STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675837	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kruse Village Senior Living Community	1700 E Stone St Brenham, TX 77833

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 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 promotes maintenance or enhancement of his or her quality of life for 1 (Resident #160) of 6 residents reviewed for resident rights. The facility failed to cover Resident #160's catheter bag during therapy in the rehabilitation unit. This failure placed residents at risk of loss of dignity, embarrassment, and diminished quality of life. Findings include: Review of Resident #160's face sheet, dated, 03/05/2025, reflected an [AGE] year-old female who was admitted on [DATE]. Resident #160 had diagnoses which included retention of urine, unspecified (the condition where the bladder does not empty or cannot completely empty, leaving some urine behind), and neuromuscular dysfunction of bladder, unspecified (a medical condition where the bladder's muscles or the nerves controlling them are not functioning as they should, causing urination problems). Review of Resident #160's admission MDS reflected it was in process on 03/11/2025. Review of Resident #160's Baseline Care Plan, dated 03/05/2025, reflected Resident #160 had a catheter (a tube used to drain urine from the bladder). Goal: will be /remain free from device-related trauma. Resident #160 was at risk for pain. She was not cognitively (the mental processes of thinking, knowing, understanding, and learning) impaired. She communicated without difficulty. Resident #160 required assistance with bathing, dressing, bed mobility, hygiene, locomotion, toileting, and transfers. Resident #160 required physical therapy and occupational therapy. Review of Resident #160's Physician Orders, dated 03/05/2025, reflected maintain drainage bag (a bag connected to a urinary catheter to collect urine that drains from the bladder) below level of bladder; keep tubing free of kinks. Monitor urinary output every shift. Perform catheter care every shift and as needed. Maintain catheter size 16 FR/ 10 cc balloon for diagnosis of urinary retention and change as needed for obstruction. (continued on next page)

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 - Few	In an observation on 03/09/2025 from 9:55 AM to 10:20 AM Resident #160 was sitting in her wheelchair when the Physical Therapist Assistant assisted Resident #160 from her room to the rehabilitation area (approximately 300 feet). Resident #160's catheter bag was uncovered. After Resident #160 finished her therapy session, the Physical Therapy Assistant assisted Resident #160 from the therapy area to Resident #160's room with the uncovered catheter bag. She did not report any issues of Resident #160's catheter bag to nursing staff or attempt to find a cover for the catheter bag. In an interview on 03/09/2025 at 10:21 AM the Physical Therapy Assistant stated she did not know if a catheter bag was expected to be covered. The Physical Therapy Assistant stated she did not check the catheter bag to ensure it was covered prior to assisting Resident #160 from her room to the area of the rehabilitation unit where other residents would be around Resident #160. The Physical Therapy Assistant stated, I see how it is with the catheter. She stated she did not report anything to the nurses about Resident #160's catheter bag. (The Physical Therapy Assistant did not elaborate on her response I see how it is or answer any other questions about catheters such as dignity issues). In an interview on 03/09/2025 at 10:45 AM Resident # 165 stated she did not enjoy looking at someone's urine and it made her sick at her stomach. She stated someone needed to cover it so no one else had to look at urine. In an interview on 03/09/2025 at 11:20 AM RN A stated all catheter bags were expected to be covered. RN A stated if a catheter bag was not covered a resident may be embarrassed to be around other people and this was a dignity issue for other residents looking at the catheter bag and not wanting to see urine. She stated any staff was expected to report to the nurse anytime there was an issue with catheters including the therapy staff. In an interview on 03/11/2025 at 9:16 AM the Administrator/RN stated if a catheter bag was not covered and a resident was sitting around other residents, there was a possibility a resident may become embarrassed/humiliated if other residents can view their urine in the catheter bag and this was a dignity issue. She stated if a therapist assisted a resident out of their room to a common area it was the therapist's responsibility to ensure the catheter bag was covered. In an interview on 03/11/2025 at 09:50 AM the Director of Therapy stated all the therapy staff were expected to report any medical concerns including catheters to the nursing staff. She stated the Physical Therapist Assistant was expected to check and make sure the catheter bag was covered prior to assisting a resident anywhere in the facility. She stated this was a dignity issue for the resident and for other residents viewing the urine in the catheter bag. In an interview on 03/11/2025 at 10:14 AM RN B stated all catheter bags were expected to be covered. RN B stated if Resident #160's catheter bag was not covered and she was sitting around other residents there was a possibility she may be embarrassed and it was a dignity issue for Resident #160 and other residents. She stated other residents may not want to see urine and it was a possibility other residents may not want to eat if they have a weak stomach when they see urine. RN B stated all staff including therapy was expected to report any type of medical concerns to the nurse including any issues with catheters. She stated if a resident had a catheter all staff were expected to inspect the catheter bag prior to transferring a resident from their room to a public area. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/11/2025 at 10:30 AM CNA G stated all catheter bags needed to be covered. CNA G stated if the catheter bag was not covered a resident may feel bad about themselves if other residents or staff saw urine in their catheter bag. CNA G stated this was against a resident right of not becoming embarrassed when around others if their catheter bag was not coved. She stated also other residents may become upset viewing the urine in someone's catheter bag. Review of the Facility's Policy on Dignity-Quality of Life , dated 10/2022, reflected In full recognition of his or her individuality, the facility promotes care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect. Review of the facility's Policy on Resident Rights, dated January 2023, reflected Residents have the right to dignity, self-determined and person-centered care. The community must protect and promote the rights of all residents and ensure that they are receiving the care and services they need. The community must provide equal access to quality care regardless of diagnosis, severity, condition, or payment source.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on interview, observation, and record review, the facility failed, to provide an ongoing activities program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for residents residing on four of four halls. The facility failed to provide activities on the weekends for the months of February and March of 2025. This failure placed residents at risk for boredom, depression, increased behaviors, and diminished quality of life. Findings include: Review of activity participation binder on 03/10/2025 reflected group activities did not occur in the facility on the weekends for the month of February 2025 and two weekends in March 2025 (03/01/2025 to 03/02/2025 and 03/08/2025 to 03/09/2025). Review of the Activity Director Personnel Record on 03/11/2025 reflected the Activity's Director's date of hire was 11/04/2024 and she did have her Activity Professional License (does not expire). Record review of Activity Calendar month of February and March 2025 reflected Activity Pact was the activity for Saturdays. Church Service and activty pact were the activities for Sundays. Observation on 03/09/2025 at 9:10 AM upon entering the rehabilitation unit revealed four residents sitting in a common area before entering the dining room. Two of the four residents' heads were leaning to the right side and they were asleep. One resident stated to another resident I wished we had something to do there is nothing to do on weekends and I get so tired of not having anything to do. Observation on 03/09/2025 at 9:40 AM on the rehabilitation unit revealed three residents sitting in the common area near the dining tables. There was one resident unable to sit still. He was wandering around the common area and attempted to go into other residents' rooms. The staff was re-directing him to his room. In an observation and interview on 03/09/2025 at 9:43 AM Resident # 52 was in his room sitting in his wheelchair. He was staring toward the floor of Resident #52 had a facial expression of sadness/depression slanting inner eyebrows and looking downward (signs of feeling sad). There was no stimulation in his room such as tv being on, radio, magazines, no activity items, etc. Resident #52 stated he wished he had something to do. He stated, I always had something to do. Resident #52 stated his [family member] would tell all the kids to always stay busy and not be a lazy person. He stated, I feel like I am being lazy just sitting here looking at my hands and this floor. Resident #52 stated he did feel sad and was thinking about how his life used to be. He stated this was why he wanted to be busy doing something. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/09/2025 at 10:35 AM Resident #165 was in the common area sitting in her wheelchair. She stated, I am here for therapy and have a lot of therapy during the week but on weekends we don't have anything to do. Resident #165 stated no one had spoken to her about the activity programs at this facility or what she enjoyed doing when she was at home and her hobbies. Resident #165 stated it would be nice if they could have a group of people to do something together. She stated no one had offered her any activity items. Resident #165 stated she never heard of activity pact(this was a folder the Activity Director placed coloring pictures , colors, and circle word puzzles) She stated if that is the activity for today no one had talked to her about it. She stated she thought someone would ask her what she liked to do and help her get something to do if no one was going to do anything with them in a group. In an interview on 03/10/2025 at 9:40 AM the Activity Director stated activity pact on the calendar was for residents to receive activity pact with coloring pictures in it for them to do in their rooms. She stated this was not considered a group activity. The Activity Director stated all activities were to be documented on the participation records. She stated she had only been working there for the past four months and she was still getting to know the residents. The Activity Director stated when a new resident comes in she was expected to explain the activity programs with them but she is the only activity person in the facility and it was difficult for her to do activities for 50 residents. She stated she worked as Activity Director at other facilities and knew how to do activities in a nursing home. The Activity Director stated it was her responsibility to ensure the residents had the activity items they needed and knew about the activity programs. She did not respond to any more questions about the importance of activities for residents in the facility and if there was a possibility a resident may have a negative outcome with their cognition, psychosocial and physical needs or who was responsible for activities on the weekends. In an interview on 03/10/2025 at 1:15 PM Resident #12 stated he was a preacher and did not have a bible in his room. He stated no one had been to his room and interviewed him about his activity preferences. Resident #12 stated he did not know the Activity Director and he had not been interviewed by anyone if he needed any more books and especially he wanted a bible. He stated no one explained to him what activity pact was, however, he did not attend group activities. Resident #12 stated he had been residing at this facility for several years. He stated he heard there was a new Activity Director but he did not know her and she had not been to his room to speak to him about his interests. Resident #12 stated he would enjoy for someone to come by and talk to him about what is going on in the facility and talk to him for a few minutes. He stated he would not want this every day but once or twice a week would be helpful to him. In an interview on 03/10/2025 at 2:05 PM during the confidential Resident Group meeting six out of six residents attending the group meeting agreed there was not any group activities on the weekends. The residents in the meeting stated on weekends has activity pack for the activity. All residents in attendance stated they had never heard of activity pact and it was never explained to them what type of activity this was and where the activity met. One of the six residents stated she thought it may be something to do in the room. Another resident stated if it was for them to do in the room it did not need to be listed as a group activity on the calendar. The residents in the group agreed they were bored on weekends and wanted to be more involved in the decisions of what type of activities they did in a group and in their room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/11/2025 at 8:57 AM the Administrator stated she expected activities be provided to the residents seven days a week in a group setting. She stated if a resident was not receiving any activities on weekends there was a potential a resident may become bored or depressed. The Administrator stated activities have an important role in the overall quality of life in the residents' lives. She stated the Activity Director was responsible to ensure all residents' activity preferences were documented and residents were provided with any activity item they may want to enhance their lives at the facility. She stated she was responsible to monitor the Activity Director. She stated she expected all activities to be documented on the participation records. The Administrator did not respond to the question of who was responsible for activities on the weekends. She stated Activity Pact was when the Activity Director left coloring pictures or puzzles on paper in a folder for residents to do on weekends. In an interview on 03/11/2025 at 9:52 AM the Social Worker stated if the residents were not receiving activities on the weekends there was a possibility a resident may become depressed, lonely and/or bored. She stated if a resident is bored there is a potential the resident may attempt to get out of their chair to do something and may fall. The Social Worker stated activities were very important to the residents and if they are not getting activities on weekends there was a possibility their cognition may decline and depression increase. She stated she did not know what an Activity Pact was and it had not been explained to her. The Social Worker stated if she was manager of the day on weekends and saw activity pact on the calendar when she came to work on a Saturday she would not know what it was if a resident asked her. In an interview on 03/11/2025 at 10:14 AM RN B stated she did not know what Activity Pact meant on the activity She stated this was the only activity listed on the calendar. She stated no one discussed with her about his activity or any activities on the weekends. RN B stated she worked a lot of weekends and she did work on 03/09/2025 and there were not any activities for the residents to do on the rehabilitation unit. She stated they were not interested in the few activity items stored on the unit. RN B stated she was not informed of what the residents' interests were on the rehabilitation unit or where to find the activity interests of the residents. She stated the Activity staff was responsible for activities on the weekends or they can give the staff activity items the residents would be interested in doing and inform the staff what activities they could do with the residents. She stated the Activity Director did not discuss of what type of activities she thought the residents may enjoy with her. In an interview on 03/11/2025 at 10:30 AM CNA G stated the Activity Director did not discuss the resident's activity preferences with her or what was activity pact. She stated she assumed it was something in a bag for residents to do in their rooms but they do not have any on the rehabilitation unit. CNA G stated there was some activity items on the rehabilitation unit but sometimes the residents became tired of doing the same thing. She stated no group activities occurred on weekends on the rehabilitation unit. CNA G stated it would be helpful if the Activity Director would discuss with the residents on what they prefer to do in group activities and the staff would attempt to do these activities if they had the supplies. She stated if a resident did not have any activities to do there was a possibility a resident may become bored and become depressed about being in the facility especially a newly admitted resident to the facility. She stated they do become bored and sad on the weekends and especially when they are new to the facility. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Activity Policy, dated 10/2022, reflected the community must provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, care plan, and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility sponsored group and individual activities, and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial wellbeing of each resident, encouraging both independence and interaction in the community. An individualized activity program for each resident will be developed. Review of the facility's Policy on Dignity- Quality of Life, dated 10/2022, reflected In full recognition of his or her individuality, the facility promotes care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect. This includes staff assisting the resident to attendance of activities of their choice. Review of the facility's Policy on Resident Rights, dated January 2023, reflected Residents have the right to dignity, self-determined and person-centered care. The community must protect and promote the rights of all residents and ensure that they are receiving the care and services they need. The community must provide equal access to quality care regardless of diagnosis, severity, condition, or payment source. Activities: o Person-centered care: means to focus on the resident as the locus of control and support the resident in making their own choices; having control over their daily lives. o Participate in social, religious, and community activities that do not interfere with the rights of other residents in the community. o Participate in activities of his/her choice that do not interfere with the rights of other residents; o Participate in community activities.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents received care, consistent with professional standards of care to prevent development or worsening of pressure ulcers for one of three residents (Resident #15) reviewed for pressure ulcers. The facility failed to ensure LVN D followed standard precautions during wound care on 03/10/2025 for Resident #15's Stage III pressure ulcer to her sacrum, when she failed to set up a clean wound dressing field without cross contamination and failed to use a cleaning technique on the pressure ulcer that did not cross contaminate the pressure ulcer or prevent the pressure ulcer once cleaned from becoming re-contaminated. This failure could place residents at risk for worsening pressure ulcers leading to discomfort, pain, and potential infections. Findings included: Review of Resident #15's face sheet dated 03/10/2025 reflected a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: dementia (A group of symptoms that affects memory, thinking and interferes with daily life.) transient cerebral ischemic attack (brief blockage of blood flow to the brain.)and malignant neoplasm of the colon (colon cancer). Review of Resident #15's significant change MDS dated [DATE] reflected she was assessed to have a BIMS score of three indicating severe cognitive impairment. Resident #15 was assessed to be at risk for pressure ulcers and was assessed to have a stage III pressure ulcer. Review of Resident #15's comprehensive care plan reflected a focus area dated 03/06/2025 Actual Potential for complications with impaired skin integrity . pressure related to incontinence, immobility and cognitive impairment. Interventions included wound care physician evaluation and treatment as needed. Review of Resident #15's weekly wound round documentation dated 03/06/2025 reflected Resident #15 had a Stage 3 Pressure ulcer to her sacrum measuring 1 cm long by 0.5 cm wide with 0.2 cm depth. Observation on 03/10/2025 at 11:06 AM, revealed LVN D preparing her clean field for Resident #15's wound care. LVN D placed a whole (newly opened) package of 4x4's, a bottle of wound cleanser and a box of gloves along with her dressings. LVN D then stated she was going down the hall to wash her hands and left her clean field while she went down the hall to wash her hands. LVN D then returned and entered Resident #15's room to preform wound care. During wound care LVN D cleansed Resident #15's pressure ulcer to her coccyx with her left hand she was holding Resident #15's left buttock to expose the coccyx pressure ulcer once she cleansed the wound she allowed the skin folds to fall back over the pressure ulcer (contaminating the wound) and without re-cleaning applied the dressing. After the treatment LVN D then took the package of 4x4's, wound cleanser, and gloves used during care and placed them back on her treatment cart. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/10/2025 at 11:42 AM, LVN D stated she did go down the hall to wash her hands and should not have left her clean field because anyone could have walked by and contaminated her field. She stated she should not have taken the package of 4x4's, wound cleanser, and gloves back to her cart because once she brought them into the room they were contaminated and should not be used on other residents. LVN D further stated she should not have let Resident #15's skin fall back over her wound because it caused the wound to be contaminated and it needed to be recleaned prior to putting the dressing on. She stated that she should have had a second person in there to help her to prevent that from happening, but they were all busy and she did not find anyone to help. In an interview on 03/10/2024 at 4:20 PM, the DON stated staff are not supposed to take items into room then bring them back to their cart she stated that was cross contamination and could lead to infections. she stated it was her expectation that staff use wound cleansing tech that do not re contaminate the wound. She stated if the skin folds fall back over the wound the wound would need to be recleaned. Review of the facility's policy Clean Dressing Change Technique (not dated) reflected What is a clean dressing change? By definition a clean dressing change involves techniques to reduce the overall number of microorganisms during a dressing change. This helps to prevent or reduce the risk of transmission of microorganisms from person to person and/or surface. This technique utilizes handwashing, maintaining a clean surface, and using gloves and sterile instruments to prevent direct contamination of supplies and materials. Clean technique is considered most appropriate for long term care, chronic wounds, and wounds not at high risk for infection .As a rule, anything that enters the room must be cleaned with an antibacterial when leaving the resident's room, this includes spray bottles, tubes/bottles of ointments, scissors, etc. No open dressings should be on the cart. Dispose of unused supplies .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure residents who are incontinent of bladder receive appropriate treatment and services to prevent urinary tract infections for two (Resident #7 and Resident #160) of seven residents reviewed for catheters. The facility failed to prevent Resident #7's and Resident #160's catheter bag/tubing from touching the floor on 03/09/2025. These failures could place residents at risk for cross contamination and urinary tract infections. Findings included: Resident #7 Review of Resident #7's face sheet, dated, 03/09/2025, reflected a [AGE] year-old male who was admitted on [DATE] and readmitted on [DATE]. Resident #7 had diagnoses which included end stage congestive heart failure and renal (kidney) insufficiency. Review of Resident #7's MDS dated [DATE] reflected a BIMS score of 8, which suggested a moderate cognitive impairment. He had an indwelling catheter. Review of Resident #7's Baseline Care Plan, dated 02/20/2025, reflected Resident #7 had an indwelling catheter (a tube used to drain urine from the bladder) related to obstructive uropathy (a condition where a blockage hinders urine flow). Goal: will be/remain free from catheter-related trauma through the review date. Observation and interview on 03/09/2025 from 01:38 PM to 01:54 PM revealed Resident #7 was lying in bed eating lunch. The catheter bag and tubing were lying flat on the floor beside the bedside table and the tubing crossed over the bottom of the bedside table wheels. Resident #7 complained about wanting to move his leg and when he pushed the bedside table away from the bed, it rolled on top of the catheter bag full of dark yellow color urine and the bag started leaking. Resident #7 stated he was aware of the bag being on the floor but was in pain and unable to answer questions about how long the bag had been on the floor. At 01:45 PM, CNA K came into the room, picked up the catheter bag up off the floor, and hooked it on the bed frame. The bag was leaking, and CNA K responded, it's a mess and left the room. A nurse responded to assess the resident's complaint of pain, noted the bag was leaking, and requested help emptying the bag. At 01:54 PM, CNA H put the catheter bag on the floor, emptied the urine, wiped the floor and the outside of the catheter bag with a towel, and hooked the catheter bag back on the bed frame. In an interview on 03/10/2025 at 09:23 AM, Resident #7 stated that he had no pain from his foley catheter when the bag and tubing were on the floor on 03/09/2025 and the bedside table rolled on top of the bag. He did not care that the bag was leaking urine, but he expected staff to clean it up. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kruse Village Senior Living Community	1700 E Stone St Brenham, TX 77833

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/11/2025 at 09:13 AM, CNA H stated he had received training on emptying catheter bags. He stated he must ensure the catheter bag was hung below the bladder and did not touch the floor because that could cause an infection. CNA H stated the bag was usually hooked onto the bed frame. He stated the catheter bag and tubing should not have been on the floor next to the bedside table, because the line (tube) could have been pulled out when Resident #7 moved the bedside table, which could have caused damage or pain to the resident. He stated it was everyone's responsibility for checking placement of the catheter bag and tubing when they entered a resident's room. In an interview on 03/11/2025 at 09:32 AM, RN C stated he had received training on catheter care. RN C stated the catheter bag must be hung below the bladder and must not touch the floor. He stated it was the CNA's responsibility to empty the bags and notify the nurse if there was concern or problem. The CNAs should pick the catheter bag up off the floor and put it back on the bed when they notice it. RN C stated that if the bag touched the floor, there was an increased risk of infection because bacteria could go up the tube. There was also an increased risk of the tube being tugged or pulled out, which could cause damage to the urethra and pain to the resident. RN C stated everyone (CNAs, nurses, and the director of nursing) should check the placement of the bag during incontinent care and when entering/exiting the residents' rooms. He stated that he did rounds in the morning to ensure placement of the catheter bags. In an interview on 03/11/2025 at 10:11 AM, the DON stated staff were trained on catheter care. The training covered placement of the bag, which included using a securement device to avoid pulling and injury to urethra. The bag must be hung below the bladder, attached to the frame of the bed if the resident was in bed, and should not be on the floor. If the bag touched the floor, that would be an infection control issue and the bag would need to be changed to avoid the risk of infection. The DON stated it was everyone's responsibility to ensure the bag was off the floor (CNAs, RNs, and the DON) and if a CNA observed it on the floor, her expectation would be to let the charge nurse know so that the bag could be changed. The bag on the floor and the bedside table on top of it would not meet her expectation and had the potential of the tubing being kinked, pulled out, or causing the resident an injury or discomfort. Resident #160 Review of Resident #160's face sheet, dated, 03/05/2025, reflected an [AGE] year-old female who was admitted on [DATE]. Resident #160 had diagnoses which included retention of urine, unspecified (the condition where the bladder does not empty or cannot completely empty, leaving some urine behind), neuromuscular dysfunction of bladder, unspecified (a medical condition where the bladder's muscles or the nerves controlling themre are not functioning as they should, causing urination problems), and cerebral infarction, unspecified (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it). Review of Resident #160's admission MDS reflected it was in process on 03/11/2025. Review of Resident #160's Baseline Care Plan, dated 03/05/2025, reflected Resident #160 had a catheter (a tube used to drain urine from the bladder). Goal: will be /remain free from device-related trauma. Resident #160 was at risk for pain. She was not cognitively (the mental processes of thinking, knowing, understanding, and learning) impaired. She communicated without difficulty. Resident #160 required assistance with bathing, dressing, bed mobility, hygiene, locomotion, toileting, and transfers. Resident #160 required physical therapy and occupational therapy. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #160's Physician Orders, dated 03/05/2025, reflected maintain drainage bag (a bag connected to a urinary catheter to collect urine that drains from the bladder) below level of bladder; keep tubing free of kinks. Monitor urinary output every shift. Perform catheter care every shift and as needed. Maintain catheter size 16 FR (French gauge, a measurement system that indicates the outer diameter of the catheter) / 10 cc (cubic centimeters a volume unit for substance) balloon for diagnosis of urinary retention and change as needed for obstruction. In an observation on 03/09/2025 from 9:55 AM to 10:20 AM Resident #160 was sitting in her wheelchair when the Physical Therapist Assistant assisted Resident #160 from her room to the rehabilitation area (approximately 300 feet). Resident #160's uncovered catheter bag and tubing dragged on the floor when she was assisted from her room to the rehabilitation area. The color of urine was yellow. The Physical Therapist Assistant placed Resident #160 in the area for the physical therapy session. There was a kink in Resident #160's tubing. Over half of Resident #160's uncovered catheter bag was lying on the floor. After Resident #160 finished her therapy session, the Physical Therapy Assistant assisted Resident #160 from the therapy area to Resident #160's room. During this transfer the uncovered catheter bag and kinked tubing dragged on the floor (approximately 300 feet). In an interview on 03/09/2025 at 10:21 AM the Physical Therapy Assistant stated she was not aware the uncovered catheter bag was partially on the floor or the tubing from the catheter had a kink and was lying on the floor when she transferred Resident #160 to and from the rehabilitation area. She stated she did not know if a catheter was expected to be covered. The Physical Therapy Assistant stated she did not check the catheter or the tubing before, during or after the therapy session. She stated she worked PRN and was not a full-time staff at the facility. The Physical Therapy Assistant stated, I see how it is with catheter. She stated she did not report anything to the nurses about the catheter bag or tubing. (The Physical Therapy Assistant did not elaborate on her response or answer any other questions about catheters such as possible negative outcome with Resident #160 if the catheter bag and tubing was lying on the floor and the tubing had a kink). In an interview on 03/09/2025 at 11:20 AM RN A stated if half of a catheter was on the floor and tubing was on the floor there was a possibility bacterium from the floor may enter the tubing or catheter. She stated if this occurred there was a potential where Resident #160 may develop an infection. RN A stated if a tubing had a kink, this may prevent urine from draining properly and may cause urinary retention and other complications. She stated all catheters and tubing was to be off the floor and hanging on a hook or on the wheelchair. She stated all catheter bags were expected to be covered. She stated any staff was expected to report to the nurse anytime there was an issue with catheters including the therapy staff. In an interview on 03/11/2025 at 9:16 AM the Administrator/RN stated catheter bags and tubing was expected to remain off the floor. She stated if a catheter and tubing was on the floor when a resident was being assisted from one area to another area in a wheelchair, there was a possibility a wheel may run over the tubing or bag and the catheter may dislodge. The Administrator stated if a catheter dislodges there was a potential for infection. She stated it was therapy's responsibility to report any medical issues including catheter bags to a nurse. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/11/2025 at 09:50 AM the Director of Therapy stated all the therapy staff was expected to report any medical concerns including catheters to the nursing staff. She stated the Physical Therapy Assistant was expected to place the catheter in its proper position and ensure the catheter bag and tubing was not on the floor during transfers or anytime during therapy. The Director of Therapy stated she expected all the therapists to report any changes of resident medical condition to the nurse. She stated there was a possibility the tubing may contract some type of bacteria from the floor. She stated Resident #160 may develop an infection. She stated if the tubing was kinked all types of medical issues may develop (when asked what type of medical issues, she did not elaborate on what type of medical issues). The Director of Therapy stated there was a potential the catheter may come out of Resident #160 and develop an infection. She stated there was only one therapist in the facility on 03/09/2025 and it was the Physical Therapy Assistant. She stated staff did receive training to report any medical issues to the nursing staff. Requested the training and it was not provided at time of exit. In an interview on 03/11/2025 at 10:14 AM RN B stated if a catheter was not properly placed and was located on the floor there was a possibility bacteria can enter the catheter tubing even if the tubing was kinked. She stated there was all types of bacteria on the floor. RN B stated Resident #160 had a potential to develop an infection if her catheter bag was on the floor, tubing on the floor with a kink in the tubing. RN B stated if staff was pushing a resident in their wheelchair and the catheter and tubing was on the floor there was a possibility the wheel on the wheelchair may run over the catheter bag or tubing. She stated if this incident occurred the catheter may dislodge, and potential problems may occur such as blood in urine, infection, and difficulty with bladder emptying. She stated all catheters were expected to be covered. RN B stated all staff including therapy was expected to report any type of medical concerns to the nurse including any issues with catheters. She stated if a resident had a catheter all staff was expected to inspect the catheter prior to transferring a resident from their room to a public area. RN B stated the correct positioning of the catheter is placed below the level of the bladder and off the floor for proper drainage. In an interview on 03/11/2025 at 10:30 AM CNA G stated she had been in-serviced to report any issues with catheters including if the tube was twisted. She stated all catheters were expected to be covered. She stated if a catheter bag or tube was on the floor it was a possibility germs may enter the tubing and cause a resident to become sick with an infection. CNA G stated she had been in-serviced on catheter bags but did not recall the date. Review of the facility's policy on Catheter-Management dated 03/01/2014 reflected The facility will have a system for the management of urinary catheters. All catheter bags are covered with privacy bags at all times. Correct positioning of catheter will be maintained. Review of the facility's policy titled Foley Catheter - Care revised 03/01/2014 reflected: Policy Proper care will be provided for the management of a Foley catheter to drain urine from the bladder and to prevent reflux of urine back into the bladder. Procedure (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The Foley bag should be hooked to the metal bed frame when resident is in bed and covered with a privacy bag. 5. The Foley bag should not be touching the floor. 6. Foley tubing should be free from kinks.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drug and biological) to meet the needs of each resident for 2 of 4 residents (Resident #14 and Resident #29) reviewed for medications and pharmacy services, in that: 1. The facility failed to ensure Resident #14's physician ordered medication Calcium and Gabapentin were available for administration. 2. The facility failed to ensure Resident #29's physician ordered medication Saccharomyces Baulardii (probiotic) was available for administration. These deficient practices could place residents at risk of not receiving therapeutic dosage of medications and symptomatic changes in vital signs. Findings include: 1.) Review of Resident #14's face sheet reflected an [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses lumbar vertebra fracture (fracture of the spine), vitamin D deficiency and low back pain. Review of Resident #14's quarterly MDS dated [DATE] reflected she was assessed to have a BIMS score of 13 indicating she was cognitively intact. Resident #14 was further assessed to have occasional pain. Review of Resident #14's comprehensive care plan reflected a problem dated 10/01/2024 At risk for potential complications with pain related to pain to shoulder .low back pain and history of fracture to first lumbar vertebra Interventions included Meds/Labs/ treatments as ordered; Resident has schedule pain meds . Review of Resident #14's consolidated physician orders dated 03/10/2025 reflected orders for calcium 500 mg with D 5mg by mouth daily for supplement related to fracture of lumbar vertebra and an order for gabapentin 300 mg by mouth three times a day for back pain. Review of Resident #14's March 2025 MAR reflected entries for calcium 500 mg with D 5mg by mouth daily and an entry for Gabapentin give 300 mg by mouth three times daily. Review of the documentation on the MAR for the calcium and gabapentin reflected a 9 was documented indicating from the facility's chart code other/ see nurses notes. Review of nurses notes reflected no entry regarding the administration of the medication. Observation on 03/10/2025 at 8:16 AM, revealed MA E prepared Resident #14's medication for administration. MA E prepared 8 medications for administration which did not include her physician ordered calcium or gabapentin. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/10/2025 at 10:30 AM, MA E stated she did not give Resident #14's calcium or gabapentin during morning medication pass because the calcium medication was not in stock, and she was not sure why the gabapentin was not available because it was ordered but she did not see it on the cart, so she did not give it. When she was asked if she reported the missing medication to her nurse she stated she had not but would. Observation and interview on 03/10/2025 at 1:26 PM, Resident #14 stated she was ok and did not have pain at this time. She stated they gave her Tylenol and that always helps. Resident #14 stated she was not really sure what medications she took and did not know she did not get all of her morning medications. In an interview on 03/10/2025 at 4:25 PM, the DON stated Resident #14's physician was notified that her calcium and gabapentin were missed, and he stated to not give her the missing dose of gabapentin to wait until the next dose. She stated the facility did not have the right calcium for Resident #14 but was able to get it from the pharmacy right away. She stated Resident #14's gabapentin was in the medication room all the med aide had to do was go get it. The DON stated it was the MA's and nurses' responsibility to make sure all medications are available for administration, and she expected the medication aides to let their nurse know if a medication is not available for administration right away. She stated the medication aide should have stopped the medication pass and looked for the medications. She stated she had re-in-serviced the MA to make sure she knew the facility's procedure to make sure the residents get the right medications at the right time. 2.) Review of Resident #29's face sheet dated 03/10/2025 reflected an [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses enterocolitis due to clostridium difficile (It is a highly contagious bacterium that causes diarrhea and colitis.) and constipation (is a condition in which you have hard, dry, or lumpy stools that are difficult or painful to pass, or fewer than three bowel movements a week.). Review of Resident #29's quarterly MDS dated [DATE] reflected he was assessed to have a BIMS score of 13 indicating he was cognitively intact. Resident #29 was further assessed to always be incontinent of bowel. Review of Resident #29's comprehensive care plan reflected a focus area dated 05/14/2024 Bowel/ Bladder . Resident #29 has meds/ dx that can/may affect his bowel and bladder status. Interventions included medications and creams as ordered. Review of Resident #29's consolidated physician orders dated 03/10/2025 reflected an order for saccharomyces boulardii (probiotic) oral capsule give one by mouth daily. Review of Resident #29's March 2025 MAR, reflected an entry for saccharomyces boulardii. Review of the documentation on the MAR for the saccharomyces boulardii reflected a 9 was documented indicating from the facility's chart code other/ see nurses notes. Review of the nurses' notes reflected no entry regarding the administration of the medication. Observation on 03/10/2025 at 8:16 AM, revealed MA E prepared Resident #29's medication for administration. MA E prepared 8 medications for administration which did not include his physician ordered saccharomyces boulardii (probiotic) capsule. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/10/2025 at 10:30 AM, MA E stated she did not give Resident #29's saccharomyces boulardii during morning medication pass because she just missed it. After she reviewed his orders she stated she should have given him the medication during the morning medication pass. In an interview on 03/10/2025 at 4:25 PM, the DON stated Resident #29's probiotic was not in stock and had to be obtained from the pharmacy. She stated it was the MA's and nurses' responsibility to make sure all medications are available for administration, and she expected the medication aides to let their nurse know if a medication is not available for administration right away she stated the medication aide should have stopped the med pass and looked for the medications. She stated she had re-in-serviced the MA to make sure she knew the facility's procedure to make sure the residents get the right medications at the right time. Review of the facility's policy medication administration dated 11/2024 reflected This community supervises or administers all medications a resident receives as ordered by their physician. The community provides appropriate methods and procedures for obtaining, dispensing, and administering drugs approved by the resident's physician and consulting pharmacist. Orders are obtained from the resident's physician either to the community or from the pharmacy, if using pharmacy-initiated orders. Medication orders initiated by the pharmacy are verified by the director of nursing (DON), executive director, or designee. Staff members responsible for administering medications review the physician's order prior to administering medications . 8. Medication is ordered on a timely basis by an approved staff member. All the information on the medication label is faxed to the preferred pharmacy. The preferred pharmacy delivers the medications the next working day; however, in an emergency, will deliver when needed .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 11.54% based on 3 out of 26 opportunities, which involved 2 of 4 residents (Resident #14 and Resident #29) and 1 of 1 MA's (MA E) observed during medication administration reviewed for medication error. 1. The facility failed to ensure Resident #14's physician ordered medication Calcium and Gabapentin was available for administration. 2. The facility failed to ensure Resident #29's physician orders medication Saccharomyces Baulardii (probiotic) was available for administration. These deficient practices could place residents at risk of not receiving therapeutic dosage of medications and symptomatic changes in vital signs. Findings include: 1.) Review of Resident #14's face sheet reflected an [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses lumbar vertebra fracture (fracture of the spine), vitamin D deficiency and low back pain. Review of Resident #14's quarterly MDS dated [DATE] reflected she was assessed to have a BIMS score of 13 indicating she was cognitively intact. Resident #14 was further assessed to have occasional pain. Review of Resident #14's comprehensive care plan reflected a problem dated 10/01/2024 At risk for potential complications with pain related to pain to shoulder .low back pain and history of fracture to first lumbar vertebra Interventions included Meds/Labs/ treatments as ordered; Resident has schedule pain meds . Review of Resident #14's consolidated physician orders dated 03/10/2025 reflected orders for calcium 500 mg with D 5mg by mouth daily for supplement related to fracture of lumbar vertebra and an order for gabapentin 300 mg by mouth three times a day for back pain. Review of Resident #14's March 2025 MAR, reflected entries for calcium 500 mg with D 5mg by mouth daily and an entry for Gabapentin give 300 mg by mouth three times daily. Review of the documentation on the MAR for the calcium and gabapentin reflected a 9 was documented indicating from the facility's chart code other/ see nurses notes. Review of the nurses' notes reflected no entry regarding the administration of the medication. Observation on 03/10/2025 at 8:16 AM, revealed MA E prepared Resident #14's medication for administration. MA E prepared 8 medications for administration which did not include her physician ordered calcium or gabapentin. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/10/2025 at 10:30 AM, MA E stated she did not give Resident #14's calcium or gabapentin during morning medication pass because the calcium medication was not in stock, and she was not sure why the gabapentin was not available because it was ordered but she did not see it on the cart, so she did not give it. When she was asked if she reported the missing medication to her nurse she stated she had not but would. Observation and interview on 03/10/2025 at 1:26 PM, Resident #14 stated she was ok and did not have pain at this time. She stated they gave her Tylenol and that always helps. Resident #14 stated she was not really sure what medications she took and did not know she did not get all of her morning medications. In an interview on 03/10/2025 at 4:25 PM, the DON stated Resident #14's physician was notified that her calcium and gabapentin were missed, and he stated to not give her the missing dose of gabapentin to wait until the next dose. She stated the facility did not have the right calcium for Resident #14 but was able to get it from the pharmacy right away. She stated Resident #14's gabapentin was in the medication room all the med aide had to do was go get it. The DON stated it was the MA's and nurses' responsibility to make sure all medications are available for administration, and she expected the medication aides to let their nurse know if a medication is not available for administration right away. She stated the medication aide should have stopped the medication pass and looked for the medications. She stated she had re-in-serviced the MA to make sure she knew the facility's procedure to make sure the residents get the right medications at the right time. 2.) Review of Resident #29's face sheet dated 03/10/2025 reflected an [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses enterocolitis due to clostridium difficile (It is a highly contagious bacterium that causes diarrhea and colitis.) and constipation (is a condition in which you have hard, dry, or lumpy stools that are difficult or painful to pass, or fewer than three bowel movements a week.). Review of Resident #29's quarterly MDS dated [DATE] reflected he was assessed to have a BIMS score of 13 indicating he was cognitively intact. Resident #29 was further assessed to always be incontinent of bowel. Review of Resident #29's comprehensive care plan reflected a focus area dated 05/14/2024 Bowel/ Bladder . Resident #29 has meds/ dx that can/may affect his bowel and bladder status. Interventions included medications and creams as ordered. Review of Resident #29's consolidated physician orders dated 03/10/2025 reflected an order for saccharomyces boulardii (probiotic) oral capsule give one by mouth daily. Review of Resident #29's March 2025 reflected an entry for saccharomyces boulardii. Review of the documentation on the MAR for the saccharomyces boulardii reflected a 9 was documented indicating from the facility's chart code other/ see nurses notes. Review of the nurses' notes reflected no entry regarding the administration of the medication. Observation on 03/10/2025 at 8:16 AM, revealed MA E preparing Resident #29's medication for administration. MA E prepared 8 medications for administration which did not include his physician ordered saccharomyces boulardii (probiotic) capsule. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/10/2025 at 10:30 AM, MA E stated she did not give Resident #29's saccharomyces boulardii during morning medication pass because she just missed it. After she reviewed his orders she stated she should have given him the medication during the morning medication pass. In an interview on 03/10/2025 at 4:25 PM, the DON stated Resident #29's probiotic was not in stock and had to be obtained from the pharmacy. She stated it was the MA's and nurses' responsibility to make sure all medications are available for administration, and she expected the medication aides to let their nurse know if a medication is not available for administration right away she stated the medication aide should have stopped the med pass and looked for the medications. She stated she had re-in-serviced the MA to make sure she knew the facility's procedure to make sure the residents get the right medications at the right time. Review of the facility's policy medication administration dated 11/2024 reflected This community supervises or administers all medications a resident receives as ordered by their physician. The community provides appropriate methods and procedures for obtaining, dispensing, and administering drugs approved by the resident's physician and consulting pharmacist. Orders are obtained from the resident's physician either to the community or from the pharmacy, if using pharmacy-initiated orders. Medication orders initiated by the pharmacy are verified by the director of nursing (DON), executive director, or designee. Staff members responsible for administering medications review the physician's order prior to administering medications . 8. Medication is ordered on a timely basis by an approved staff member. All the information on the medication label is faxed to the preferred pharmacy. The preferred pharmacy delivers the medications the next working day; however, in an emergency, will deliver when needed .

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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. Based on observations, interviews, and record reviews the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety in one of one kitchen reviewed for kitchen and food sanitation. The facility failed to ensure [NAME] J wore gloves and used proper hand hygiene while preparing purée food for residents on 03/10/2025. The facility failed to ensure Culinary Aide I wore gloves while preparing a cake on 03/11/2025. These failures could have placed residents at risk for food contamination and foodborne illness. Findings included: Observation on 03/10/2025 at 11:11 AM revealed [NAME] J had just finished checking temperatures of the baked chicken, rice, and beans that she pulled out of the oven wearing an oven mitt, and then proceeded to purée beans in the grinder. [NAME] J did not wash her hands and did not put on gloves before starting the purée process. [NAME] J touched the inside of the grinder blade as she adjusted the grinder prior to putting the beans in the grinder. She stood with the palms of her hands touching the countertop and then touched the inside of the grinder lid during the puréed process. She did not wash her hands and was not wearing gloves. Observation and interview on 03/10/2025 at 11:19 AM revealed [NAME] J washed her hands and then did the chicken purée. During the chicken purée process, [NAME] J touched her shirt, her pants, put her hand in her pants pocket and then inside an oven mitt, touched the inside of the chicken pan, the kitchen counter, a meal cart by the stove that had dirty dishes sitting on top, and did not wash her hands nor put on gloves after she touched multiple surfaces in the kitchen. [NAME] J rested her hands on the kitchen counter while preparing the purée chicken. [NAME] J stated that she received training in hand hygiene and knew that she needed to wash her hands when she arrived in the kitchen and before touching food to avoid cross contamination, otherwise residents get sick. She did not think she had done anything wrong and stated she did not directly touch any of the food she was pureeing. In an interview on 03/10/2025 at 11:45 AM, the Registered Dietitian stated that kitchen staff were to always wear gloves when preparing food, which included the purée food process to avoid bare hands encountering food. This was to avoid cross contamination and sanitation issues. She stated that if a kitchen staff were to touch their face or other surfaces in the kitchen while preparing food, they must change gloves, wash their hands, and put on new gloves. Also, staff needed to wash their hands in between tasks such as after checking temperatures and before starting to prepare food. She stated that [NAME] J not wearing gloves during the purée process and touching multiple surfaces in the kitchen would not meet her expectations and stated they needed in-service training about hand hygiene and glove usage. (continued on next page)

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	675837	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/10/2025 at 11:51 AM, the Culinary Director stated that kitchen staff should wash hands when they arrived in the kitchen and in between different tasks. She stated she would expect staff to wear gloves while preparing food to avoid cross-contamination and to maintain proper sanitation. She stated lack of proper hand hygiene could make residents ill. Observation and interview on 03/11/2025 at 08:58 AM, revealed Culinary Aide I was preparing food in the kitchen. She was opening dry ingredients (batter) and pouring it in a large bowl. She was not wearing gloves. She stated that she was baking a cake and made all the desserts for the facility. She stated she had been trained on hand hygiene and the use of gloves. Culinary Aide I stated she knew to wash hands before and after tasks, after touching surfaces in the kitchen, and before and after putting on gloves. She stated she must wear gloves when she had direct contact with food to avoid bacteria and germs getting into the food, which could make the residents sick. In an interview on 03/11/2025 at 10:24 AM, the DON stated kitchen staff must wear gloves when handling food. Her expectation would be that staff wore gloves during food preparation, including food purée process, and washed their hands before putting on gloves, and after touching multiple surfaces in the kitchen. The DON stated that the best prevention against infection was proper hand washing and the use of gloves to prevent food borne illnesses to residents, which could cause nausea, diarrhea, and dehydration, especially in the elderly population. The DON stated that [NAME] J not wearing gloves while puréeing food for residents and not washing her hands after touching multiple surfaces in the kitchen and her clothes, would not meet her expectations. The DON stated the kitchen staff needed training on proper hand hygiene and glove usage. In an interview on 03/11/2025 at 01:14 PM, the Administrator stated it was the facility's policy to wash hands before prepping meals and to wear gloves during food preparation process. She stated that if staff did not have gloves on and they touched any part of their body or other surfaces in the kitchen, she would expect them to wash their hands and put on new gloves to prevent food borne illness and protect residents from getting sick. The Administrator stated that [NAME] J not wearing gloves while puréeing food for residents and not washing her hands after touching the inside of the grinder, multiple surfaces in the kitchen and her clothes, and putting her hand inside an oven mitt, would not meet her expectations. Review of the kitchen's in-service trainings from September 2024 to March 1, 2025 revealed kitchen staff had not been trained on hand hygiene and glove usage prior to the survey. Review of the facility's undated Policy & Procedure Manual titled Food Safety and Sanitation reflected, Policy: All local, state, and federal standards and regulations will be followed in order to assure a safe and sanitary food and nutrition services department. Procedure: 2. Employees (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Employees will wash their hands just before they start to work in the kitchen and after smoking, sneezing, using the restroom, handling poisonous compounds or dirty dishes, and touching face, hair, other people or surfaces or items with potential for contamination. Review of the facility's undated Policy & Procedure Manual titled Employee Sanitary Practices reflected, Policy: All food and nutrition services employees will practice good personal hygiene and safe food handling procedures. Procedure: All employees will: 2. Wash hands before handling food, using posted hand-washing procedures. 4. Use a single use glove to cover bandages on cuts or sores located on the fingers, hands, or wrists when working with exposed food. Review of the facility's undated Policy & Procedure Manual titled Hand Washing reflected, Policy: Employees will wash hands as frequently as needed throughout the day using proper hand washing procedures (and surrogate prosthetic device washing procedures as appropriate). Hand washing facilities will be readily accessible and equipped with hot and cold running water, paper towels, and/or automatic hand dryer, soap, trash cans and signage outlining hand washing procedures . Procedure: Hands and exposed portions of arms (or surrogate prosthetic devices) should be washed immediately before engaging in food preparation. 1. When to wash hands: g. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During food preparation, as often as necessary to remove soil or contamination and to prevent cross contamination when changing tasks. j. After engaging in other activities that contaminate the hands. Review of the facility's undated Policy & Procedure Manual titled Bare Hand Contact with Food and Use of Plastic Gloves reflected, Policy: Single-use gloves will be worn when handling food directly with hands to assure that bacteria are not transferred from the food handlers' hands to the food product being served. Bare hand contact with food is prohibited. Procedure: 1. Staff will use good hygienic practices and techniques with access to proper hand washing facilities (available soap, hot water, and disposable towels and/or heat/air drying methods). Antimicrobial or antiseptic gel will not be used in place of proper hand washing techniques. 2. Staff will use clean barriers such as single-use gloves, tongs, deli paper and spatulas when handling food. 3. Gloved hands are considered a food contact surface that can become contaminated or soiled. If used, single use gloves shall be used for only one task (such as working with ready-to-eat food or with raw animal food), used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. 4. Hands are to be washed when entering the kitchen and before putting on the single-use gloves (before beginning work with food) and after removing single use gloves. 5. Clean barriers such as single-use gloves are to be used when: a. Handling ready-to-eat foods. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Handling raw meat, poultry, raw eggs, fish, and shellfish. c. Preparing foods such as meatloaf or meat salads. d. Hand tossing salad, mixing coleslaw, potato or macaroni salad. e. Bagging bread or cookies. f. Anytime hands would otherwise touch food DIRECTLY. 6. Gloves are just like hands. They get soiled. Anytime a contaminated surface is touched, the gloves must be changed, and hands must be washed: c. After handling soiled trays or dishes. d. After handling anything soiled. g. During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks. I. Any time a contaminated surface is touched.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 one of five residents (Resident #15) reviewed for infection control practices. The facility failed to ensure LVN D followed standard precautions during wound care on 03/10/2025 for Resident #15's Stage III pressure ulcer to her sacrum, when she failed to set up a clean wound dressing field without cross contamination and failed to use a cleaning technique on the pressure ulcer that did not cross contaminate the pressure ulcer or prevent the pressure ulcer once cleaned from becoming re-contaminated. This failure placed resident at risk for developing wound infections, and at risk for healthcare associated cross-contamination and infection. Findings included: Review of Resident #15's face sheet dated 03/10/2025 reflected a [AGE] year-old female admitted the facility on 10/28/2020 with the following diagnoses dementia (A group of symptoms that affects memory, thinking and interferes with daily life.) transient cerebral ischemic attack (brief blockage of blood flow to the brain.)and malignant neoplasm of the colon (colon cancer). Review of Resident #15's significant change MDS dated [DATE] reflected she was assessed to have a BIMS score of three indicating severe cognitive impairment. Resident #15 was assessed to be at risk for pressure ulcers and was assessed to have a stage III pressure ulcer. Review of Resident #15's comprehensive care plan reflected a focus area dated 03/06/2025 Actual Potential for complications with impaired skin integrity . pressure related to incontinence, immobility and cognitive impairment. Interventions included wound care physician evaluation and treatment as needed. Review of Resident #15's weekly wound round documentation dated 03/06/2025 reflected Resident #15 had a Stage 3 Pressure ulcer to her sacrum measuring 1 cm long by 0.5 cm wide with 0.2 cm depth. Observation on 03/10/2025 at 11:06 AM, revealed LVN D prepared her clean field for Resident #15's wound care. LVN D placed a whole (newly opened) package of 4x4's, a bottle of wound cleanser and a box of gloves along with her dressings. LVN D then stated she was going down the hall to wash her hands and left her clean field while she went down the hall to wash her hands. LVN D then returned and entered Resident #15's room to preform wound care. During wound care LVN D cleansed Resident #15's pressure ulcer to her coccyx with her left hand she was holding Resident #15's left buttock to expose the coccyx pressure ulcer once she cleansed the wound she allowed the skin folds to fall back over the pressure ulcer (contaminating the wound) and without re-cleaning applied the dressing. After the treatment LVN D then took the package of 4x4, wound cleanser and gloves used during care and placed them back on her treatment cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/10/2025 at 11:42 AM, LVN D stated she did go down the hall to wash her hands and should not have left her clean field because anyone could have walked by and contaminated her field. She stated she should not have taken the package of 4x4's, wound cleanser, and gloves back to her cart because once she brought them into the room they were contaminated and should not be used on other residents. LVN D further stated she should not have let Resident #15's skin fall back over her wound because it caused the wound to be contaminated and it needed to be recleaned prior to putting the dressing on. She stated that she should have had a second person in there to help her to prevent that from happening, but they were all busy and she did not find anyone to help. In an interview on 03/10/2024 at 4:20 PM, the DON stated staff are not supposed to take items into room then bring them back to their cart she stated that was cross contamination and could lead to infections. she stated it was her expectation that staff use wound cleansing tech that do not re contaminate the wound. She stated if the skin folds fall back over the wound the wound would need to be recleaned. Review of the facility's policy Infection Prevention and Control Program dated 02/2024 reflected The community will maintain an organized, effective community-wide program designed to systematically identify and reduce the risk of acquiring and transmitting infections among residents. visitors and team members. This program involves the collaboration of many programs and services within the community and is designed to meet the intent of regulatory and accrediting agencies . Review of the facility's policy Clean Dressing Change Technique (not dated) reflected What is a clean dressing change? By definition a clean dressing change involves techniques to reduce the overall number of microorganisms during a dressing change. This helps to prevent or reduce the risk of transmission of microorganisms from person to person and/or surface. This technique utilizes handwashing, maintaining a clean surface, and using gloves and sterile instruments to prevent direct contamination of supplies and materials. Clean technique is considered most appropriate for long term care, chronic wounds, and wounds not at high risk for infection .As a rule, anything that enters the room must be cleaned with an antibacterial when leaving the resident's room, this includes spray bottles, tubes/bottles of ointments, scissors, etc.No open dressings should be on the cart. Dispose of unused supplies .