 11/19/24 10:20 AM revealed she did not like the dirty floors because she kept her house very clean prior to coming to the facility. She stated it made her feel bad, like she lived in a dirty place. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with LVN B, Charge Nurse, on 11/21/24 at 02:18 PM, she stated if she saw a dirty room, she would pass it off to maintenance. She did not round with the intent to make sure the resident's rooms were clean, but housekeeping should. She stated any dirty rooms should be passed off the housekeeping. Any major repairs or deep cleanings should be uploaded to the centralized reporting system for maintenance and housekeeping. She believed having a dirty floor would make residents feel bad about their room. Interview with the Administrator on 11/21/24 at 04:26 PM, he said the housekeeping was responsible for cleaning. The supervisor had daily cleaning sheets the housekeeping aids completed. The supervisor should go behind them and double check if the rooms were clean. If a CNA identified a room was dirty, they should either clean it up or report it to the housekeeping manager. He could not speak to how it felt for the residents or how it would negatively impact their perception of the environment . Record review of the facility's Grievance Logs revealed a complaint of room cleanliness on 09/10/24, 10/22/24, and 11/19/24 . No daily cleaning sheets were provided upon exit.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on interviews and record review, the facility failed to ensure data was encoded within 7 days after a facility completed a resident assessment for subject items upon a resident's transfer, reentry, discharge and death for 1 of 4 discharged residents (Resident #109) reviewed for data encoding and transmission. The facility failed to ensure Resident #109's Discharge MDS was encoded or transmitted as of 07/26/2024. This failure could place residents at risk of not having their assessments transmitted timely. The findings include: Record review of Resident #109's face sheet revealed an [AGE] year old female admitted to the facility 06/13/24 and discharged on [DATE] home. Resident #109 had diagnoses which included acute embolism and thrombosis (blood clot conditions that affect the veins and arteries), Takotsubo syndrome (a condition that causes the heart muscle to suddenly weaken and change shape), and other forms of acute ischemic heart disease (a type of heart disease that occurs when the heart's arteries narrow, reduction blood flow to the heart muscle). Record review of Resident #109's EMR revealed the resident's Admission MDS was completed and accepted, but the Discharge MDS assessment was not initiated to where the assessment would be visible, coded, or transmitted as of 11/21/2024, the date it was signed verifying assessment completion. Record review of the RAI (Resident Assessment Instrument) Manual OBRA Assessment Summary, dated October 2023, revealed OBRA Discharge assessments -Return Not Anticipated (A0310F = 10) Must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days. Must be completed (item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days). Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days). In an interview on 11/21/2024 at 2:21 PM, the RN CM MDS personnel, in charge of Medicaid and private pay, stated she missed the discharge assessment and said it was human error and an oversight . In an interview on 11/21/24 at 3:34 the Administrator stated there should be an MDS discharge for every resident. (continued on next page)

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Brenham Nursing and Rehabilitation Center	400 E Sayles St Brenham, TX 77833

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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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Record review of the facility MDS policy, dated 10/24/2022, reflected the purpose of the policy is to provide a system to complete standardized assessments in a timely manner, according to the current RAI Manual. The MDS/RAI Coordinator will be responsible for tracking due dates for all MDS assessment, including OBRA and Medicare PSS assessments. A calendar of schedule assessment, including type of assessment and assessment reference date, will be communicated to those individuals responsible for completing portions of the MDS on a monthly and PRN basis. An OBRA discharge assessment will be completed within 14 days of the discharge date . Part A PPS discharge assessment must be completed within 14 days after the end date of the most recent Medicare stay (A2400C + 14 calendar days). If combined with an OBRA discharge assessment, it must be completed 14 days after the ARD of the OBRA discharge date .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming and personal and oral hygiene for five of ten residents (Resident #74, Resident #79, Resident #83, Resident #103 and Resident #279) reviewed for quality of life. 1. The facility failed to ensure Resident #74 , Resident #79 and Resident #83's nails were cleaned, trimmed, and did not have any rough edges on 11/19/2024. 2. The facility failed to ensure Resident #103 and Resident #279 received their showers. These failures could place residents at risk for not receiving adequate care and services to prevent infection, injury, and diminished quality of life. Findings included: 1. Record review of Resident # 79's face sheet, dated, 12/21/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #79 had diagnoses which included lack of coordination (uncoordinated movement due to a muscle control problem that causes inability to coordinate movements), cognitive communication deficit (difficulty with communication that is caused by an impairment such as memory, attention, or problem-solving), Alzheimer's disease - unspecified (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest task), unspecified dementia, unspecified severity without disturbance, psychotic disturbance, mood disturbance, and anxiety (the loss of cognitive functioning such as: thinking, remembering, and reasoning to the extent that it interferes with a person's daily life and activities without any behavior or mood disturbances), and muscle wasting and atrophy, not elsewhere classified, multiple sites (gradual loss of muscle mass and strength). Record review of Resident #79's Annual MDS Assessment, dated 10/08/2024, reflected the resident had a BIMS score of 3, which indicated her cognition was severely impaired. Resident #79 required supervision or touching assistance with personal hygiene, lower and upper body dressing, and toileting hygiene. Record review of Resident #79's Comprehensive Care Plan, completed on 10/17/2024, reflected Resident #79 had an ADL self-care performance deficit related to unsteadiness on feet, weakness, muscle wasting, dementia, repeated falls, and physical debility. Interventions: Bathing/Showering- check nails cleanliness, length, and trim as needed on bath day and as needed. Report any changes to charge nurse. Resident #79 had severely impaired cognitive function and impaired thought process related to dementia. Resident #79 had severely impaired cognitive function and impaired thought processes related to dementia. Intervention: Anticipate and meet needs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 11/19/2024 at 10:01 AM revealed Resident #79 were in her room lying in bed. Her nails on her right hand were not smooth around the edges and had a blackish/ brownish substance underneath her middle and ring fingernails on her right hand. She also had a blackish/brownish substance on the tip of the middle finger on her right hand. Resident #79 had an odor from her right hand of bowel movement. Resident #79 was not interview able . 2. Record review of Resident #83's face sheet, dated 11/21/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #83 had diagnoses which included lack of coordination (uncoordinated movement due to a muscle control problem that causes inability to coordinate movements), cognitive communication deficit (difficulty with communication that is caused by an impairment such as memory, attention, or problem-solving), Alzheimer's disease - unspecified (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest task), unspecified dementia, unspecified severity without disturbance, psychotic disturbance, mood disturbance, and anxiety (the loss of cognitive functioning such as: thinking, remembering, and reasoning to the extent that it interferes with a person's daily life and activities without any behavior or mood disturbances), and muscle wasting and atrophy, not elsewhere classified, multiple sites (gradual loss of muscle mass and strength). Record review of Resident #83's Quarterly MDS Assessment, dated 08/27/2024, reflected Resident #83 had a BIMS score of 13, which indicated her cognition was intact. Resident #83 required set-up supervision for personal hygiene, oral hygiene and eating. She required substantial/maximal assistance (helper does more than half the work) with showers, upper and lower body dressing, and toileting hygiene. Record review of Resident #83's Comprehensive Care Plan, with a revision date on 11/06/2024, reflected Resident #83 had an ADL self-care performance . Intervention: Resident #83 required extensive assistance from one staff with personal hygiene. She was total dependent on one staff with bathing/showering. Observation on 11/19/24 at 11:12 AM revealed Resident #83 was sitting in the dining room, on her right hand underneath her middle and ring fingernails was blackish/brownish substance. Resident #83 had rough edges around her fingernails on her middle and ring finger on her right and left hand. 3. Record review of Resident #103's Admission Record, dated 11/20/24, revealed reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #103 had with diagnoses that which included heart failure, heart disease, Hypertension (high blood pressure), insomnia (difficulty sleeping), malaise (feeling of general discomfort), muscle wasting, abnormalities of gait and mobility, age related physical debility, chronic kidney disease, difficulty walking, unsteadiness on feet, lack of coordination, and pacemaker. Record review of Resident #103 Quarterly MDS, dated [DATE], revealed reflected Resident #103 had a BIMS score of 13, indicating which indicated Resident #103 had moderate impairment. Record review of Resident #103 documentation revealed reflected he did not have an MDS. His admitted was 11/12/24 and the survey was completed prior to the 14-day required MDS completion deadline. Record review of Resident #103's care plan reflected: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	problem ADL self-care initiation, dated 10/17/2023 and revised 11/19/2024. goal the resident will improve current level of function in (specify ADLs) through review dated initialed 06/07/2024. interventions bathing/showering Resident #103 requires assistance with lower body washing, hair, and back (X1) staff with shower/bathing as scheduled and as necessary. Resident #279 5. Record review of Resident #279's face sheet, dated 11/20/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #279 had diagnoses which included with a diagnosis rhabdomyolysis (a serious medical condition that occurs when muscles tissue breaks down and releases proteins and electrolytes into the bloodstream), staphylococcal arthritis (a painful joint infection caused by the Staphylococcus aureus (bacteria), right knee, and atherosclerotic heart disease of native coronary artery without angina pectoris (disease that occurs when plaque builds up in the arteries, narrowing them and limiting blood flow to the heart). Record review of Resident #279 documentation revealed reflected he did not have an MDS. His admitted was 11/12/24 and the survey was completed prior to the 14-day required MDS completion deadline. Record review of Resident #279's care plan reflected: problem ADL self-care initiation, dated 11/12/2024 and revised 11/18/2024. goal the resident will improve current level of function in (specify ADLs) through review, dated initialed 11/12/2024. interventions bathing/showering provide sponge bath when a full bath or shower can be tolerated, initiation dated 11/18/24, and bathing/showering the resident required extensive assistance resident requires (extensive assistance) by (X1) staff with personal hygiene. Observation and interview on 11/19/2024 at 10:01 AM revealed Resident #74 were was in her room lying in bed. Her nails on her right hand were not smooth around the edges and had a blackish/ brownish substance underneath her middle and ring fingernails on her right hand. She also had a blackish/brownish substance on the tip of the middle finger on her right hand. Resident #74 had an odor from her right hand of bowel movement. Resident #74 was not interview able . Observation on 11/19/24 at 11:12 AM revealed Resident #83 was sitting in the dining room, on her right hand underneath her middle and ring fingernails was blackish/brownish substance. Resident #83 had rough edges around her fingernails on her middle and ring finger on her right and left hand. An interview with Resident #103 on 11/19/2024 at 9:47 AM with Resident #103 revealed that she did not feel the care was good. She stated she had to beg to get her showers . She stated there were times she would go a week without getting a shower. She stated that she had only refused a shower one time . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 11/21/2024 at 10:30 AM, the Director of Nurses stated she would need to refer to the facility's policy on nail care when she was asked of his expectations of cleaning and trimming residents nails. An interview with the DON on 11/21/2024 at 11:18 AM revealed her expectation was for staff to give the resident a preference as to when the resident would like to have a shower. She said staff should give the resident according to their preference. She stated the CNAs were responsible for giving the residents their showers. She said residents should get a shower as needed but at minimum three times a week. She stated the showers were documented in the point of care system. She said the resident could get an infection if they did not get a shower. She said a resident would not get a shower if they refused and the staff would have the refusal documented . She stated she did not know why the residents did not get their showers like they wanted. An interview with CNA J on 11/21/2024 at 1:02 PM revealed residents should get showers when they needed them or on their shower day. She said the CNAs were responsible for giving the residents their showers. She said some residents got their showers more than three times a week and some got their showers twice a week. She said the resident would get depressed or smell if they did not get a shower. She said a resident would not get a shower if they refused or out of the building and it would be documented. She said she did not know why the residents did not get their showers when they were supposed to and when they wanted them. An interview on 11/21/2024 at 2:00 PM, the ADON stated that if Resident #279 had been at the facility since 11/12/24, he should have had a shower and it should have been done on either 11/12/2024 or 11/14/2024 because his shower schedule was Tuesday, Thursday, Saturday. The ADON stated that residents could have skin breakdown or get rashes and get depressed if they did not get cleaned . An interview with LVN B on 11/21/2024 at 2:08 PM revealed that residents were to get a shower three days a week or as needed. She said the CNA's were responsible for giving the residents their showers. She stated the showers are were documented in the point of care system. She said some residents are were just stuck in their ways and do did not want to take a shower. She said if a resident refused it should be documented. She said that if a resident did not get a shower, it could cause them to have breakdown. She said she did not know that the residents did not get their showers on their shower day or when they wanted a shower. An interview with the Administrator on 11/21/2024 at 3:28 PM revealed that residents were to have their showers three times a week on their scheduled day. He said that a resident would not get a shower if they refused, and staff were required to document the refusal. He also said if a resident refused, that staff were to see if another staff member could get the resident to take a shower. He said that if a resident did not get their shower, the resident could have skin breakdown or an infection. He said he had not had complaints about showers recently. He said when he does receive a complaint, he would in-services the staff and talk to the resident and offer a shower right then and there. He said he did not know why the residents did not get their showers on their shower day or when they wanted one. Record review of Resident #279's EMR shower record, dated from his admission on 12/12/2204 2024 through 12/20/2024, reflected he did not receive a shower until 12/29/2024, 8 days after Resident #279's admission to the facility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #103's EMR shower record, dated 10/24/2024 through 11/19/2024, revealed reflected that the resident did not receive a shower from 10/31/2024 until 11/05/2024, 5 days between her showers. She also did not receive a shower from 11/05/2024 until 11/9/2024, 4 days between her showers. She also did not receive a shower from 11/09/2024 until 11/14/2024, 5 days between her showers. Record review of the facility's grievances for October 2024 revealed reflected there were 4 grievances on ADLs . Record review of the facility's grievances for September 2024 revealed reflected there were 6 grievances on ADLs . Record review of the facility's Activities of Daily Living Policy, dated 05/26/2023, revealed reflected The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: Bathing, dressing, grooming and oral care. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 49097

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 50472 Based on observation , interview and record review the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service taking into consideration resident assessments, individual plans of care and the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment for 1 of 1 main kitchen reviewed for sufficient staff and competencies . 1. The facility failed to provide proper training upon hire and regular in services to maintain standards of practice in the kitchen. This deficient practice could place residents at-risk of foodborne illness. The findings were : Observation on 11/19/2024 at 10:45 AM revealed Dietary [NAME] O failed to wash her hands before beginning to make purees. She did not reference her recipes. She did not sanitize her workspace before beginning. She then proceeded to touch the inside of the food processor with her bare hand while attaching it to the base. She did not wash her hands or the machine before grabbing the beef and pouring it into the machine. She went into the pantry and grabbed a beef broth can added to the processor and did not wash her hands. After pouring the broth into the processor she grabbed the lid from side which touched the food and turned it on. When the food was processing beef broth spun out of the container and onto all the other surfaces around. Dietary [NAME] O failed to wash her hands after cleaning up the broth. Observation on 11/19/2024 at 11:40 AM revealed Dietary [NAME] O taking temperatures on the steam table. While she took temperatures of the beef and the potatoes, she did not sanitize the surface before she set down the thermometers. She cleaned off the thermometers and placed them on a dirty surface. She did not leave the thermometer in until the temperature had stabilized. Observation on 11/19/2024 at 12:15 PM revealed Dietary Staff T, while plating trays for lunch service, read a meal slip, placed items on the slip. After looking at the slip Dietary Staff T missed 2/4 items on the tray. Interview with Dietary Staff T at 11/19/2024 at 1:15 PM, he stated he had been at the facility for a while and had shadowed other employees for his kitchen training. When asked about who was responsible for cleaning, he stated he was not sure, but thought it was everyone . Interview with Dietary [NAME] O at 11/19/2024 at 1:20 PM, she stated she was hired in 2021 and did her training shortly after that. She stated the dietitian did in-services and they did one on uniforms recently. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Dietary Manager on 11/20/2024 at 2:15 PM, she stated they do not have a training procedure or policy. All training done in the kitchen was shadowing other employees. The cooks work side by side with her to learn purees. She has no documentation of training done after completion of the basic facility online training. She stated it would be beneficial to have a list of items learned while people progress through their training in the kitchen. Interview with Dietitian on 11/20/2024 at 2:30 pm, she stated she does monthly in-services, but did not have the records with her. Interview with the Regional CDM on 11/19/2024 at 3:45 PM, she stated they needed in-services regularly on hand hygiene and uniforms. The online learning program they had in place covered sanitation, falls, temperatures, uniform, and personal dress. She stated the dietitian did a monthly in-service. Record review of the facility's training program provided for Dietary [NAME] O only covered trainings with the title, Bloodborne Pathogens and Standard Precautions, Clinical and Foodborne Illness and Kitchen Safety . Dietary [NAME] O had a food handler's license. Record review of the facility's policy entitled Hand Washing reflected, Immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles. During food preparation, as often as necessary to remove soil and contamination and prevent cross contamination when changing tasks. Record review of 1 in-service provided by facility staff was entitled uniforms. No other in-services were available. Record review of the facility policy entitled Sanitizing and Calibrating Thermometers, dated 12/01/2011, reflected, Between food items, wipe off any food and place the stem or probe in a sanitizing solution for at least five seconds, then air dry. Record review of the facility policy entitled Taking Food Temperatures, dated 12/01/2011, reflected Food temperatures are recorded once the temperature reading stabilizes.

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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. 50472 Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for one of one kitchen and one of one nourishment room reviewed for food and nutrition services . 1. The facility failed to ensure Dietary [NAME] S wore an effective hair restraint while in the kitchen. 2. The facility failed to ensure the Nourishment Room was maintained, ice was stored properly, and items were correctly labeled and dated. 3. The facility failed to ensure Dietary [NAME] O properly sanitized her hands between tasks . 4. The facility failed to ensure hot water was available for handwashing sinks. 5. The facility failed to ensure personal drinks and cleaning chemicals were separated from the cooking area. These failures could place residents at risk for health complications, foodborne illnesses and decreased a quality of life. Findings include: Observation on 11/19/2024 at 9:10 AM the Maintenance Director was fixing the hand washing sink next to the dining room door. At that time there was no running cold water or hot water . Observation on 11/19/2024 at 9:10 AM there was no hot water in the hand-washing sink by the dry storage. Observation on 11/19/2024 at 9:10 AM revealed Dietary [NAME] S stood by the door with a hairnet worn over her ears and left 3 inches of hair that covered the forehead exposed. Dietary Staff S was also wearing large gold hoop earrings. Observation on 11/19/2024 at 9:10 AM sugar and salt packets laying on the floor behind the shelves in the dry storage. Observation on 11/19/2024 at 9:10 AM, in refrigerator 3, revealed glasses of cranberry juice, 2 glasses of milk, and 1 glass of orange juice sitting in a grey plastic tub covered with no labels or dates. The bottom of the tub contained an unknown liquid and ice. Observation on 11/19/2024 at 9:10 AM revealed an undated and a bucket that was dirty on the outside containing cream cheese icing. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/19/2024 at 9:10 AM revealed an opened carton of eggs in a large plastic container with a lid with an unknown gel like substance on the bottom and shredded cheese scattered throughout the container. Observation on 11/19/2024 at 9:10 AM revealed the floor in the walk-in refrigerator 3 had small packets of butter on the floor, unknown dirt and debris, a single frozen French fry, and a tennis ball sized chunk of ice on the floor. Observation on 11/19/2024 at 9:10 AM revealed a spray can of stainless-steel cleaner and an employee's pink drink cup underneath the steam table. Observation on 11/19/2024 at 9:10 AM revealed the kitchen ice machine with brown substance up inside the ice machine's internal dispenser. Observation on 11/19/2024 at 9:15 AM revealed an empty cardboard glove box and an empty dessert cup underneath the dishwasher. Observation on 1/19/2024 at 9:25 AM revealed a pack of opened and dried cleaning wipes on top of the popcorn machine. Observation on 11/19/2024 at 9:25 AM revealed the inside the popcorn machine residual had a flake like substance. Observation on 11/19/2024 at 9:25 AM revealed a large white ice chest with small brown/black spots over all four walls of the cooler and water inside the cover. The ice chest had a moldy odor when opened. Observation on 11/19/2024 at 9:25 AM revealed an unknown brown substance inside the ice machine of the nourishment room. Observation in nourishment room on 11/19/2024 at 9:30 AM revealed an ice chest with an unknown clear liquid in the bottom. The microwave had a brown paper towel inside it with an unknown red sauce splatter on the top of the microwave. The hot water was not available in the nourishment room. Unlabeled cups were filled with straws next to the cart for ice and water. There was an opened unlabeled coffee creamer, undated cold brew coffee, Styrofoam cups with fluid in them were unlabeled or dated. There was a pack of egg rolls with resident's name but no date. A blue ice chest with ice in it and scoop still in the ice. There was orange soap in same cabinet with food items. Observation on 11/19/2024 at 10:30 am revealed Dietary [NAME] O grabbed the inside of the food processor with her bare hands. She did not wash her hands before starting. She did not wear gloves while preparing the foods. Interview with Dietary [NAME] O on 11/19/2024 at 1:20 pm, she stated she was trained on purees a while ago. It had been over a year since she did her initial training with the facility training program. Interview with the Maintenance Director on 11/19/2024 at 9:10 AM, he stated the water was shut off in this sink for a few days and he was fixing it currently . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Regional CDM on 11/19/2024 at 3:45 PM revealed all hair should be covered by a hairnet. The Regional CDM stated the facility followed the Texas Administrative Code for grooming standards for hair, nails, and jewelry. She stated the dietary staff should be cleaning out the bin completely when juice spills, cleaning out the ice chests when they were emptied of ice, and for maintaining the nourishment room. The facility training program covered sanitation, falls, temperatures, uniform and personal dress and the dietitian did a monthly in-service. Interview with the Dietary Manager on 11/20/2024 at 2:15 PM, she explained they did not have a system set up to clean out the nourishment rooms. She cleaned out the ice machines every three months and they cleaned the scoops daily. They did not have a formal training plan after completing the facility's general training program. They worked with the Dietary Manager and other staff members for 3 days. She stated she did not have any checklists for training. She stated they did in-services on a regular basis. For the coolers, the dietary department cleaned the coolers and refilled them with ice from the kitchen. She had a cleaning schedule that was supposed to be completed by the end of the day. She stated the employees hair should be completely covered by the hair net. Interview with the Administrator on 11/21/2024 at 4:30 PM, he stated the Dietary Manager monitored the cleaning schedule. The dietary staff was responsible for the nourishment room. He was unsure about how often to clean out the ice machines. He stated the dietary staff was supposed to be responsible for throwing away material and the Dietary Manager ensured they were trained. He stated the employees had grooming and uniforms in their job descriptions and they should have followed that. Record review of the facility's policy posted on the nourishment room door stated the refrigerator is for resident's items only, everything should have a label and date, or it will be thrown away . Record review of the facility's job description provided for a cook did not include any details about uniforms or grooming. Record review of the facility's training program provided did not include any trainings about uniforms or grooming. Record review of 1 in-service provided by facility staff was entitled uniforms was performed 10/1/2024. No other in-services before survey started were provided. Record review of the facility's policy entitled Food Storage, dated 12/01/2011, reflected, All refrigerated foods are dated, labeled and tightly sealed, including leftovers, using clean, nonabsorbent, covered containers that are approved for food storage. All leftovers are used within 48 hours. Items that are over 48 hours old are discarded . Record review of the facility's policy entitled Employee Sanitation reflected, hair restraints, such as hats, hair coverings or nets, caps, and beard/moustache restraints (snoods) or other effective hair restraints are worn to keep hair from contacting food and food-contact surfaces. Record review of the facility's policy titled Food Brought by Family/Visitors reflected Food brought by family or visitors that is left with the resident to consume later will be labeled and stored in a manner that is clearly distinguishable. The nursing staff will discard perishable foods on or before the use by date. (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 facility policy entitled Food Preparation and Handling, dated 12/01/2011, reflected, Hands are properly washed before beginning food preparation. Soiled food carts, food equipment or garbage containers are not brought through the food preparation area.

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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** 37435 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 ----- of ----- reviewed for infection control. 1. ADON and LVN did not don a gown before providing care to Resident #112, who was on Enhanced Barrier Precautions. 2. The facility failed to ensure a resident room did not have a urine saturated brief on the floor. These failures could place residents at risk of transmission of disease and infection. Findings include: Record review of Resident #112's face sheet reflected a [AGE] year-old female who was initially admitted to the facility on [DATE]. Her diagnoses included malignant neoplasm of rectum (rectal cancer), history of malignant neoplasm of ovary (ovarian cancer), hypertension, muscle wasting and atrophy of multiple sites (muscles shrinking), chronic kidney disease, age-related osteoporosis (bones softening/brittle), pain, and need for assistance with personal care. Record review of Resident #112's care plan, dated 09/28/24, reflected the resident had alternation in gastrointestinal status colostomy to LUQ related to malignant neoplasm of rectum, and an impairment to skin integrity of the sacrococcygeal related to cancer lesions. Record review of Resident #112's Quarterly MDS assessment, dated 10/10/24 reflected a BIMS score of 14, which indicated her cognition was intact. Resident #112 was incontinent with bowel and bladder. Record review of Resident #112's Skin Assessment, dated 11/18/24, reflected a medial sacrococcygeal cancerous tumor located on the sacrococcygeal area. Record review of Resident #12's Physician Orders, dated 11/19/24, reflected a medial sacrococcygeal cancerous tumor located on the sacrococcygeal area. Wound care orders for tumor to sacrum reflected, Cleanse with wound cleanser/normal saline, pat dry with gauze and leave open to air one time a day for skin management. Keep air clean and dry/Monitor for increased bleeding. and as needed for skin management. Observation on 11/19/24 at 9:00 AM revealed an adult brief in room [ROOM NUMBER] on the floor to the left of the resident's bed beneath the bed side table. The wetness indicator on brief was the blue which indicated the brief was wet and needed changing. Observation on 11/19/24 at 02:17 PM revealed Resident #112 was resting in her bed. She appeared clean and well-groomed, and her room was clean and free of odors. Observation on 11/19/24 at 02:25 PM of peri-care and wound care for Resident #112 was conducted by the ADON and LVN D. The ADON and LVN D did not don a gown prior to providing resident care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/21/24 at 11:24 AM with the DON revealed staff were required to follow Enhanced Barrier Precautions when providing direct care to residents who had indwelling medical devices, wounds, urinary catheters, feeding tubes, and tracheostomies. She stated this practice helped reduce the spread of MDRO-resistant bacteria from one resident to another, and when not followed could increase the risk of infection to other residents. In an interview on 11/21/24 at 2:00 PM, CNA K stated there was a saturated brief on the floor in room [ROOM NUMBER]. The brief was removed from the resident and put on the floor because she did not have any plastic bags on her person to put the brief in and dispose of it. She did not want to put the brief in the resident's trash can. CNA K said this was an infection control issue because when housekeeping mopped the floors after a dirty brief being on the floor the mop could continue to spread infection into other areas of the facility. She said she thought the wet brief was on the floor for about 20 minutes. Interview on 11/21/24 at 02:52 PM With LVN D revealed the importance of following Enhanced Barrier Precautions when providing resident care was because you don't want to spread an infection to other residents. LVN D further stated if Enhanced Barrier Precautions were not followed there was a possibility of cross-contamination between residents. LVN D stated she had forgotten to put on a gown before going in to provide incontinent care and wound care for Resident #112. Interview on 11/21/24 at 02:16 PM with LVN B revealed Enhanced Barrier Precautions should be followed for residents who had a g-tube, a colostomy, an open wound, or a foley catheter. Consequences of not following Enhanced Barrier Precautions included exposure to bodily fluids, and always a risk for cross- contamination which could spread infection to the resident and other residents. LVN B stated she received training on Enhanced Barrier Precautions. LVN B further stated Resident #112 had a cancerous mass on her rectum, and since it had drainage, staff should follow enhanced barrier precautions when providing her care. Interview on 11/21/24 at 03:25 PM with the Administrator revealed he had been with this facility almost 9 years. The Administrator stated the importance for staff to be following Enhanced Barrier Precautions when providing direct care to residents was it was part of the infection control practice and they tried to keep everyone safe and free of the spread of infection. The facility policy on Enhanced Barrier Precautions was for staff to follow Enhanced Barrier Precautions when providing direct care to residents who had wounds, indwelling medical devices, and other openings to reduce the spread of infection to other residents and staff. One resident could pass an infection to another resident if Enhanced Barrier Precautions, and Infection Control protocols were not followed. The Administrator further stated staff should have donned a gown with gloves prior to providing care to Resident #112, and his expectation was for all direct care staff to follow Infection Control guidelines. Interview on 11/21/24 at 3:34 PM, the Administrator stated he heard a CNA was rushing and she left a urine saturated resident brief on the floor of a resident's room. The Administrator stated the problem was an infection control hazard. Record review of the facility's Policy and Procedure, dated 04/05/24, titled Enhanced Barrier Precautions reflected, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.

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F 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure each resident has 1) at least one window to the outside in a room; 2) a room at or above ground level; 3) adequate bedding; 4) furniture that meets the resident's needs; or 5) adequate closet space. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on observation, interview and record review the facility failed to ensure each resident was provided with functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident for 1 of 10 residents (Resident #19) reviewed for physical environment. The facility failed to ensure the top drawer of Resident #19's bed side table was unlocked allowing her access to her possessions. This deficient practice could place residents at risk of a lack of access to their personal belongings. The findings were: Record review of Resident #19's face sheet reflected a [AGE] year-old female admitted on [DATE]. Resident #19 had diagnoses which included spinal stenosis lumbar region (a condition that occurs when the spinal canal narrows, putting pressure on the spinal cord and nerve roots), obesity, chronic respiratory failure with hypoxia (occurs when the body has a low level of oxygen in the blood), and vascular dementia (a type of dementia that occurs when blood vessels in the brain are damaged, which reduces blood flow and oxygen to the brain). Record review of Resident #19's quarterly MDS assessment, dated 10/02/24, reflected a BIMS score of 11, which indicated moderate cognitive impairment. Resident #19 ambulated using a wheelchair. Record review of Resident #1's quarterly care plan reflected the following: Problem dated 01/27/23 and revised on 03/02/23, Resident #19 as physical mobility related to weakness, self-care deficit, obesity, and muscle wasting. Interventions, dated 01/27/23, provide supportive care, assistance with mobility as needed. Document assistance as needed. Observation on 11/20/24 at 9:38 AM of the top drawer of Resident #19's bedside table revealed when the handle to top draw pulled, the drawer did not open. Interview on 11/20/24 at 9:38 AM, Resident #19 stated the top drawer of her bedside table was locked and her laptop was in it. She said she told the Maintenance Director she wanted it to be fixed but it was still locked. She said she was frustrated because she could not get into the drawer for the things she wanted. Resident #19 told the Maintenance Director, a couple of weeks ago, she was unable to get into the top drawer of her bedside table, but he did not get back with her and she did not mention it again. (continued on next page)

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F 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/21/24 at 4:23 pm with the Maintenance Director revealed a couple of weeks ago Resident #19 told him she could not get into the top drawer of her bedside table and he did not get back to fix it. He said that when he was passing in the residents in hallway and residents stopped him to ask him to fix something it was difficult to remember what they asked him to do. Interview on 11/21/24 at 3:34 PM, the ADM stated it was a problem Resident #19 could not open the top drawer of her bedside table and the maintenance director should have addressed the situation when Resident #19 told him, or he should have entered it in TELS. (a technology platform designed to streamline building management tasks making it easier for maintenance teams to manage daily operations and emergencies within a facility). Record review of the facility's, undated, work order policy, provided by facility ADM, in response to facility maintenance policy, reflected TELS Inspection: Daily, Weekly, and Monthly. Expect complete, accurately and on-time. Documentation upload: Expect 100%. No other facility maintenance policy provided.