

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675806	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/02/2025
NAME OF PROVIDER OR SUPPLIER  The Laurenwood Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  330 W Camp Wisdom Rd Duncanville, TX 75116	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070</b></p> <p>Based on interviews and record reviews the facility failed to ensure all alleged violations involving abuse, neglect, including injuries of unknown source were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for one (Resident #179) of five residents reviewed for injury of unknown origin reporting.</p> <p>The facility failed to ensure on 03/12/25 Resident #179's injury of unknown origin was reported to HHSC when the staff did not know why she had an unwitnessed fall (03/10/25) that was later diagnosed (03/12/25) as periprosthetic fracture (broken) in the region of the greater trochanter (hip).</p> <p>This failure could place fall risk residents of getting more injuries, bruises, and pain which could result in emotional turmoil and cause decreased health and psycho-social well-being.</p> <p>Findings included:</p> <p>Record review of Resident #179's Admission MDS assessment dated [DATE] revealed, an [AGE] year-old female who admitted on [DATE], and did not return after hospitalization . Resident #179 had diagnoses which included: hypertension (high blood pressure), anemia, (low red blood cells), dementia (confusion), and malnutrition (skinny). Resident #179 was severely cognitively impaired and unable to make all decisions for herself and required one staff for total care for all activities of daily living. Resident #179 had not been coded for falls, as she had no actual falls.</p> <p>Record review of Resident #179's Care Plan dated 12/10/24 revealed, Impaired cognitive function/dementia or impaired thought processes related to dementia. On 12/10/24 At risk for at risk for falls related to decreased safety awareness, impaired cognition, and gait and balance problems. On 03/11/25 was dependent on staff for activities, cognitive stimulation, social interaction related to cognitive deficits. On 03/10/25 had an actual fall. On 03/12/25 was diagnosed with periprosthetic fracture (broken) in the region of the greater trochanter (hip).</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #179's Incident Report by LVN C dated 03/10/25 at 9:38 a.m. revealed, Incident Description Nursing Description: Resident was observed on the floor leaning on left side with left elbow holding her head up. Incident was unwitnessed. Resident Description: Resident was unable to specify. Was this incident witnessed: No. Immediate Action Taken: Description: ROM exercises and Neuro checks within normal limits. No injuries noted, continue to monitor. Resident Taken to Hospital? No. Mental status: oriented to person, lack of safety awareness, forgetful. Predisposing physiological factors: confused, gait imbalanced, DON, ADON, doctor, and family member notified.</p> <p>Record review of the nursing progress notes dated 03/12/25 at 5:21 p.m. by LVN G reflected, Upon last completion of rounds. [Patient] Resident #179 in bed resting with eyes closed during assessment and repositioned Patient showed objective signs of pain as evidence by yelling out and guarding left thigh. The nurse immediately notified doctor with orders for x-ray of entire left leg STAT (right away). Pain medication ordered and given. Family notified and DON notified.</p> <p>Record review of Resident #179's Left Hip X ray dated 03/12/25 reflected, S/p total hip arthroplasty. There is periprosthetic fracture in the region of the greater trochanter, this appears new.</p> <p>Record review on Resident #179's Nurses note dated 03/12/25 by LVN F revealed, [physician] new order to send resident to ER for evaluation.</p> <p>Record review of Resident #179's Medication Administration Record dated March 2025 reflected no pain medications administered after 03/10/2025 until 03/12/2025, when Resident #179 was assessed by LVN G and Resident #179 was transferred to the emergency room following the positive x-ray results.</p> <p>Interview on 04/02/25 at 10:39 am, LVN C stated she worked 6:00 a.m. through 2:00 p.m. She stated Resident #179 admitted several years ago and she was very familiar with Resident #179. Resident #179 normally wheeled about in her wheelchair and was always leaning over trying to pick up something or touch someone and they always made sure her bed was in the lowest position. She stated they also increased monitoring of Resident #179 and anticipated her needs and that she was alert and oriented to herself. She stated Resident #179 was doing well wheeling without assist. She stated she worked on the day shift the day she was found on the floor in the television room. LVN C stated she had seen Resident #179 earlier sitting in her wheelchair in the television room. She stated she did not remember Resident #179 having any other falls for over three months. She stated when she assessed Resident #179, she found no injuries. She stated she began neurological checks and continued to monitor for pain, as was the policy to monitor for 72 hours after any fall in case there were latent injuries. LVN C stated Resident #179 had no pain for the remaining of her shift and had no pain assessed the next day during her shift of 6:00 a.m. to 2:00 p.m. LVN C stated she reported the fall to the DON, ADON, and the family. LVN C stated through the monitoring another nurse assessed Resident #179, the resident exhibited pain and guarding with the left leg, the nurse notified physician and gotten x-rays ordered, that later indicated a left hip fracture. Resident #179 was sent to the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/02/2025 at 1:15 p.m. with CNA F revealed CNA F worked 6:00 a.m. to 2:00 p.m. shift and was working the day that Resident #179 fell . CNA F stated she had seen Resident #179 in the television room approximately 20 minuets earlier and she was sitting in her wheelchair. CNA F sated she came back around by the television room and Resident#179 was on the floor. CNA F stated she went and got the nurse in charge LVN C, who assessed her and Resident #179 did not complain of any pain. CNA F stated she and LVN C got Resident #179 up an into her wheelchair, she did not want to go back to bed, and she started wheeling around, she ate a very good lunch and then I placed her back in bed and completed incontinent care. CNA F stated she did not complain of any pain during care. CNA F stated that Resident #179 had no current falls and she had a low bed in place, with a stability mat. Resident #179 had been in therapy and anti-tip bars had been added to the wheelchair and the seat had been lowered on the wheelchair. CNA F stated Resident #179 was a busy lady she liked to pick up items on the floor and pat other resident's on their back, she also likes to rearrange and arrangements that are available to her. CNA F stated she had taken care of Resident #179 the next day after the fall and she complained of no pain that day, The CNA performed transfer, incontinent and got her dressed.</p> <p>Interview on 04/02/2205 at 2:00 p.m. with CNA I revealed she worked 10:00 p.m. through 6:00 a.m. shift. CNA I stated she did care for Resident #179 and she complained of no pain, when she performed incontinent care. CNA I stated she would have told the charge nurse.</p> <p>Interview on 04/02/2025 at 2:15 p.m. with LVN G revealed she was working on the 2:00 p.m. through 10:00 p. m. shift. LVN G stated she was aware that Resident #179 had fallen out of her wheelchair in the television room, and there was no witness to the fall. LVN G stated she was making her rounds and completing the assessment her assessment of Resident #179, when she exhibited pain and guarding. LVN G stated she contacted the physician, followed orders for the x-ray and later the resident was transported to the hospital for further evaluation of her left hip. LVN G stated Resident #179 had exhibited no pain prior to this assessment.</p> <p>Interview on 04/02/25 at 2:02 p.m., the Administrator stated she was on maternity leave at the time and had no idea Resident #179 had fallen and had an injury of unknown origin. The Administrator said if she had been working at the time, she would have investigated the incident and reported it to HHSC. The Administrator knew that it was supposed to be reported should have been reported timely, but she was not there at the time. The Administrator the facility had various interims that were sitting in her place, as she was out on maternity leave, but was not aware of who the individuals were.</p> <p>Interview on 04/02/2025 at 2:45 p.m. with CNA H revealed that he works the 2:00 p.m. through 10:00 p. m. and had taken care of Resident #179. CNA H stated was working when she complained of pain with her leg during the LVN G's nursing assessment, she did not complain of any pain when I had gone in to check on her earlier. CNA H stated he had taken care of her on the day that she had fallen. Resident #179 complained of no pain, the CNA stated he performed incontinent care, changed her clothing, had gotten her up for dinner and placed her back in bed, she did not complain of any pain.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/02/25 at 3:30 p.m. the DON stated there was different people covering for the Administrator while she was out on maternity leave. The DON could not recall who was there on the day that Resident #179 fell . The DON was aware that the resident had fallen and later had a diagnosis of a hip fracture but was unaware that the incident had not been reported and investigated as an unwitnessed fall. The DON stated she had never been trained how to report incidents and would have reported and investigated if she had of known how. The DON stated that different individuals were sitting in during the Administrator's maternity leave, but she had no idea who they were or who was there when this occurred.</p> <p>Review of the neurological assessments dated 03/10/2025 through 03/12/2025 reflected that each nursing shift was following the neurological assessments for each shifts with no omissions noted, or complaints of pain or related changes in conditions, until the assessment reflected a change of condition completed by LVN G.</p> <p>Record review of the facility's policy Abuse, Neglect, and exploitation dated January 2012 and revised December 2024 revealed, Purpose: It is the policy of this facility to provide protections for health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property .IV Identification of Abuse, Neglect, and Exploitation: B. Possible indicator of abuse include, but not limited to: 3. Physical injury of a resident, of unknown source . V. Investigation of Alleged Abuse, Neglect and Exploitation A. and immediate investigation is warranted .B. 1. Identify staff responsible for investigation; . 3. Investigation of different types of alleged violations; 4. Identify and interview all involved person . and other who might have knowledge .5. Focusing the investigation on determine if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent and cause; 6. Proving complete and through documentation of the investigations.VII Reporting/Response . 1. Reporting of alleged violations to the Administrator, state agency A. immediately, but not later than 2 hours after . if the event . result in bodily injury 13. The Administrator should/will follow-up with the government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070</b></p> <p>Based on interviews and record review, the facility failed, in response to allegations of neglect, have evidence that all alleged violations were thoroughly investigated and report the results of all investigations to the administrator and to other officials in accordance with State law, including the State Survey Agency, within 5 working days of the incident for 1 of 5 (Resident #179) residents reviewed for abuse, neglect, and exploitation investigations.</p> <p>The facility failed to investigate an injury of unknown origin sustained by Resident #179 that was suspicious of abuse or neglect.</p> <p>This failure could cause diminished quality of life and place residents at risk for mistreatment.</p> <p>Findings included:</p> <p>Record review of Resident #179's Admission MDS assessment dated [DATE] revealed, an [AGE] year-old female who admitted on [DATE], and did not return after hospitalization . Resident #179 had diagnoses which included: hypertension (high blood pressure), anemia, (low red blood cells), dementia (confusion), and malnutrition (skinny). Resident #179 was severely cognitively impaired and unable to make all decisions for herself and required one staff for total care for all activities of daily living. Resident #179 had not been coded for falls, as she had no actual falls.</p> <p>Record review of Resident #179's Care Plan dated 12/10/24 revealed, Impaired cognitive function/dementia or impaired thought processes related to dementia. On 12/10/24 At risk for at risk for falls related to decreased safety awareness, impaired cognition, and gait and balance problems. On 03/11/25 was dependent on staff for activities, cognitive stimulation, social interaction related to cognitive deficits. On 03/10/25 had an actual fall. On 03/12/25 was diagnosed with periprosthetic fracture (broken) in the region of the greater trochanter (hip).</p> <p>Record review of Resident #179's Incident Report by LVN C dated 03/10/25 at 9:38 a.m. revealed, Incident Description Nursing Description: Resident was observed on the floor leaning on left side with left elbow holding her head up. Incident was unwitnessed. Resident Description: Resident was unable to specify. Was this incident witnessed: No. Immediate Action Taken: Description: ROM exercises and Neuro checks within normal limits. No injuries noted, continue to monitor. Resident Taken to Hospital? No. Mental status: oriented to person, lack of safety awareness, forgetful. Predisposing physiological factors: confused, gait imbalanced, DON, ADON, doctor, and family member notified.</p> <p>Record review of the nursing progress notes dated 03/12/25 at 5:21 p.m. by LVN G reflected, Upon last completion of rounds. [Patient] Resident #179 in bed resting with eyes closed during assessment and repositioned Patient showed objective signs of pain as evidence by yelling out and guarding left thigh.The nurse immediately notified doctor with orders for x-ray of entire left leg STAT (right away). Pain medication ordered and given. Family notified and DON notified.</p> <p>Record review of Resident #179's Left Hip X ray dated 03/12/25 reflected, S/p total hip arthroplasty. There is periprosthetic fracture in the region of the greater trochanter, this appears new.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070</b></p> <p>Based on observations, interviews, and record review, the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise for 2 of 4 residents (Residents #44 and #30) reviewed for nutritional status.</p> <p>MA A administered nutritional supplement to Resident #44, who was interviewable but moderately confused and unable to make decision for herself, without a physician's order.</p> <p>MA administered nutritional supplement to Resident # 30, who was interviewable moderately confused and unable to make decisions for herself, without a physician's order.</p> <p>This failure could result in residents not having an accurate overall view of their care and services.</p> <p>The findings included:</p> <p>Record review of Resident #44's admission MDS assessment dated [DATE], revealed a [AGE] year-old female who admitted to the facility on [DATE]. Resident #44 had diagnoses which included: hypertension (high blood pressure), Peripheral vascular disease (inadequate blood circulation), and diabetes (high blood sugar). Resident #44 was moderately cognitively impaired, and unable to make all decisions for herself and required one staff for assistance with activities of daily living.</p> <p>Record review of Resident #44's Physician Order Summary report dated 03/10/2025 revealed there was no written order for a nutritional supplement.</p> <p>Record review of Resident #44's Medication Administration Record dated 03/20205 revealed there was no area to document the nutritional supplement.</p> <p>Record review of Resident #30's quarterly MDS Assessment, dated 03/26/25, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #30 had diagnoses which included: cerebrovascular accident (stroke), hypertension (increased blood pressure), and cerebrovascular disease (clogged up vessels in heart). Resident #30 was moderately cognitively impaired and unable make all decisions for herself and required one staff for assistance with activities of daily living.</p> <p>Record review of Resident #30's Physician Order Summary Report dated 03/21/25 revealed there was no written order for a nutritional supplement.</p> <p>Record review of Resident #30's Medication Administration Record dated 03/2025 revealed there was no area to document the nutritional supplement.</p> <p>Observation on 03/31/2025 at 8:26 a.m. with MA A during the morning medication pass revealed she administered 4 ounces of nutritional supplement to Resident #44.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  The Laurenwood Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  330 W Camp Wisdom Rd Duncanville, TX 75116	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 03/31/15 at 8:44 a.m. with MA A during the morning medications pass revealed she administered 4 ounces of nutritional supplement to Resident #30.</p> <p>An interview on 04/02/2025 at 10:47 a.m. with MA A revealed if she gave the nutritional supplement to residents, she would have physician orders to do so. The MA stated if she gave the nutritional supplement to resident's #44 and #30 and did not have a physician order, she would be wrong. The MA said if a resident asked for the nutritional supplement she would have to tell the charge nurse, to get a doctor's order, before it could be given.</p> <p>An interview on 04/02/2025 at 10:58 a.m. with LVN D revealed all the nutritional supplements given to the residents must have a physician order before anyone can give.</p> <p>An interview on 04/02/2025 at 11:00 a.m. with LVN C revealed the nurse or the medication Aide must have a physician order to give nutritional supplements to any resident, unless they eat less than 50% of their meal, then the staff can give them a health shake, but that was not the same as nutritional supplement.</p> <p>An interview on 04/02/2025 at 11:52 a.m. with the DON revealed that any resident receiving nutritional supplements, including Resident #44 and #30, had a nutritional reason to need them and they must have physician orders to receive them. If the nutritional supplements were given without a physician order, that could possibly cause harm to the resident. The physician orders are followed-up monthly by nursing administration.</p> <p>Record review of the facility policy and procedure titled Medications Orders, dated December 2024 revealed in part, .Purpose: The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders . Recording Orders: . 7. Commercial Dietary Supplements-When recording orders for commercial dietary supplements, specify the type, amount, and frequency. Resident must give physician's order to receive nutritional supplements</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50948</b></p> <p>Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food safety.</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure dented cans were placed in a separate storage area.</li> <li>2. The facility failed to ensure food items were labeled and dated with the preparation date or discard by date.</li> </ol> <p>These failures could place residents at risk for food-borne illness and cross contamination.</p> <p>Findings Include:</p> <p>Observation of the dry storage on [DATE] at 7:50am revealed the following:</p> <ul style="list-style-type: none"> <li>-1 4lbs can of tuna received date [DATE] was dented on top right.</li> <li>-1 4lbs can of tuna received date [DATE] was dented on front.</li> <li>-1 3lbs 2 oz can of cream of mushroom received date [DATE] was dented on front and bottom right,</li> <li>-1 3lbs 2oz can of cream of mushroom received date [DATE] was dented on back.</li> <li>-1 6.27 lbs can of zucchini tomato juices received date [DATE] was dented on bottom left.</li> </ul> <p>Observation of the dining room on [DATE] at 8:09am revealed the following:</p> <ul style="list-style-type: none"> <li>-4 large pitchers of unidentified liquid drinks. There was no label description or preparation dates.</li> </ul> <p>In an interview with the DM on [DATE] at 11:18 am she stated her, or the kitchen aides were responsible for putting away canned goods once the canned goods were delivered. She stated dented cans were kept in her office and then returned to vendor. She stated all kitchen staff were responsible for ensuring food and drinks were labeled and dated. She stated the risks of dented cans not stored in a separate area and food and drinks could cause residents to become sick.</p> <p>Interview with [NAME] E on [DATE] at 11:30am she stated dented cans were stored in the DM's office. She stated all kitchen staff were responsible for checking canned goods for dents. She stated all kitchen staff were responsible for correctly labeling and dated all food items. She stated the risks of not separating dented cans could cause residents to be sick. She stated not labeling and dating food or drinks could cause staff to serve expired or spoiled food that could cause residents to become sick.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility's Food Receiving and Storage Policy, revised 2017 reflected, Policy Statement: Food and supplies will be received according to facility approved standards and practices to ensure quality of products received. Procedure: Unacceptable products (dented cans) will be rejected, and a notation made on both the delivery receipt and the order form. Cool per regulations, label, and date all food.</p> <p>Record review of the U.S. FDA Food Code 2022 reflected: Chapter 3 . FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard. Food Labeling [* .(b) A food which is subject to the requirements of section 403(k) of the act shall bear labeling, even though such food is not in package form. Section ,d+[DATE].12 Food Storage Containers, Identified with Common Name of Food: Except for containers holding FOOD that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food. Section , d+[DATE].17 . Commercial processed food: Open and hold cold . B . 1. The day the original container is opened in the food establishment shall be counted as Day 1. 2. The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety . C. 2. Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (A) of this section. 3. Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section. Definitions 3 . Food Receiving and Storage - Section ,d+[DATE].11 Packaged and Unpackaged Food-Separation, Packaging, and Segregation Food shall be protected from cross contamination by: when combined as ingredients, separating raw animals' foods during storage, preparation, holding, and display.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070</b></p> <p>Based on observation, interview, 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 2 of 2 (MA A and CNA B) staff members and 4 of 4 residents (Residents #4, #30, #54, and #31) reviewed for infection control procedures.</p> <p>MA A failed to disinfect the blood pressure cuff in between blood pressure checks for Residents #4 and #30.</p> <p>CNA B failed to change their soiled gloves and perform hand hygiene during incontinent care on Residents #54 and #31.</p> <p>These failures could place residents at risk for cross contamination and infections.</p> <p>Findings included:</p> <p>Record review of Resident #4's quarterly MDS assessment, dated 02/24/25, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #4 had diagnoses which included: Schizophrenia (mental illness), and hypertension (high blood pressure). Resident #4 was not cognitive and unable to make decisions and required assistance of one staff for activities of daily living.</p> <p>Record review of Resident #4's physician orders dated 03/14/25 reflected, amlodipine Besylate (high blood pressure) 5mg give one tab by mouth two times a day and to obtain blood pressure one time a day on each shift.</p> <p>Record review of Resident #30's quarterly MDS Assessment, dated 03/26/25, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #30 had diagnoses which included: cerebrovascular accident (stroke), hypertension (increased blood pressure), and cerebrovascular disease (clogged up vessels in heart). Resident #30 was moderately cognitively impaired and unable make all decisions for herself and required one staff for assistance with activities of daily living.</p> <p>Record review of Resident #30's physician orders dated 03/21/25 (open ended) reflected, Coreq (high blood pressure) 3.125 mg give one tab by mouth two times a day. Obtain blood pressure one time a day on each shift.</p> <p>Record review of Resident #54's quarterly MDS Assessment, dated 01/15/25, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #54 had diagnoses which included: peripheral vascular disease (clogged arteries), hypertension (increased blood pressure), and diabetes (high blood sugar). Resident #53 was moderately cognitively impaired and able make all decisions for herself and required one staff for assistance with activities of daily living. She was incontinent of bowel and bladder.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #31's quarterly MDS Assessment, dated 03/18/25, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #31 had diagnoses which included: end stage renal disease (kidneys do not work correctly), cerebrovascular accident (stroke), and diabetes (high blood sugar). Resident #31 was moderately cognitively impaired and able make all decisions for himself and required one staff for assistance with activities of daily living. He was incontinent of bowel and bladder.</p> <p>Observation on 03/31/25 at 8:29 a.m., revealed MA A performing morning medication pass, during which time she checked the blood pressure on Resident #4. MA A failed to sanitize the blood pressure cuff before or after using it on Resident #4.</p> <p>Observation on 03/31/25 at 8:44 a.m., revealed MA A performing morning medication pass, during which time she checked the blood pressure, on Resident #30, used the same blood pressure cuff used on Resident #4. MA A failed to sanitize the blood pressure cuff before or after using it on Resident #30.</p> <p>An interview on 03/31/25 at 9:00 a.m., MA A stated she did not think about cleaning the blood pressure cuff between usage, she did not know she needed to. MA A stated she had washed her hands between each usage when she took the blood pressure. MA A stated if the cuff was on the residents and then not cleaned it could spread germs to others.</p> <p>Observation on 03/31/2025 at 9:30 a.m. CNA B entered the room to perform incontinent care and activities of daily living with Resident #54. CNA B did not use hand gel in the hallway or wash his hands and donned clean gloves. Resident #54 was lying on her back in the bed. CNA B explained to the resident what he was going to do, the resident agreed. CNA B picked out the clothing that Resident #54 requested. CNA B unfastened the brief tabs and wiped the pubic area with a disposable wipe, discarded the wipe. CNA B used another wipe on the peri area and discarded. CNA B repositioned Resident #54 to her right side while pulling the clean brief under the resident, He then used another wipe on the left buttocks, pulling the urine soiled brief off and placing in the trashcan. CNA B repositioned Resident #54 to her left side while pulling the clean brief under the resident. CNA B without changing his soiled gloves or washing his hands fastened the tabs of the clean brief, placed on the resident's pants and shirt, repositioning her on the bedside. CNA B picked up a clean pillowcase placed on a pillow and placed the pillow in the wheelchair, transferred the resident into her wheelchair. CNA B while still wearing his soiled gloves and not washing his hands, combed the resident's hair, placed on her glasses, moved her around in the wheelchair, and placed her bedside table in front of the resident, turned on the TV using the remote. CNA B placed his gloves in the trashcan and left the room, without washing his hands or using hand sanitizer.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 04/01/2025 at 10:00 am with CNA B entered the room to perform incontinent care on Resident #31. CNA B did not use hand gel in the hallway or wash his hands and donned clean gloves. Resident #31 was lying on his back in the bed. CNA B explained to the resident what he was going to do, the resident agreed. CNA B unfastened the brief tabs and wiped the pubic area with a disposable wipe discarded wipe, and used another disposable wipe cleaned the penal shaft and head of penis discarded the wipe. CNA B assisted Resident #31 to reposition to his left side, used a disposable wipe and cleaned the left buttocks and anal area of urine and small soft bowel movement. CNA B placed the clean brief under Resident #31, assisted in repositioning Resident #31 to his right side, pulling the urine and bowel movement soiled brief from under resident. CNA B placed the brief in the trashcan. CNA B used additional disposable wipes to clean the right buttocks and anal area, discarding the wipes. CNA B wearing the same soiled gloves applied barrier cream to Resident #31's buttocks, then assisted the resident to reposition himself to his back. CNA B still wearing the soiled gloves and not washing his hands pulled the clean gown down for the resident and pulled the clean linens up over the resident. The CNA moved the bedside table back into place and offered the resident the television remote. CNA B removed the soiled gloves, placed them in the trashcan and left the room with the surveyor, without washing his hands or using hand sanitizer.</p> <p>An interview on 04/01/2025 at 10:00 a.m. with CNA B revealed the CNA stated, he did not bring his [A game] yesterday, but today he was going to show the surveyor how good he was and how he was supposed to do incontinent care. CNA B stated he knew he did not change his gloves. CNA A did not appear to understand that by not removing his gloves what could happen.</p> <p>An interview with the DON, who was the infection control preventionist on 04/01/25 at 2:39 p.m., revealed the DON stated that all direct care staff must clean equipment, including blood pressure cuffs after having contact with each resident. The DON stated, the staff has available the disinfectant wipes that will kill all germs. The DON stated the staff when performing incontinent care should be changing gloves from dirty to clean and washing their hands or using the available hand sanitizer. The DON stated she had just had an in-service on 03/25/25 concerning all of this, presenting step by step the cleaning of equipment and incontinent care. The DON stated that some of the CNAs she had spent extra time with, to make sure they understood. The DON stated during the in-service the staff did not ask any questions and appeared to understand and indicated they knew everything. The DON stated if they do not clean the blood pressure cuffs appropriately and change gloves and clean their hands when they should, they could spread germs to themselves and the residents.</p> <p>Record review of an in-service log dated 03/25/25 revealed MA A and CNA B, had received cleaning and properly storing equipment after each use and how to perform correct incontinent care.</p> <p>Record review of the Facility's Policy titled Infection Control Guidelines for All Nursing Procedures dated December 2024, reflected: Purpose: to provide guidelines for general infection control while caring for residents . for residents when performing high-contact resident care activities: dressing, grooming, transferring, providing hygiene, changing linens, changing briefs ., 4. Employees must wash hands for twenty (20) seconds or longer using antimicrobial or non-antimicrobial soap and water under the following conditions: .a. after direct contact with resident, d. after removing gloves, after handling items potentially contaminated with blood, body fluids, or secretions,</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the Facility's Policy titled Cleaning and Disinfecting Resident Care items and Equipment dated December 2024 reflected: Resident care equipment, including reusable items Will be cleaned an disinfected . 4. Reusable resident care equipment with be decontaminated and/or sterilized between residents</p> <p>Record review of the Facility's Policy titled Perineal/Incontinent Care dated December 2024 reflected: Purpose: The purposes of this procedure are to provide cleanliness an discomfort to the resident t, to prevent infections and skin irritations, and to observe the resident's skin condition . Steps to procedure 1. Place equipment on bedside . 2. Wash and dry your hands thoroughly . 7. Put on gloves . [steps to perform incontinent care for male/female] . 12. Remove gloves and discard into designated container. Wash and dry hands thoroughly. 13. Replace the bed covers. Make the resident comfortable . 17. Wash and dry hands thoroughly</p>