STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675842	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MI Casita Nursing and Rehabilitation Center	2400 Quaker Ave Lubbock, TX 79410

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** 49305 Based on observations, interviews, and record reviews, the facility failed to ensure each resident was treated with respect, dignity, and care for each resident in a manner and in an environment that promoted the maintenance or enhancement of their quality of life, recognizing each resident's individuality. The facility failed to protect and promote the rights of the resident for 1 of 18 (Resident #33) residents reviewed for resident rights. CNA D failed to provide Resident #33 privacy during incontinent care. This failure could place residents at risk for diminished quality of life and loss of dignity and self-worth. Findings included: Record review of Resident #33's face sheet dated 01/13/24, revealed a [AGE] year-old male with an original admitted [DATE] with the following diagnoses: Type 2 Diabetes Mellitus (inability of the body to use insulin properly), cerebral infarction (stroke), diverticulosis (digestive condition), cognitive communication deficit (communication difficultly caused by cognitive impairment), dysphagia (difficulty swallowing) and anxiety. Record review of Resident #33's admission MDS dated [DATE] revealed a BIMS of 08, indicating mild cognitive impairment. Section H-Bladder and Bowel revealed Resident #33 was always incontinent of bowel and bladder. Record review of Resident #33's comprehensive care plan revised on 07/25/24, revealed the resident was incontinent with an intervention to provide incontinence care after each incontinent episode. During an incontinent care observation on 01/07/25 at 10:51 AM for Resident #33, CNA D failed to pull the privacy curtain before performing incontinent care, which placed the resident at risk of exposure if a staff member or resident opened the door. During incontinent care, CNA D left Resident #33 uncovered while he went to the resident's restroom to sanitize his hands between glove changes, which exposed the resident's lower back and buttocks areas. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/07/25 at 3:12 PM with CNA D, he stated he failed to properly provide privacy to Resident #33 during incontinent care by not pulling the privacy curtain and not draping the resident when he left the bedside to sanitize his hands. He stated he had been trained to provide privacy during incontinent care, but he was rushing and got in too big of a hurry. CNA D stated he had received privacy training from the DON and the ADON and through monthly training videos. He stated a potential negative outcome for failure to provide privacy during care was the resident could be exposed and have a lack of privacy. During an interview on 01/08/25 at 11:38 AM with the ADM, she stated she was not aware that staff were not providing proper privacy to residents during care. She stated all staff had been trained on privacy and dignity by nursing administration. When asked what her expectation was for staff to provide privacy during care, she stated, It is a big deal to me. A lot of people are modest, and I expect staff to always maintain the residents' privacy. The ADM stated a potential negative outcome for failure to provide privacy during care was that the resident would be embarrassed or have a decreased level of self-esteem. During an interview on 01/08/25 at 12:09 PM with the DON, she stated she was not aware that staff were not providing proper privacy to residents during care, prior to survey. She stated privacy during care should be provided to each resident by closing the door, pulling the privacy curtain, closing the blinds, and draping the resident appropriately. She stated she was responsible to assure staff were trained on providing privacy during care and training was conducted through in services as well as through monthly video trainings. The DON stated a potential negative outcome for failure to provide privacy during care was that resident dignity was not intact. Record review of the facility's policy titled; Dignity, date revised February 2021 revealed: Policy Statement: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Policy Interpretation and Implementation: 1. Residents are always treated with dignity and respect. 11. Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. 12. Demeaning practices and standards of care that compromise dignity is prohibited. Staff are expected to promote dignity and assist residents . Record review of the facility's policy titled; Resident Rights, date revised February 2021 revealed: Policy Statement Employees shall treat all residents with kindness, respect, and dignity. Policy interpretation and Implementation (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity; . t. privacy and confidentiality;

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46425 Based on interviews and record review, the facility failed to ensure all residents had the right to formulate advance directives for 1 of 15 residents (Resident #11) reviewed for advanced directives. The facility failed to ensure Residents #11, who was listed as DNR (Do Not Resuscitate), had an Out-of-Hospital Do Not Resuscitate (OOH-DNR) form that did not have missed required information on the OOH-DNR. These failures could place residents at risk for not having their end of life wishes honored and incomplete records. Findings included: Resident #11 Record review of Resident #11's undated face sheet revealed a [AGE] year-old-female who was admitted to the facility on [DATE] and had diagnosisies which included Cerebral infarction (lack of blood supply to the brain), Dementia (irreversible that causes mental deterioration) and Type 2 Diabetes (problem with blood sugar). The face sheet indicated under the advance directive section - DNR-Do Not Resuscitate. Record review of Resident #11's physician order summary dated 01/08/24 reflected the following order: DNR-Do Not Resuscitate dated 05/19/23. Record review of Resident #11's care plan, dated 12/05/24, reflected care plan for DNR. Record review of Resident #11's OOH-DNR form dated 05/17/23 reflected there was no date that accompanied one of the witness's signatures. During an interview on 01/08/24 at 12:25pm with the SW, she stated OOH DNR was not valid if it's not filled out correctly. She stated she was responsible for ensuring OOH-DNRs were completed correctly. She verified missing information on OOH-DNR for Residents #11. She stated there was no system for monitoring OOH-DNRs for accuracy. She stated the reason the DNR's were not complete was human error. She stated she has been trained on OOH-DNRs. The SW stated the potential negative outcome for residents if a DNR was not completed correctly was the Resident may not have their final wishes honored and the facility may be taken to court. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/08/24 at 1:05PM with the ADM, she stated the OOH DNR was not valid if not filled out correctly. She stated the DON was responsible for making sure the OOH DNR was completed accurately. She stated they did not have a system in place to monitor OOH DNR for accuracy. She stated the DON should be reviewing the OOH DNRs for accuracy. She verified missing information on OOH DNR for Residents #11. She stated she did not know why the information was missing. She stated the potential negative outcome was the Resident's end of life wishes may not be honored. She stated she was trained on how to complete OOH DNR and her expectations were for them to be filled out completely and be correct. Record review of the Social Services Policies and Procedures Advanced Directives (Revised March 2021) reflected the following: Policy Our facility will not use cardiopulmonary resuscitation and related emergency measures to maintain life functions on a resident when there is a Do Not Resuscitate Order in effect. A DNR order form must be completed and signed by the attending physician and resident or resident's legal surrogate and placed in the front of the resident's medical record. Should the resident be transferred to the hospital, a photocopy of the DNR order form must be provided to the personnel transporting the resident to the hospital. The DNR orders will remain in effect until the resident or legal surrogate provides the facility with a signed and dated request to end the DNR order. The interdisciplinary care planning team will review advance directives with the resident during quarterly care planning sessions to determine if the resident wishes to make changes in such directives. The resident's attending physician will clarify and present any relevant medical issues and decisions to the resident or legal representative as the resident's condition changes to clarify and adhere to the resident's wishes. Inquiries concerning do not resuscitate orders/requests should be referred to the administrator, director of nurses, or the social services director.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49927 Based on observations, interviews, and record reviews, the facility failed to provide a safe, clean, comfortable, and homelike environment for 1 (Resident #10) of 4 residents reviewed for ADL care. The facility failed to ensure Resident #10's wheelchair was clean. This deficient practice could place residents at risk of neglect, infection, and a diminished quality of life. Findings included: Review of Resident #10's admission record, dated 01/08/2025, reflected a [AGE] year-old male resident who was admitted to the facility on [DATE] with diagnoses including Sacral spina bifida (a condition that occurs when the spine and spinal cord don't form properly, type of neural tube defect) without hydrocephalus (a condition that occurs when fluid builds up in the skull and causes brain swelling), age-related nuclear catarac, bilateral (cloudy lens that hardens and turns yellowish over time, leading to decreased vision), primary optic atrophy bilateral (damage to optic nerve, which carries impulses from your eye to brain), dysphagia oropharyngeal phase (inability to swallow food or drink due to neurological, neuromuscular, or structural impairments), paraplegia (paralysis of the legs and lower body), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Review of Resident #10's quarterly MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 15, indicating the resident was cognitively intact. Review of Resident #10's Care Plan dated 12/11/2015, revised on 11/19/2020, indicated the following: The focus area stated Incontinence and Mr. [NAME] has frequent bowel and bladder incontinence. The goal stated, He will reman free from skin breakdown due to incontinence. The interventions included BRIEF USE: He wears Med disposable briefs. Change every 2 hours if damp, every4 hours if dry and as needed, moisture barrier and needed or indicated. During an observation on 01/07/2025 at 09:25 AM, a motorized wheelchair was observed in the hallway, outside of Resident #10's room. The wheelchair was observed to have brown spots covering the backrest of the wheelchair as well as brown spots on the seat of the wheelchair. During an observation and interview on 01/07/2025 at 09:51 AM, the motorized wheelchair was observed in the same place, in the hallway, outside of Resident #10's room. CNA C was then observed moving the wheelchair into Resident #10's room. CNA C was asked who the wheelchair belonged to, and she stated it belonged to Resident #10. During an observation on 01/07/2025 at 12:10 PM Resident #10 was observed in his wheelchair in the dining area during lunch. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 01/07/2025 at 01:15 PM Resident #10 was observed going into his room in his wheelchair. CNA C was observed assisting Resident #10 in his room. Resident #10 was heard saying he had a blowout, and he asked CNA C, did it get on my chair?. The door to Resident #10's room was closed after they entered and the conversation could no longer be heard. During an observation on 01/07/2025 at 02:23 PM, the motorized wheelchair was observed again in the hallway, outside of Resident #10's room. The wheelchair was observed to have the same brown spots covering the backrest of the chair, as well as on the seat. During an observation and interview on 01/07/2025 at 04:40 PM, the motorized wheelchair was observed again in the hallway, outside of Resident #10's room. The wheelchair was observed to have the same brown spots covering the backrest of the chair as well as on the seat. Resident #10 was observed in his bed. Resident #10 stated his wheelchair had not been cleaned all day. Resident #10 stated he was aware the wheelchair was soiled all day. Resident #10 stated he did not know why it had not been cleaned throughout the day. Resident #10 stated it did bother him that his wheelchair was soiled, and he wanted it to be cleaned. Resident #10 stated he wanted the nursing staff to be notified that his wheelchair needed to be cleaned. During an interview on 01/07/2025 at 04:45 PM, LVN B stated the CNAs were responsible for ensuring wheelchairs were cleaned when they were soiled during their shift. LVN B stated she was not aware Resident #10's wheelchair was soiled. LVN B stated CNA C was the CNA assigned to Resident #10's room, that shift, and stated she would have CNA C clean Resident #10's wheelchair. During an interview on 01/08/2025 at 12:05 PM CNA A stated Resident #10 was incontinent and had frequent bowel movements due to the medication he was prescribed. CNA A stated it was a CNA's responsibility to clean up Resident #10 and to clean any soiled area such as bedding or Resident #10's wheelchair. CNA A stated she did not work on the previous day , but she frequently cleaned Resident #10's wheelchair during her work shifts. CNA A stated if a resident's wheelchair was left soiled with feces, it would have been unsanitary and could have been embarrassing to the resident. During an interview on 01/08/2025 at 12:15 PM CNA B stated she did not work on the previous day, and she did not see Resident #10's wheelchair soiled recently. CNA B stated Resident #10 was incontinent, and it was common for Resident #10 to defecate through his brief. CNA B stated, when this occurred, it was the CNA's responsibility to clean Resident #10 and his bedding or wheelchair. CNA B stated it was important to maintain the cleanliness of residents' wheelchairs because it was not sanitary to leave a wheelchair soiled with feces. During an interview on 01/08/2025 at 12:45 PM the DON stated Resident #10's wheelchair had to be washed frequently due to incontinence. The DON stated the nursing staff overnight was responsible for cleaning all residents' wheelchairs. The DON stated, if a wheelchair was soiled through out the day, it was the CNA's responsibility to clean the soiled wheelchair. The DON stated any staff who observed the soiled chair should have ensured it was cleaned promptly. The DON stated the CNA who transferred the resident in and out of the wheelchair should have noticed the chair and cleaned it after the resident was cleaned and situated. The DON stated there was potential for embarrassment to the resident as well as an unsanitary environment. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/08/2025 at 1:30 PM the ADM stated wheelchairs were cleaned during the night shift and should have been cleaned daily for every resident. The ADM stated Resident #10 was incontinent and had frequent bowel movements that would leak from his brief. The ADM stated the CNA that transferred Resident #10 should have observed the soiled wheelchair and cleaned it after the CNA cleaned up the resident. The ADM stated any staff that observed the soiled wheelchair was responsible for ensuring it was cleaned promptly. The ADM stated the resident's wheelchair should have been cleaned after every transfer since the resident had frequently soiled briefs. The ADM stated it was not sanitary to have the resident placed on a soiled wheelchair with clean clothing, and there was a risk of embarrassment to the resident which could have affected his self esteem. During an interview on 01/08/2025 at 02:30 PM CNA C stated it was the CNAs responsibility to clean a resident's wheelchair if the wheelchair was soiled. CNA C stated she was assigned on the hallway where Resident #10 resided the previous day. CNA C stated she helped transfer Resident #10 to and from his wheelchair during her shift. CNA C stated she did not see Resident #10's wheelchair soiled with feces, but she did clean Resident #10 after he was incontinent. CNA C stated Resident #10 had frequent bowel movements that leaked outside of his brief, and this got on his wheelchair at times. CNA C stated she did not know why the wheelchair was not cleaned throughout the day on the previous date. CNA C stated she was unaware that the wheelchair was soiled. CNA C stated she could not recall checking the wheelchair during the day. CNA C stated she cleaned the wheelchair after LVN B asked her to, at the end of her shift. CNA C stated the wheelchair should have been cleaned right away if it was soiled. CNA C stated the wheelchair should have been cleaned before the resident was helped back into it. CNA C stated Resident #10's wheelchair remaining soiled throughout the day could have been a sanitary concern as well as a concern for the resident's dignity. Review of the facility's policy titled Cleaning and Disinfection of Resident-Care Items and Equipment revised September 2022 revealed the following documentation: Policy Statement Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard. Policy Interpretation and Implementation I. The [NAME] Classification System is used to distinguish the levels of sterilization/disinfection necessary for items used in resident care: a. Non-critical items are those that come in contact with intact skin but not mucous membranes. i. Non-critical resident-care items include bedpans, blood pressure cuffs, crutches and computers. ii. Non-critical environmental surfaces include bed rails, bedside tables, etc. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	iii. Non-critical items require cleaning followed by either low- or intermediate-level disinfection following manufacturers' instructions. Disinfection is performed with an EPA-registered disinfectant labeled for use in healthcare settings. All applicable label instructions on EPA registered disinfectant products are followed (e.g. , use-dilution, shelf life, storage, material compatibility, safe use and disposal). 1. Low-level disinfection is defined as the destruction of all vegetative bacteria (except tubercle bacilli) and most viruses, some fungi, but not bacterial spores. Examples of low-level disinfectants include EPA-registered hospital disinfectants with a HBV and HIV label claim. Low-level disinfection is generally appropriate for most non-critical equipment. 2. Intermediate-level disinfection is traditionally defined as destruction of all vegetative bacteria, including tubercle bacilli, lipid and some nonlipid viruses, and fungi, but not bacterial spores. EPA-registered hospital disinfectants with a tuberculocidal claim are intermediate-level disinfectants. Intermediate-level disinfection is considered for non-critical equipment that is visibly contaminated with blood. However, a low-level disinfectant with a label claim against HBV and HIV may also be used.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 46425 Based on observations, interviews, and record review, the facility failed to provide information to resident's and their representatives on their rights related to filing grievances or concerns for 9 of 15 confidential residents. The facility failed to ensure 9 of 15 confidential residents were provided, through postings in prominent locations, the Grievance Procedure, were provided access to the Grievance form, were provided information who the facility grievance official was, their contact information, how to file an anonymous grievance, and their right to obtain a written decision related to their grievance. This failure could place the residents at risk of unresolved grievances and decreased quality of life. Findings included: Interviews and Record Review during Resident Council on, 01/07/2024 at 1:30pm, attendees 9 of 15 confidential residents, stated they did not have access to the Grievance form, they did not know they could file a Grievance anonymously, the Grievance procedure had never been discussed in Resident Council, and they had not observed a posting of the Grievance procedure in prominent locations. Residents attending Resident Council did not know where to acquire a grievance form, who to turn the form into, and what happened once a grievance was filed. The Residents did not know they had the right to receive a written decision once their grievance was resolved. 9 Residents attended the meeting, the 9 Residents in attendance had all been Residents of the facility for 6 plus months. Observed and toured the facility; there were no Grievance forms available to Residents and there was no access to submit a Grievance anonymously. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the ADM on 1/8/2024 at 1:05pm; the ADM stated she was the Grievance Officer for the facility. The ADM stated she alone reviewed Grievances, assigned the Grievance to the appropriate department head, ensured the resolution to the Grievance was documented on the Grievance form, and she followed up with the resident and their family members to inform them of the resolution to the Grievance. The ADM stated the form was kept in her office and at each of the nurses' station. The ADM stated she did not remember informing the Residents or the Activities Director of the location of the Grievance form. The ADM stated she was not aware Residents needed access to the Grievance form and she was not aware the Residents needed an avenue to submit a Grievance anonymously. The ADM stated she completed Grievance forms for residents, Residents did not ask for forms or complete them on their own. The ADM stated there were no procedures for Residents to submit Grievances anonymously. The ADM stated she addressed Grievances immediately and she expected department heads to address Grievances immediately. The ADM stated she did not know what the facility policy stated the timeframe was for Grievances to be addressed. The resolution for all Grievances were documented on the Grievance form and the completed form was submitted to the ADM for review. The ADM stated completed Grievance forms were kept in a notebook for 3 years. The ADM stated she monitored the Grievance process for success by following up with the staff member assigned to resolve the Grievance, the ADM stated she also met with the complainant to ensure they were satisfied with the resolution. The ADM stated she was responsible for ensuring staff were trained on the Grievance process. The ADM stated she was not aware the Grievance procedure was not being discussed in Resident Council. Grievance Policy Record Review indicated the policy was last revised in June 2005. Our facility investigates all grievances and complaints filed with the facility. Policy Interpretation and Implementation: 1. The ADM was assigned the responsibility of investigating Grievances and complaints. 2. Upon receiving and complaint report the ADM will investigate the allegations. The department head involved in the Grievance. 3. The Grievance Form must be filed with the ADM within 5 days of the complaint. 4. The Resident or their Representative will be informed of the findings of the investigation, as well as any corrective actions recommended within 5 working days of the filing of the complaint. 5. A copy of the Grievance form must be filed in the business office. 6. A copy of the resolution must be attached to the Grievance form and made available to the Resident and/or the Resident's representative.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42515 Based on observation, interview and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as was possible for 1 of 15 Residents (Resident #16). The facility failed to store Resident #16's portable oxygen tank properly when not in use. These failures could place residents at risk for avoidable injuries related to improperly storing a portable oxygen tank. The findings included: Record review of Resident #16's admission record, dated 01/08/25, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: end stage renal disease (kidneys stopped working), heart failure, and chronic respiratory failure (breathing problems). Record review of Resident #16's quarterly MDS assessment, dated 10/03/24, revealed a BIMS score of 13, indicating Resident #16 had intact cognition. The MDS further revealed Resident #16 used a wheelchair and was able to use his wheelchair independently. Record review of Resident #16's order summary report, dated 01/08/24, revealed an order: Oxygen: May have oxygen at 1-5L via cannula/mask by concentrator/tank. With a start date of 02/29/24. During an observation on 01/07/25 at 2:23 PM in Resident #16's room revealed 1 portable oxygen tank free-standing and resting up against the wall. The oxygen tank was stored sticking out from the wall on the bottom with the top of the oxygen tank resting up against the wall and was not secure. During an interview on 01/07/25 at 2:26 PM, the DON stated the portable oxygen tank should be stored in a secure area. The DON stated a portable oxygen tank should be kept stored in a single cart with wheels or in a cage that prevents the tank from tipping over. During an interview on 01/08/25 at 10:35 AM, Resident #16 stated the staff put a portable oxygen tank on the back of his chair when he went to dialysis. Resident #16 stated he does not take the oxygen tank on and off his wheelchair. Resident #16 stated staff took his oxygen tank on and off the back of his wheelchair and stated he could not remember which staff member took his portable oxygen tank off yesterday. Resident #16 stated sometimes staff left the oxygen tank in his room against a wall or they would take it somewhere else. (continued on next page)

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MI Casita Nursing and Rehabilitation Center	2400 Quaker Ave Lubbock, TX 79410

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/08/25 at 12:24 PM, the DON stated she was not sure exactly why the portable oxygen tank was unsecured in Resident #16's. The DON stated the staff have been verbally trained on properly securing the portable oxygen tanks. The DON stated a potential risk to the residents with a portable oxygen tank not being secured was it could fall over and become a projectile missile. During an interview on 01/08/25 at 12:31 PM, the ADM stated she expected the portable oxygen tanks to be secured in holders. The ADM stated she has never seen Resident #16 take off his own portable oxygen tank from the back of his wheelchair. The ADM stated the portable oxygen tanks could also be stored in a single rack with wheels if needed. The ADM stated staff have been trained on properly storing portable oxygen tanks and she was unsure why a tank was unsecure in Resident #16's room. The ADM stated a potential risk to the resident was it could explode if it fell over. Record review of the facility's policy and procedure titled, Fire Safety and Prevention, with a revised date of May 2011, reflected the following: Policy Statement: All personnel must learn methods of fire prevention and must report condition(s) that could result in a potential fire hazard. Policy Interpretation and Implementation: .Oxygen Safety: f. Store oxygen cylinders in racks with chains, sturdy portable carts, or approved stands. Never leave oxygen cylinders free-standing. Do not store oxygen cylinders in any resident room or living area Record review of the facility's policy and procedure titled, Hazardous Areas, Devices and Equipment, with a revised date of July 2017, reflected the following: Policy Statement: All hazardous areas, devices and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49305 Based on observations, interviews, and record review the facility failed to ensure that its medication error rate was less than 5 percent. The facility had a medication error rate of 6.52% based on 3 out of 46 opportunities, which involved 3 of 5 residents (Residents #43, #44, and #23) reviewed for medication administration. MA A failed to administer Resident #43's ordered Fluticasone medication (given for allergies), resulting in a missed dose. MA B failed to verify the dose on Resident #44's ordered medication Gabapentin (given for nerve pain), resulting in Resident #44 being underdosed. MA B failed to properly verify and dispense Resident #23's ordered medication Methylphenidate (given for nervous system disorder). These failures could place residents at risk of incomplete therapeutic outcomes, increased negative side effects, and decline in health. Findings included: Resident #43 Record review of Resident #43's face sheet dated 01/08/25 revealed a [AGE] year-old male with an admitted [DATE] with the following diagnoses: unspecified dementia unspecified severity with other behavioral disturbance (loss of memory, language, problem-solving and other thinking abilities), anemia (deficiency of red blood cells or hemoglobin in the blood), moderate protein calorie malnutrition (when not enough protein and calories are consumed), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and allergic rhinitis (inflammation of the nasal passages). Record review of Resident #43's Admission MDS dated [DATE] revealed a BIMS of 13, which indicated the resident was slightly cognitively impaired. Record review of Resident #43's current physicians orders revealed an order for Fluticasone Propionate Nasal Suspension 50 MCG (Fluticasone Propionate (Nasal)) 1 spray in both nostrils one time a day for allergies . During a medication administration observation on 01/07/25 at 09:18 AM for Resident #43, MA A failed to administer Fluticasone Propionate Nasal Suspension 50 MCG/ACT (Fluticasone Propionate (Nasal)) 1 spray in both nostrils one time a day for allergies. MA A documented in the MAR that she administered this medication to Resident #43. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with MA A on 01/07/2024 at 11:05 AM, she stated the MAR reflected she administered Fluticasone Propionate Nasal Suspension 50 MCG/ACT (Fluticasone Propionate (Nasal)) to Resident #43 at 9:21 AM. MA A stated she did not administer the medication to Resident #43. MA A stated she did not know why she marked the medication as being administered since it was not given to the resident. MA A stated this error could lead to Resident #43 not receiving his medication as ordered by his physician. Resident #44 Record review of Resident #44's face sheet dated 01/07/25 revealed a [AGE] year-old male originally admitted to the facility on [DATE] with the following diagnoses: Type 2 Diabetes Mellitus (disease causing blood sugar to be elevated), peripheral vascular disease (circulatory condition causing reduced blood flow to the limbs), cutaneous abscess of right foot (skin infection), hypertension (high blood pressure), complete traumatic amputation at level between left hip and knee (surgical absence of left leg above the knee and below the hip), respiratory failure with hypoxia (condition resulting in inadequate oxygen in the body's tissues), respiratory distress syndrome (breathing condition causing low oxygen in the body), and muscle weakness. Record review of Resident #44's current physician orders dated 01/07/25 revealed an order for Gabapentin Oral Capsule 100 mg (Gabapentin) Give 2 capsules by mouth three times a day related to complete traumatic amputation at level between left hip and knee. During a medication administration observation on 01/07/25 at 9:38 AM, for Resident #44, MA B dispensed one (1) Gabapentin 100 mg capsule into a 30cc clear medication cup and administered the medication, which resulted in Resident #44 being underdosed. MA B failed to verify the medication with the order prior to administering the medication. During an interview with MA B on 01/07/25 at 9:44 AM, she stated she did not administer Resident #44's medication, Gabapentin, correctly. She stated the order was for 2 capsules to be given but she dispensed and administered only one capsule. She stated it was an oversight on her part and it would be considered a medication error and she would let the DON know. MA B dispensed a second Gabapentin 100 mg capsule and administered the medication to Resident #44. She stated failure to give Resident #44 the accurate dose of Gabapentin could result in the resident having an increased level of pain. Resident #23 Record review of Resident #23's face sheet dated 01/07/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses: vascular dementia with behavioral disturbance (dementia caused by impaired blood to the brain), cerebral infarction (stroke), aphasia (difficulty communicating), hemiplegia (paralysis of one side of the body), hemiparesis (muscle weakness to one side of the body), heart failure, disorder of the nervous system, and secondary hypertension (high blood pressure caused by another medical condition). Record review of Resident #23's admission MDS dated [DATE] revealed a BIMS score of 08, indicating the resident had mildly impaired cognition. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #23's comprehensive care plan dated 10/31/24 revealed a focus which stated The resident had a cerebral vascular accident. Medications: Topiramate, Clopidogrel, Gabapentin, Methylphenidate with Interventions/Tasks listed as: Give medications as ordered by the physician. Monitor/document side effects and effectiveness. Record review of Resident #23's current physician orders revealed an order for Methylphenidate HCl Oral Tablet 5 mg (Methylphenidate HCl) Give 1 tablet by mouth one time a day related to other post-procedural complications and disorders of nervous system During a medication administration observation on 01/07/24 at 9:48 AM for Resident #23, MA B was observed preparing morning medications for administration which included nine medications, one of which was a controlled medication. MA B placed the following nine (9) medications into a 30cc clear medication cup: Aspirin 81 mg delayed release - 1 tablet Docusate Sodium 100mg tablet - 2 tablets Multivitamin-Minerals tablet - 1 tablet Fenofibrate 54 mg tablet - 1 tablet Clopidogrel 75 mg tablet - 1 tablet Fluoxetine HCl 40 mg - 1 tablet Topiramate 25 mg tablet - 1 tablet Gabapentin 300 mg capsule - 1 capsule (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MA B was observed to unlock the narcotic box and open the narcotic book to Resident #23's medication count sheet for Methylphenidate 5 mg tablet (given for nervous system disorder). The count for Methylphenidate 5 mg was noted at 5 remaining tablets. MA B was observed to sign out one tablet then wrote the remaining count at 4 tablets and signed her name. A resident in the hallway asked MA B a question, and MA B directed her attention to the resident and answered the question. MA B was then observed to pick up the blister pack for the controlled medication (Methylphenidate 5 mg) and place it back into the lock box drawer, lock the box, then close the drawer to the cart. MA B failed to remove the controlled medication from the blister pack prior to placing the medication back in the cart. MA B failed to verify medications in the cup with physician's orders to verify the correct number of medications to be administered. MA B was then observed to pour water into a drinking cup, lock her medication cart, pick up the cup of medications, and began walking into Resident #23's room to administer the medications. At that time, the surveyor provided intervention and asked MA B to verify the medications in the cup with Resident #23's physician's orders. MA B then opened her computer and counted the number of medications that were to be administered and stated, There should be 10 medications in the cup. MA B counted the medications in the cup and stated, Oh, I only have 9 pills here. I don't know which one is missing. I think I'll have to go back through the medication cards and verify each one. Observed MA B pull Resident #23's medication cards from the medication cart and reconcile the medications in the cup to the orders on her computer screen. MA B was observed to check approximately half the medications, then she accidentally spilled the cup of medications on top of the cart, requiring her to place the medications back into the cup, and restart the verification process. MA B verified 9 routine medications then stated, It must be the narcotic that I missed. MA B then unlocked the narcotic box and pulled out Resident #23's Methylphenidate 5 mg medication card which was observed to have 5 remaining tablets in the blister pack. MA B stated, I guess I got distracted and didn't pop the med after I signed it out. I would have caught it at shift change when the narc count was off, but it would have been too late to give the dose by then. MA B was then observed to dispense one tablet of Methylphenidate 5 mg into the cup with Resident #23's other medications, totaling ten (10) medications. MA B administered the medications from the cup to Resident #23. During an interview on 01/07/25 at 10:28 AM, MA B stated she did not verify medications to be dispensed with physician's orders for Resident #44 and Resident #23. She stated she did not normally count the medications in the cup prior to administering the medications and she had not been trained to do so in her MA training, nor the at the facility. When asked how she would know she had administered the correct number of medications without verifying the order and the count she stated, Well, I wouldn't, but I will definitely count and verify meds going forward because it's obviously easy to make a mistake. MA B stated she worked at the facility as a medication aid as needed and did not recall receiving medication administration training in the past year. She stated she had done a skills check for medication administration with the DON approximately three (3) months ago. MA B stated a potential negative outcome for failure to verify medications with physician's orders would be a higher chance of medication errors. She stated a potential negative outcome for not receiving medications as ordered by the physician would be that a resident might have pain if they miss a pain pill or it could cause other trouble for the resident, depending on what the medication is given for. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/08/25 at 11:38 AM, the ADM stated she was made aware that two staff members made medication errors during medication pass observations. She stated all nursing staff were trained on proper medication administration and the facility's nursing administration was responsible for conducting training. She stated her expectation of staff for administering medications was that staff read orders, administer medications according to the MAR and contact the DON if they have any questions about a medication. The ADM stated a potential negative outcome for failure to administer medications according to physician's orders was the resident could become sick or have a decline in health. During an interview on 01/08/25 at 12:09 PM, the DON stated she was made aware that two staff members made medication errors during medication pass observations. She stated all nurses and medication aids were trained on medication administration and it was the responsibility of nursing administration to conduct training. She stated she conducted skills checks for medication administration for all staff who administer medications. She stated nursing staff were also trained via periodic computer training and medication aids attended recertification training on an annual basis. She stated a potential negative outcome for failure to dispense medications according to physicians' orders was a decline in resident outcomes and residents not being within therapeutic levels of ordered medications. Record review of the facility-provided training document for Medication Pass Competency dated 12/06/24 and marked satisfactory was signed by MA A and the ADON. Record review of the facility-provided training document for Medication Pass Competency dated 12/06/24 and marked satisfactory was signed by MA B and the ADON. Record review of facility-provided policy titled Administering Medications, dated April 2019, revealed: Policy Statement Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation 4. Medications are administered in accordance with prescriber orders, including any required time frame. . 10. The individual administering the medications checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. 22. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next one.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49927 Based on observation, interviews, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments for 1 of 1 medication room reviewed for storage, in that: The facility had a Schedule IV narcotic stored improperly in the medication storage room refrigerator. This failure could result in medication diversion, leading to a resident not receiving ordered treatment, affecting the resident's treatment and care, which could result in deterioration of their health. Findings included: During an observation on 01/07/2025 at 11:05 AM of the medication storage room refrigerator, revealed an unlocked lockbox containing a prescription Lorazepam 2 MG/ML oral concentrate. The lockbox containing the narcotic was not locked, as the padlock for the lockbox was unsecured and open, hanging on the lockbox. During an interview on 01/07/2025 at 11:05 AM with LVN A revealed the following: LVN A opened the lock box in the medication storage room refrigerator and stated the medication found in the lockbox was Lorazepam 2 MG/ML. LVN A stated he was not aware the medication was in the lockbox as he thought the lock box was empty. LVN A stated the lock box should have been locked with the attached padlock since it contained the narcotic, and he was not sure why it was not locked. LVN A locked the lock box and placed it back into the refrigerator. LVN A stated Lorazepam was a medication that was required to be stored in the lockbox to prevent the medication from being stolen. LVN A stated he was not sure who placed the medication inside of the lockbox and stated he did not know how long it had been there. LVN A stated he did not have a key to the lockbox and stated the DON had the key. During an interview on 01/07/2025 at 12:06 PM with DON revealed the following: The DON stated she was not sure why the lock box was not locked inside of the medication storage room refrigerator. The DON stated the medication storage room remained locked at all times and only nursing staff and the ADM had access to the room. The DON stated Lorazepam was a narcotic and was required to be locked in the lock box, inside of the locked room, to ensure the medication was stored properly and to prevent theft of the medication. The DON stated she did not know who left the lockbox unlocked or why it was not locked. The DON stated she was unaware of the medication being stored in the lockbox and she thought the lockbox was empty. The DON stated she and the ADON had the only keys to the lockbox. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/08/2025 at 12:45 PM with the DON revealed the following: The DON stated that nursing staff were notified through orders of any new medications, and this was how they were usually made aware of narcotics that required additional storage restrictions. The DON stated she thought the medication was brought by Hospice for a resident and this was why it was overlooked. The DON stated it should have still been seen during nursing staff's reconciliation at the end of each shift. The DON stated all nursing staff were also required to complete counts of all medication at the end of each shift, and the nursing staff should have checked the medication storage room, including the refrigerator, to ensure all medications were stored properly. The DON stated the medication storage room door should have remained locked at all times as well as the lock box in the refrigerator. The DON stated an in-service would be completed to re-educate staff. The DON stated she was responsible for training staff and ensuring medications were stored properly. The DON stated that staff received regular in-service training pertaining to medication counting and storage, as well as training that they received when they were hired. The DON stated all narcotics had to be stored with a double locking process and had to be reconciled at every shift change. The DON stated this information was included in staff training. The DON stated all nursing staff were responsible for ensuring medications were stored properly. The DON stated there was a risk of narcotics being stolen and residents not receiving their medications as needed, if medications were not stored properly. During an interview on 01/08/2025 at 01:30 PM with the ADM revealed the following: The ADM stated all narcotics should have been under a double lock process. The ADM stated the medication storage room door remained locked at all times, and this was the first lock for the medications. The ADM stated the second lock should have been on the lockbox to properly secure the medication. The ADM stated she was not sure why this lock was not locked. The ADM stated all nursing staff were responsible for reconciling narcotics at the end of each shift. The ADM stated this training was conducted regularly by the DON as well as upon hire for nursing staff. The ADM stated both the door to the medication room as well as the pad lock on the lock box inside of the refrigerator should have been locked at all times. The ADM stated the DON and all nursing staff were responsible for ensuring medications were stored properly and narcotics were under a double lock. The ADM stated there was a potential risk of medication being stolen if they were not stored properly. Record review of the facility's policy Storage of Medications revised November 2020 revealed the following: Policy heading The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation 8. Schedule IJ-V controlled medications are stored in separately locked, permanently affixed compartments. Access to controlled medication is separate from access to non-controlled medications.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42515 Based on observation, interview, and record review the facility failed to provide each resident with a diet that met his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident for 3 (Resident #16, Resident #40, and Resident #25) of 15 residents reviewed for dietary services. The Facility did not provide Resident #16 or Resident #25 with their dietary preferences for 1 of 2 meals reviewed (Lunch on 01/07/25). The Facility did not provide Resident #40 with double portions or his dietary preferences for 1 of 2 meals reviewed (Lunch on 01/07/25). This failure could place residents, who ate meals from the kitchen, at risk for weight loss, altered nutritional status and diminished quality of life. Findings included: Observation of the Lunch meal service on 01/07/25 that began at 11:54 AM revealed sour cream enchiladas were prepared for the main entree and there was not enough sour cream enchiladas for all the residents who requested sour cream enchiladas. Observation on 01/07/25 at 12:34 PM revealed Resident #25 sitting up in a wheelchair in the main dining room. Resident #25 was observed eating a hamburger and was served potato chips alongside the hamburger. Observation on 01/07/25 at 12:35 PM revealed Resident #40 sitting up in a wheelchair in the main dining room. Resident #40 was observed with a plate in front of him with a hamburger and potato chips. Observation on 01/07/25 at 12:38 PM revealed Resident #16 sitting up in his room. Resident #16 was observed eating a hamburger and was served potato chips alongside the hamburger. Interview on 01/07/25 at 12:23 PM, [NAME] A stated they ran out of enchiladas. [NAME] A stated the residents were provided with hamburgers or fish sandwiches to ensure all residents were provided a meal at lunch. [NAME] A stated she thinks there was a problem with the lunch meal because some residents must have changed their mind and originally wanted a hamburger but wanted enchiladas at the last minute. [NAME] A stated the CNA's could also have marked the residents choice incorrectly on the lunch meal dietary slips. Interview on 01/07/25 at 4:29 PM, [NAME] A and the DM stated they were able to see that 39 residents wanted enchiladas for lunch and each resident received 2 enchiladas as their portion. [NAME] A stated the enchiladas come to the facility pre-rolled and when she was making the recipe, she made a total of 75 enchiladas. [NAME] A stated she thought 75 enchiladas was enough for residents to get a serving if they wanted one. [NAME] A agreed 75 enchiladas was not enough for all the residents when 2 enchiladas per resident for 39 residents is a total of 78 enchiladas. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #25's admission record, dated 01/08/25, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: contracture, right knee (joints shorten and become very stiff), major depressive disorder (mood disorder), and hypokalemia (low potassium in blood). Record review of Resident #25's admission record, dated 01/08/25, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: contracture, right knee (joints shorten and become very stiff), major depressive disorder (mood disorder), and hypokalemia (low potassium in blood). Record review of Resident #25's significant change MDS assessment, dated 12/05/24, revealed a BIMS score of 10, indicating Resident #25's cognition was moderately impaired. The MDS further revealed Resident #25 required set-up or clean-up assistance with eating. Record review of Resident #25's order summary report, dated 01/08/25, revealed an order: Regular diet, regular texture, regular consistency with a start date of 07/14/23. During an interview on 01/08/25 at 10:28 AM Resident #25 stated he had asked for the main entree (enchiladas with rice and beans) yesterday (01/07/25) for lunch and was given an alternate meal (hamburger with chips) instead. Resident #25 stated the dietary staff told him they ran out of the main entree and that was why he received an alternate meal instead. Resident #25 stated this was the first time it happened to him. Resident #25 stated it was ok that he got a hamburger but he was looking forward to eating enchiladas. Record review of Resident #40's admission record, dated 01/08/25, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: major depressive disorder (mood disorder), anemia (blood disorder), and severe protein-calorie malnutrition (not getting enough nutrient from food). Record review of Resident #40's quarterly MDS assessment, dated 10/28/24, revealed a BIMS score of 09, indicating Resident #40's cognition was moderately impaired. The MDS further revealed Resident #40 required set-up or clean-up assistance with eating. Record review of Resident #40's order summary report, dated 01/08/25, revealed an order: Regular diet, Regular texture, regular consistency, Fortified foods with all meals. Large protein portions with lunch and dinner meal with a start date of 08/23/24. During an interview on 01/08/25 at 10:32 AM, Resident #40 stated he asked for enchiladas yesterday for lunch and was given an hamburger and chips. Resident #40 stated he does not know why he did not get enchiladas for lunch yesterday. Resident #40 stated sometimes the kitchen serves him something different than what he asked for and stated it does not happen often. Record review of Resident #16's admission record, dated 01/08/25, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: end stage renal disease (kidneys stopped working), type 2 diabetes mellitus (blood sugar problems), and cirrhosis of liver (damaged liver that does not function properly). (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #16's quarterly MDS assessment, dated 10/03/24, revealed a BIMS score of 13, indicating Resident #16's cognition was intact. The MDS further revealed Resident #16 was independent with eating. Record review of Resident #16's order summary report, dated 01/08/25, revealed an order: Low Concentrated Sweets diet. Regular texture, regular consistency, please limit bananas, potatoes, raw tomatoes and citrus with a start date of 10/20/21. During an interview on 01/08/25 at 10:35 AM, Resident #16 stated he had wanted enchiladas for lunch yesterday and it turned into a hamburger. Resident #16 stated the dietary staff told him there was not enough enchiladas for all the residents who wanted them. Resident #16 stated the dietary [department] has been running out of food lately. Resident #16 stated he is always given food to eat, but lately it is not always what he requested. Record review of the facility's menu titled, Fall Winter 2024 Week 4 with January 7, 2025 listed in the dates. The menu for January 7, 2025 was as follows: Sour Cream Enchiladas, Spanish Rice, Refried Beans, Churro Bites, Salt/Pepper/Margarine, Choice of Beverage, and Water. Record review of the facility's document titled Meal Preferences, dated Lunch 01/07/25, revealed Resident #16, Resident #25, and Resident #40 requested the regular meal. Record review of the facility recipe titled, Chicken Enchiladas (Sour Cream Chicken Enchiladas) For Service: Week 4, Tuesday, lunch, reflected the following: Enchilada Chicken: Servings 45 - 90 each Record review of the facility document titled, Resident Council Minutes dated 07/25/24 reflected the following: Dietary - .sometimes run out of food. Record review of the facility document titled, Resident Council Minutes dated 08/22/24 reflected the following: Kitchen often runs out of food so no seconds Record review of the facility document titled, Resident Council Minutes dated 09/26/24 reflected the following: Dietary - constantly running out of food Record review of the facility document titled, Resident Council Minutes dated 10/30/24 reflected the following: Dietary is still running out of food. Bread, eggs, and milk. Record review of the facility document titled, Resident Council Minutes dated 11/29/24 reflected the following: (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dietary - running out of food or dietary staff is throwing away right after they serve, so if we go back for seconds there isn't anything. Record review of the facility document titled, Resident Council Minutes dated 12/27/24 reflected the following: Dietary has improved but occasionally run out of bread, turkey, and cheese. Interview on 01/08/25 at 11:52 AM, the DM stated the cooks were trained to follow the recipes for the meals provided to the residents. The DM stated she thought [NAME] A made enough enchiladas for lunch on 01/07/25 and thought the residents changed their minds and that was why the kitchen was short on enchiladas. The DM stated a potential negative outcome was the residents families could get upset the resident was not served what they wanted. Interview on 01/08/25 at 12:30 PM, the ADM stated she did not know what happened yesterday at lunch with the enchiladas. The ADM stated she thought the staff got mixed up with who wanted hamburgers and who wanted the enchiladas. The ADM stated it was the first time the kitchen staff had a confusion like that. The ADM stated kitchen staff were trained on following the recipes for the menu. The ADM stated a potential negative outcome to the residents was they could refuse to eat the alternate that was provided. Record review of the facility policy titled, Food and Nutrition Services, with a revised date of October 2017, reflected the following: Policy Statement: Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.

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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. 42515 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services. 1) The facility failed to keep refrigerator, freezer and oven handles clean. 2) The facility failed to properly store food in the pantry and refrigerator. These failures could place residents at risk for food contamination and foodborne illness. The findings include: Observation during a kitchen tour on 01/06/25 beginning at 1:54 PM revealed 3 freezer handles, 2 fridge handles and 1 oven handles that had dry, sticky substances on the outside and inside handle, a gallon sized zip lock bag of fruit loops, dated 01/02, that was not fully sealed in the pantry and bag of lunch meat, stored in a gallon sized zip lock bag, date was not legible, that was not fully sealed in the refrigerator. Interview on 01/06/25 at 2:21 PM, the DM stated she did not know why the refrigerator handles, freezer handles and oven handles were not clean. The DM stated the zip lock bags popped open easily but all food should be stored completely sealed. Interview on 01/08/25 11:52 PM, the DM stated the dietary staff usually followed a daily cleaning schedule but this week had been short staffed due to an employee quitting on 01/06/25. The DM stated there had been a lot going on in the kitchen and she did not have time to make sure kitchen items were cleaned. The DM stated all the kitchen staff had been trained on kitchen cleanliness and food storage. The DM stated the zip lock bags did not work well and they should be replaced when they did not want to shut easily. The DM stated the residents had a potential risk of getting sick due to kitchen items not being clean or food items not being stored properly. Interview on 01/08/25 at 12:30 PM, the ADM stated she expected dietary staff to follow the cleaning schedules and keep kitchen items clean. The ADM stated she expected the dietary staff to store all foods properly. The ADM stated she did not know why the refrigerator handles, freezer handles, or oven handles were not clean or why food was not stored completely sealed in the pantry or refrigerator. The ADM stated sometimes the zip lock bags do not seal correctly if the staff are in a hurry. The ADM stated the residents have a risk for cross-contamination due to food not being stored properly or kitchen items not being clean. Record review of the facility's policy and procedure title, Food Receiving and Storage with a revised date of November 2022, reflected the following: Food shall be received and stored in a manner that complies with safe food handling practices (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy and procedure titled, Sanitation with a revised date of November 2022, reflected the following: Policy Statement: The food service area is maintained in a clean and sanitary manner

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49305 Based on observation, interview and record review, the facility failed to maintain an infection control program designed to provide a safe, comfortable, and sanitary environment to help prevent the development and transmission of communicable diseases for 2 of 5 (Resident #10 and Resident #31) residents and 2 of 6 (CNA E, and LVN B) staff reviewed for infection control. CNA E failed to perform hand hygiene between glove changes while providing incontinent care for Resident #10. LVN B failed to wear proper PPE when providing wound care for Resident #31 who was on Enhanced Barrier Precautions (EBP). These failures could place residents at risk for spread of infection and cross contamination. Findings included: Resident #10 Record review of Resident #10's face sheet dated 01/07/25 revealed a [AGE] year-old male with an original admitted [DATE] with the following diagnoses: sacral spina bifida (malformation of the spine and spinal cord), dysphagia (difficulty swallowing), major depressive disorder (persistent depression), cognitive communication deficit (difficulty in communication), Gastro-esophageal Reflux Disease (digestive condition), peripheral vascular disease (condition causing reduced blood flow to the limbs), muscle wasting, paraplegia (paralysis of lower body), end stage renal disease (kidney failure) and atrial fibrillation (irregular heart rhythm). Record review of Resident #10's annual MDS dated [DATE] revealed a BIMS of 15, indicating intact cognition. Section H - Bladder and Bowel indicated Resident #10 was always incontinent. Record review of Resident #10's comprehensive care plan revised on 11/19/20 revealed the resident was frequently incontinent of bowel and bladder and required incontinent care every two hours. During an incontinent care observation on 01/07/25 at 11:51 AM for Resident #10, CNA E sanitized her hands and put on gloves. CNA E performed male incontinent care then changed her gloves and applied a new brief. CNA E failed to sanitize her hands between glove changes. CNA E then repositioned the resident, removed her gloves and washed her hands prior to exiting the room. During an interview on 01/07/25 at 4:43 PM with CNA E, she stated she did not sanitize her hands between glove changes. She stated she was not prepared to do incontinent care when the resident caught her in the hallway and requested to be changed. She stated sanitizing her hands after changing gloves just slipped my mind. CNA E stated she had been trained on proper hand hygiene upon hire in August 2024. She stated she also received training through in-services conducted by the DON and through computer-based training videos. She stated a potential negative outcome for failure to sanitize hands between glove changes was bacteria and germs could be spread and cause infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident # 31 Record review of Resident #31's face sheet dated 01/06/25 revealed a [AGE] year-old male with an original admitted [DATE] with the following diagnoses: pneumonia (lung infection), respiratory failure (condition causing low oxygen in the blood), kidney failure, cerebral infarction (stroke), peripheral vascular disease (condition causing low blood flow to the limbs), lymphedema (swelling of the limbs), dementia (condition caused by impairment of brain function), anxiety, chronic ulcer of right lower leg and foot, hypertension (high blood pressure), Gastro-esophageal Reflux Disease (digestive condition) and generalized muscle weakness. Record review of Resident #31's current physician's orders revealed an order with a start date of 12/12/24 for Enhanced Barrier Precautions (EBP) for infection prevention and control every shift. Record review of Resident #31's annual MDS dated [DATE] revealed a BIMS score of 05, indicating severe cognitive impairment. Section M - Skin Conditions revealed the resident had 2 (two) stage 3 pressure ulcers and 1 (one) unstageable pressure ulcer which required application of medications or ointments and a nonsurgical dressing. Record review of Resident #31's comprehensive care plan revealed a focus of Enhanced Barrier Precautions, initiated on 09/18/24. Interventions/Tasks revealed: A gown is worn for direct resident contact if the resident has uncontained secretions or excretions. Gloves and gown will be used when performing contact activity before entering the room. During a wound care observation on 01/07/25 at 2:14 PM for Resident #31, LVN B sanitized her hands and put on a gown and gloves prior to beginning wound care. LVN B cleansed the resident's wounds to the left heel and applied ordered treatment and dressing. LVN B then left the room to get additional supplies to perform wound care to right buttocks. Upon re-entering the room, LVN B sanitized her hands and put on clean gloves. LVN B performed wound care to stage 2 right buttocks wound according to physician's orders. LVN B failed to put a gown on prior to performing wound care to Resident #31's right buttocks wound. LVN B removed her gloves and washed her hands following the wound care procedure. During an interview on 01/07/25 at 2:35 PM with LVN B she stated Resident #31 was on Enhanced Barrier Precautions due to his wounds. She stated the purpose of EBP was to prevent infection in residents who had an open wound or invasive device such as a catheter. She stated she forgot to put a gown on when she returned to Resident #31's room to complete wound care. She stated she had been trained on EBP through in-services conducted by the DON and ADM, as well as through computer-based training. LVN B stated a potential negative outcome for failure to wear proper PPE during direct care of a resident on EBP would be the spread of infection. During an interview on 01/08/25 at 11:38 AM with the ADM, she stated she was not aware, prior to survey, that staff failed to observe proper hand hygiene and follow EBP protocol. She stated all staff had been trained on proper hand hygiene and EBP practices and that nursing administration was responsible for conducting the training. She stated her expectation of staff for proper hand hygiene and EBP standards was to follow the facility policy at all times. The ADM stated a potential negative outcome for failure to observe proper hand hygiene and EBP protocol would be the spread of infection to residents and staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/08/25 at 12:09 PM with the DON, she stated she was not aware, prior to survey, that staff failed to observe proper hand hygiene and follow EBP protocol. She stated hands should always be sanitized between glove changes. She stated the proper PPE for direct care of a resident on EBP was a gown and gloves. She stated all staff were trained on proper hand hygiene and proper use of PPE through in-services conducted by nursing administration and skills checks performed annually and as needed. The DON stated a potential negative outcome for failure to observe proper hand hygiene and EBP protocol would be infection. Record review of the facility's training for EBP, dated 12/04/24 which was conducted by the DON and ADON was signed by LVN B. Record review of the facility's training for Handwashing, dated 12/02/24 which was conducted by the DON and ADON was signed by CNA E. Record review of Hand Hygiene Competency Validation for CNA E was signed by the CNA on 08/16/24. Record review of the facility's policy titled Handwashing/Hand Hygiene revised October 2023 revealed: Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Policy Interpretation and Implementation: Administrative Practices to Promote Hand Hygiene . 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. Indications for Hand Hygiene 1. Hand hygiene is indicated: a. immediately before touching a resident; . c. after contact with blood, body fluids, or contaminated surfaces; d. after touching a resident; . f. before moving from work on a soiled body site to a clean body site on the same resident; and g. immediately after glove removal (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled Enhanced Barrier Precautions, dated August 2022 revealed: Policy Statement Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. Policy Interpretation and Implementation 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: . h. wound care (any skin opening requiring a dressing).