STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675874	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lamun-Lusk-Sanchez Texas State Veterans Home	1809 N Hwy 87 Big Spring, TX 79720

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43150 Resident #5 Advance Directives 07/11/24 11:23 AM observed DNR with no date by the physician signature and no date by the resident name. Resident #16 Advance Directives 07/10/24 02:15 PM signature for person signing on behalf of resident did not provide a signature and no date next to the witnesses. Resident #54 Advance Directives 07/10/24 04:18 PM observed Resident # 54 with no date next to name on DNR. Resident #120 Advance Directives 07/11/24 12:09 PM observed no date by physician signature and no date by the witness signature. 49927 Based on interview and record review, the facility failed to ensure all residents had the right to formulate an advance directive for 5 of 32 residents (Residents #5, #54, #84, #120, and #124) reviewed for advanced directives. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Residents #5, #54, #84, #120, and #124 were listed as a DNR (Do Not Resuscitate) but had Out-of-Hospital Do Not Resuscitate (OOH-DNR) forms that were incorrectly filled out or missing required information. This failure could place residents at risk for not having their end of life wishes honored and incomplete records. Findings included: Resident #5: Record Review of Resident #5's face sheet, date retrieved on 07/11/2024, revealed an [AGE] year-old male, admitted on [DATE]/2021 with a primary diagnoses of: dementia (a group of thinking and social symptoms that interferes with daily functioning), hyperglycemia (high glucose), high blood pressure, depression, depression, muscle weakness, bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wear's down). Record Review of Resident #5's Care Plan date received 06/01/2022, revealed: my Family has completed documentation for DNR status. I wish to be designated as DNR. Record Review of Resident #5's physician orders dated 06/14/2024 revealed: phone orders placed for DNR. During Record Review of OOH-DNR records for Resident #5 on 07/11/2024 at 11:19 AM revealed: Under Section B, labeled, Declaration by legal guardian, agent or proxy on behalf of the adult person who is incompetent or otherwise incapable of communication, was not dated next to the Legal Guardian. Under the Physician Statement, next to the Physician signature was not dated. Resident #54: Record Review of Resident #54 face sheet, date retrieved on 07/11/2024, revealed an [AGE] year-old male, admitted on [DATE]/2021 with a primary diagnoses of: dementia (a group of thinking and social symptoms that interferes with daily functioning), hyperglycemia (high glucose), high blood pressure, depression, depression, muscle weakness, bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wear's down). Record Review of Resident #54's Care Plan dated 03/27/2024, revealed: I/Family/RP has completed documentation for DNR status. Record Review of Resident #54's physician orders dated 03/27/2024 revealed: prescriber written order placed for DNR. During Record Review of OOH-DNR records for Resident #54 on 07/11/2024 at 10:11 AM revealed: Under Section A next to Resident #54's signature was not dated. Resident #84 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #84's face sheet dated 07/10/2024 revealed a [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses to include type 2 diabetes mellitus, bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), hyperlipidemia (a condition that causes high levels of lipids, such as cholesterol and triglycerides, in your blood), migraine, and generalized anxiety. Record review of Resident #84's physician's order summary dated 07/10/2024 revealed an order Do Not Resuscitate - DNR dated 10/27/2022. Record review of Resident #84's care plan, dated 11/02/2022, revealed a care plan for DNR. Record review of Resident #84's Out of Hospital Do Not Resuscitate form dated 10/27/2022 revealed under the last section, no signatures by the resident nor the witnesses. Resident #120: Record Review of Resident #120's face sheet, date retrieved on 07/11/2024, revealed an [AGE] year-old female, admitted on [DATE] with a primary diagnoses of: hyperlipidemia (a condition in which there are high levels of fat particles in the blood), high blood pressure, vitamin B12 deficiency, depression, anxiety, post-traumatic stress disorder (a disorder in which a person has difficulty or witnessing a terrifying event), pulmonary fibrosis (is a condition in which the lungs become scarred over time), osteoporosis (a condition in which bones become weak and brittle), urinary tract infection, and cystic disease of liver (is a rare condition that causes cysts fluid filled sacs to grow throughout the liver), Record Review of Resident #120's Care Plan dated 05/08/2024, revealed: I/Family/RP has completed documentation for DNR status. I wish to be designated as DNR. Record Review of Resident #120's physician orders dated 05/08/2024 revealed: prescriber written order for DNR. During Record Review of OOH-DNR records for Resident #120 on 07/11/2024 at 10:11 AM revealed: Under the Witnesses Section, there was no date next to the signature of the second witness. Resident #124 Record review of Resident #124's dated 07/10/2024 face sheet revealed an [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses to include unspecified dementia, type 2 diabetes mellitus, unspecified atrial fibrillation (atrial fibrillation), transient cerebral ischemic attack (a short period of symptoms similar to those of a stroke), and essential hypertension (high blood pressure). Record review of Resident #124's physician's order summary dated 07/10/2024 revealed an order Do Not Resuscitate - DNR dated 04/04/2024. Record review of Resident #124's care plan, dated 04/05/2024, revealed a care plan for DNR. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #124's Out of Hospital Do Not Resuscitate form dated 04/04/2024 revealed under the witness section, there were no witness signatures. Also, in the last section, there were no signatures by the resident representative nor the witnesses. An interview was conducted on 7/11/2024 at 1:20 p.m., the ADM stated DNR's were sometimes completed by other entities, prior to the resident entering the facility. She stated the facility's social services (social workers) were responsible for ensuring DNR's should be completed and updated accurately. The ADM stated it would've been the social worker's responsibility to ensure DNR's were completed thoroughly and accurately, if they were completed prior to the resident entering the facility. She stated it would be the social worker's responsibility to ensure these forms were updated, if they were missing any information or were incorrectly filled out. The ADM stated the facility was working on updating any incomplete or incorrect DNR over the past year, and staff have been trained on how to properly complete a DNR. The ADM reviewed the DNR for Resident #84 and Resident #124 and confirmed they were not completed properly. The ADM stated both social workers for the facility were not available for the interview, as they were currently on leave. The ADM stated a resident's DNR not being completed thoroughly could potentially result in a negative outcome for the resident by which the resident's wishes may not be followed. An interview was conducted on 7/11/2024 at 1:20 p.m., the NAC stated she assisted with audits of resident's DNR's recently. The NAC stated it was the responsibility of the facility's social workers to ensure DNR's were completed properly. The NAC stated the facility's social workers have received training on how to properly complete a DNR for a resident. The NAC reviewed Resident #84 and Resident #124's DNR's and confirmed they were not filled out properly. The NAC stated if a resident's DNR was not completed properly this could possibly result in the wishes of the resident not being followed. Record review of the facility's policy, Advance Directives, Revised January 2023, revealed the following documentation: Compliance Guidelines Every resident has the right to formulate an advance directive and to refuse treatment. The community will determine the existence of an advance directive at the time of admission A copy of the advance directive and subsequent revisions will be included in the resident's medical record. Advance Directive Modifications The resident has the right to modify the advance directive at any time. Although the resident should advise the community whenever a change is made, it is the community's responsibility to ensure that it has current copies of all advance directives. The community will survey its residents at least annually regarding any advance directives changes. Record Review of the Instructions For Issuing An OOH-DNR Order (Undated) revealed the following: INSTRUCTIONS FOR ISSUING AN OOH-DNR ORDER PURPOSE (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	IMPLEMENTATION: A competent adult person, at least [AGE] years of age, or the person's authorized representative or qualified relative may execute or issue an OOH-DNR Order. The person's attending physician will document existence of the Order in the person's permanent medical record. The OOH-DNR Order may be executed as follows: Section B - If an adult person is incompetent or otherwise mentally or physically incapable of communication and has either a legal guardian, agent in a medical power of attorney, or proxy in a directive to physicians, the guardian, agent, or proxy may execute the OOH-DNR Order by signing and dating it in Section B. Section C - If the adult person is incompetent or otherwise mentally or physically incapable of communication and does not have a guardian, agent, or proxy, then a qualified relative may execute the OOH-DNR Order by signing and dating it in Section C . Section F - If an adult person is incompetent or otherwise mentally or physically incapable of communication and does not have a guardian, agent, proxy, or available qualified relative to act on his/her behalf, then the attending physician may execute the OOH-DNR Order by signing and dating it in In addition, the OOH-DNR Order must be signed and dated by two competent adult witnesses, who have witnessed either the competent adult person making his/her signature in section A, or authorized declarant making his/her signature in either sections B, C, or E, and if applicable, have witnessed a competent adult person making an OOH-DNR Order by nonwritten communication to the attending physician, who must sign in Section D and also the physician's statement section. Optionally, a competent adult person or authorized declarant may sign the OOH-DNR Order in the presence of a notary public. However, a notary cannot acknowledge witnessing the issuance of an OOH-DNR in a nonwritten manner, which must be observed and only can be acknowledged by two qualified witnesses. Witness or notary signatures are not required when two physicians execute the OOH-DNR Order in section F. The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professionals.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 42515 Based on observations, interviews and record reviews, the facility failed to provide a safe, clean, comfortable, and homelike environment for 2 of 32 residents; The facility failed to address complaints for 2 of 10 confidential resident's that were interviewed and voiced concerns related to missing personal laundry These problems could result in residents having a lack of personal clothing to wear and low self-esteem. The findings included: During a confidential resident and family interview, the family member stated the resident has problems with clothing coming back from the laundry. The family member stated all of the residents clothing was marked with their name, so it was unknown what the problem was. The family member stated staff members have been asked about the missing laundry, but nothing gets done. During a confidential interview with a resident, it was stated that the resident had several missing clothing items and it had never been returned or found. The resident stated that when asked the nursing staff about the missing clothing that nothing gets done. The resident stated that no one from laundry brings the clothing around to the residents to locate missing clothing. The resident stated that their means of income was limited and the resident does not have the money to keep buying clothing. The resident stated that they would just like to have their clothing back. The resident stated that they do not feel that they have a choice if they are able to keep their clothing here or not because if it was sent to laundry that there was a big chance that it won't make it back. During an observation of the laundry during survey process on 07/10/24 at 3:15 PM, it was determined that a plan for missing or lost laundry had not been acquired. There was a big bin in a room in the laundry sitting in the corner that had been piled up with clothes and the top was covered. During an interview on 07/10/2024 at 5:15 PM, the ADM stated the laundry staff and housekeeping were responsible for ensuring the missing laundry or unmarked laundry gets back to the residents. The ADM stated the facility has a heat label maker for clothing and the residents should have their clothing marked with the heat label maker. The ADM stated the facility replaced any missing laundry but she was unaware of any laundry needing to be replaced recently. The ADM stated she did not know why the missing laundry bin became so large. The ADM stated a potential negative outcome to the residents was they would not have clothes to wear. During an observation on 07/11/2024 at 1:44 PM. Observed a big bin in a separate area of the laundry room, parked in a corner with a covering over the top. The bin was filled with clothes that were lost or missing. Could not observed what kind of clothing was in the bin or how many. It was not open for residents to be able to easily view or look through. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/11/2024 at 1:50 pm, the Laundry Staff Member stated that for missing clothing items that were missing labels they would put it in the bin until the residents came to get the item. She stated that the pile of clothes has been there for a long time but was unsure of how long exactly. She stated that they do not take the clothing around to the residents because they do not have time to do that. She stated that they have not always been able to locate the missing items. She stated that she was unsure of what the staff do if they can not locate the items in the missing clothing bin. She stated that sometimes the residents will get really mad if they were unable to locate their clothing. She stated that usually they would tell the nurse and then the nurse would go to the laundry and attempt to locate them. She stated that there was a possibility that if the nurse gets busy that she may forget to look for the items. During an interview on 7/11/2024 at 2:28 pm, the Laundry Manager stated that the lost or missing clothing items program had not been effective when the washers broke and there were no labels on the clothing to be able to locate the owners. She stated that they had to just put it in the bin. She stated that if she had to say how many clothes were in the bin it would be approximately a few months' worth. She stated that they do have a place for lost or missing clothing by putting them in the big bin in the laundry room. She stated that they were waiting for the activity director to get back next week to be able to take the clothing into the dining room and lay it all out on the tables. She stated that the Administrator will usually ask the CNA's and nurses if anyone had reported missing clothing items and then the laundry staff will look through the items to see if they can locate something that matches that description. She stated that sometimes the residents will come to them and ask about the missing clothing. She stated that sometimes they were able to locate the missing item and sometimes they were not. She stated that they do not have a schedule to where they take the clothes around to the residents. She stated they can't take the clothes around to the residents because there were too many clothes to do that. She stated that when the resident's come to look for their missing clothing she needed a description of the color of the item and the size. She stated that if they did not know the size then she would have to look at the size of the person and just guess the size. She stated that if they could not locate the missing clothing that was in the bin then they would start to donate the clothing to the residents that do not have anything. She stated that the residents have an opportunity to realize if they were missing clothing and can ask about them. She stated that for the resident's that were unable to talk they could notify the nursing staff with the communication style that they used, report it to them, and the nursing staff would come to report it to the laundry staff. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/11/2024 at 2:54 pm, the Account Manager stated that the facility does have a plan for the lost or missing plan. She stated that they did not have an effective plan before because the washer had broken, a staff shortage, the laundry just kept piling up and there were no labels on the clothes. She stated that the clothes that did not have a label were put into the lost or missing bin. She stated that the amount of clothing that was lost or missing had accumulated over the span of a few months, and it quickly became an overwhelming. She stated that there was no attempt to relocate the clothing because it quickly became overwhelming amount of clothing. She stated that they had come up with a plan as of last Monday (07/08/2024). She stated that the plan would start on Wednesday 07/17/2024, but if there were too many activities then it will have to wait until the next weekend. She stated that she had talked to the Administrator last week and the new plan would be to empty the large bin of missing or lost clothing out on the dining room tables in the dining room and let the residents come into the dining room and claim the clothing. If there were clothes that were unclaimed they would donate those clothes to the residents who do not have much or anything at all. She stated that they will start doing this plan once a week until all of the clothes were either located or donated. She stated that she believed the problem for not having an effective plan was a shortage in staff. She stated that when a resident came to look for their missing clothing, she would have to immediately look for it because her memory was not as good as it used to be and if she doesn't immediately do it then she will forget. She stated that they will work hard from now on to locate the missing laundry because she knew two residents on hall 600 that won't even leave their room if they do not have pants on. She stated that they did not attempt to locate the missing clothing due to a staff shortage. She stated that the negative potential outcome of residents clothing missing or lost was that they will begin to lose trust in the facility and begin to think that the facility is not capable of handling their items. She stated that it definitely impacted the resident's dignity when their clothes were missing or lost and could impact their dignity. During an interview on 07/11/2024 at 3:09 PM, the Corporate District Manager stated that they did not have an effective plan for the laundry at the time but have since come up with a plan. She stated that she had just got to this facility just a few months ago. She stated that last Monday they pulled every piece of lost clothing out of the laundry room in the big missing bin and went through it. She stated that this past Monday all the clothes were pulled out to check for names so they could attempt to identify and they were just put back into the bins because of no names. She stated that the plan was this Wednesday (07/17/2024), all the missing clothes from the missing bin, would be put on racks in the dining room. She stated that the activity director would help a section of residents at a time to look through the clothing to see if they recognized anything as their clothing. She stated that if all the clothing is not located at that point, then the facility would take around to all residents to see if then they may recognize something as theirs. She stated that for residents that can not come out of their room, they would take the racks around to them. She stated that for the residents that can not communicate they would call the family members to see if the family can come up and go through the clothing to see if they might recognize something that belonged to their loved one. She stated that there should have been a better plan in place for missing or lost clothing. She stated that this would change as of now. She stated that the negative potential outcome was that it may make the residents unhappy and feel upset. She stated that hopefully with this plan they would have a better outcome and get issues resolved. Record review of the facility policy title, Laundry Operations, revised 09/2017 reflected the following: (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.In long-term care, no area of laundry management is more critical to patient care and dignity issues than they are of resident clothing. Residents, residents' families, admissions, social services, administration, and, of course, nursing are all involved with laundry in creating policies for getting resident clothing collected, washed, dried, and returned to residents on a timely basis . If clothing is unmarked, do not let it accumulate in the laundry. All missing clothing grievances must be researched, answered, and clothing returned (either found or replaced) within 24-48 hours. Laundry employees must bring any unmarked clothing for the day up to the units for identification by the CNAs who are more familiar with the residents and their belongings. Once the owner of unmarked clothing is identified, label the garment immediately

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49154 Based on observation, interview and record review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one of thirty-two residents (Resident #109) reviewed for quality of care. The facility failed to follow physician ordered skin treatments for edema to Resident #109's legs on 07/10/24. These failures could place residents at risk for complications including skin break down, infection, or decreased physical and mental functioning. Record review of Resident #109's undated face sheet reflected Resident #109 was an [AGE] year-old male whose admitted to the facility was on 1/18/24. Resident #109 had the following diagnoses: chronic obstructive pulmonary disease (airflow blockage and breathing-related problems), type 2 diabetes mellitus with unspecified complications (inability for the body to use insulin properly), chronic kidney disease stage 3B (moderate to severe loss of kidney function), essential primary hypertension (high blood pressure), chronic pain syndrome (symptoms beyond pain alone that interferes with daily life), hypothyroidism (underactive thyroid), mood disorder (mental health condition), anxiety disorder (mental health condition), and hyperlipidemia (excess of fat in the blood). Record review of Resident #109's clinical record reflected his comprehensive MDS assessment was completed on 2/1/2024 listing him with a BIMS score of 13, which indicated he was cognitively intact. Record Review of Resident #109's Care Plan, dated 1/18/24, revealed Resident #109 had an actual or would've been at risk for skin impairment: Pitting and weeping edema. Interventions were to apply treatment as ordered. Record review of Resident #109's physician active orders dated 7/10/24 revealed an order dated 7/05/24 to cleanse bilateral lower extremities with normal saline/wound cleanser, or soap and water, pat dry. Apply moisturizing lotion to bilateral lower extremities and wrap with Kerlix (dressing for wounds to secure and prevent movement of primary dressing) daily from 0700 to 1900 one time a day for edema. Record review of Resident #109's licensed nurse medication administration record (LNAR) dated 7/1/24 - 7/31/24 revealed to cleanse bilateral lower extremities with normal saline/wound cleanser, or soap and water, pat dry. Apply moisturizing lotion to bilateral lower extremities and wrap with Kerlix (dressing for wounds to secure and prevent movement of primary dressing) daily from 0700 to 1900 one time a day for edema, with a start date of 7/06/24 at 0700. Furthermore, on this order revealed documentation on 07/10/24 by LVN B that the ordered skin treatment task was completed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 7/9/24 at 3:34 PM, Resident #109 stated he arrived at the facility on 1/18/24 and had issues with his legs prior to entering the facility. He stated the facility was not consistent with the skin treatments on his legs which caused discomfort and itching. He stated they were supposed be wrapped from 7:00 AM to 7:00 PM, however they were not being done on time and sometimes staff came to wrap them several hours late. He stated he had received medication for pain as needed. He stated he was frustrated with these inconsistencies and felt this caused the condition of his legs not to improve. Resident #109's shin and ankle areas of both legs were observed to be wrapped with Kerlix wrap. During observation and interview on 7/10/24 at 9:37 AM, Resident #109 stated staff had not done the skin treatment on his legs today. He stated his legs were itching. There was no wrap observed on Resident #109's shin and ankle areas of both legs. During observation and interview on 7/10/24 at 2:27 PM, Resident #109 stated staff had not done the skin treatment on his legs today. He stated his legs were itching. There was no wrap observed on Resident #109's shin and ankle areas of both legs. During observation and interview on 7/10/24 at 5:23 PM, Resident #109 stated staff had not done the skin treatment on his legs today. He stated his legs were itching. There was no wrap observed on Resident #109's shin and ankle areas of both legs. During an interview on 7/10/24 at 5:24 PM, a Family Member stated she asked a staff that was passing out medications on the hall this morning around 10:10 AM if she was going to complete the skin treatment on Resident #109's legs and that staff member told her that was not her responsibility and was the responsibility of the TN. The Family Member stated she did not approach any other staff about it. The Family Member stated the facility had not been consistent with the skin treatment on Resident #109's legs since he admitted in January 2024. During an interview on 7/10/24 at 5:34 PM, LVN B stated she was the charge nurse for Resident #109's hall. She stated there were orders for Resident #109 to self-administer Salvaderm Cream (skin moisturizer) on his legs as well as Triamcinolone Cream (steroid cream) as needed. She stated Resident #109 was prescribed Gabapentin for nerve pain in his legs. She stated there were physician orders for staff to clean, apply lotion, and wrap Resident #109's legs daily at 7:00 AM and remove at 7:00 PM. She stated the TN was responsible for completing the skin treatment orders. She stated she believed the skin treatment on Resident #109's legs were completed today. She stated she did not know where the notes of the completion of the treatment was documented in the EHR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/10/24 at 5:48 PM, the ADNS stated Resident #109 had physician orders for skin treatment on his legs. The ADNS stated the TN was responsible to complete those orders and she believed the skin treatment was completed today. She was trying to confirm with the TN but had not been able to get ahold of her. She stated the orders indicated the skin treatment was to be done at 7:00 AM and then the Kerlix wrap was to be removed at 7:00 PM daily. She stated Resident #109 had complained about the timing that staff had gone to wrap his legs. She explained to him that the time the TN could complete the skin treatment may fluctuate due to the demand of other residents in the facility. She stated Resident #109 was very particular and had refused medications and care in the past if they were not done exactly at the time listed on the order, which could be why he reported the skin treatment was not being done consistently. She stated Resident #109 was particular about staff that provided care to him. She stated she was not sure where the skin treatment task was documented in the EHR and would provide that information after she had spoken to the TN. She stated staff were supposed to document any refusal of care in the EHR and reported it to the NP and to hospice. She stated she had received training on the following physician orders and that the facility provided in-services to all staff. She stated the ADNS's as a team were responsible for ensuring staff followed physician orders. During observation and interview on 7/10/24 at 6:00 PM, the ADNS asked Resident #109 if the skin treatment was completed on his legs today. Resident #109 replied that it was not and that his legs were itchy. The ADNS asked Resident #109 to raise his pant legs which he complied. There was no wrap observed on Resident #109's shin and ankle areas of both legs. The ADNS stated since there was no wrapping observed on Resident #109's legs, this meant the skin treatment was not completed today. She stated she would follow up with the TN to determine why it was not done but did not have an answer for why it was not done. During observation and interview on 7/11/24 at 1:19 PM, Resident #109 stated staff completed skin treatment on his legs this morning around 7:00 AM. He stated staff never completed the skin treatment yesterday. Resident #109's shin areas of both legs were observed to be wrapped with Kerlix wrap. He stated he understood that staff cannot always come exactly at 7:00 AM to provide the skin treatment and had never refused the skin treatment when they come at a reasonable time. He stated he felt it was pointless for them to do it late in the afternoon when the orders say the wrap must be removed by 7:00 PM every evening. During observation and interview on 7/11/24 at 1:34 PM, the TN stated she had not administered any physician ordered skin treatments to Resident #109's legs yesterday or today. She stated she was trained that her duties as the TN were to complete the orders listed on the TAR. She stated Resident #109's orders were listed on the LNAR, which were the responsibility for the charge nurses on duty to complete. The TN pulled up the LNAR on her screen which showed that Resident #109's skin treatments were listed on the LNAR. She stated LVN B approached her this morning and told her she completed the skin treatment orders on Resident #109 for her this morning, in which she responded to her that those orders were supposed to be completed by the charge nurse since they were on the LNAR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/24 at 2:45 PM, LVN B stated she was the charge nurse for halls 400 and 500 and worked from 6:00 AM to 6:00 PM. She stated she began working at the facility about a month and a half ago. She stated she was not sure who was responsible to complete the skin treatment on Resident #109's legs but she did not think it was her responsibility. She stated she thought it was the TN's responsibility, due to hospice ordering it. She stated charge nurses were responsible to complete physician orders listed on the LNAR and TN's completed orders listed on the TAR. She stated on the LNAR the task would turn green on the screen when the task was completed and would turn red if the task did not get completed. She observed the LNAR and verified that her initials were on the LNAR on 7/10/24, which indicated that she completed the skin treatment task for Resident #109. She stated she had not completed that task. She stated she did not know why it was not done yesterday. She stated she knew the skin treatment was supposed to be done daily for Resident #109. She stated the TN would not have done it because the task was on the LNAR because charge nurses were responsible for completing the tasks on the LNAR. She stated she checks the LNAR daily because she knew the tasks on it were her responsibility as the charge nurse. She stated she had received training that she must follow physician orders. She stated she was trained on her 2nd day of working at the facility. She stated she did not think pre-charting was best nurse practice. She stated she was trained that items on the LNAR were her duties. She stated a potential negative outcome of Resident #109 not receiving his skin treatment was that he could develop cellulitis due to scratching the itch which could cause a progression of the disease and more health complications. She stated a potential negative outcome of not documenting accurately was that the staff may not remember to go back and change the task if it was not done or of the resident refused it. She stated another negative outcome was that the staff may not remember what exactly happened in that situation. During an interview on 7/11/24 at 3:20 PM, the ADNS stated there were physician orders to wrap Resident #109's legs daily. She stated usually the TN did them, but the regular TN was out this week, so they had another one filling in. That was why it was not done yesterday. She stated the skin treatment was moved to the LNAR for the charge nurse to do it because of the amount of time it took to complete the task. She stated it was a failure on her part because the TN told her she was going to put it on the LNAR, and she forgot to relay the information to the charge nurse. She stated charge nurses were trained that they were responsible to complete tasks on the LNAR, but she also should have told her. She stated she was able to confirm the skin treatment for Resident #109 was not completed yesterday because she observed that his legs were not wrapped, and she asked him, and he said they were not. She stated she was not aware Resident #109's skin treatment was not done yesterday prior to the state surveyor intervention. She stated staff were not trained to chart a task on the LNAR before the treatment had taken place and they should not have done that. She stated herself, the TN, and charge nurses train other staff. She stated she expected for staff to document tasks completed on the LNAR after the task had been completed. She stated the facility policy stated they must follow doctor orders. She stated they use the EHR as their system for tracking when tasks were due, completed, or not completed. She stated the screen would show the item as yellow for tasks that were scheduled to be done. She stated the screen would show green when completed and red when it was not completed and past due. She stated a potential negative outcome was that the resident's EHR would be inaccurate because you don't know what the outcome would be, the order could get missed, and the resident would not get the care they were supposed to get. This could prevent wounds from healing and cause them to worsen. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/24 at 4:28 PM the DON stated she expected staff to follow physician orders. She stated herself, administrative nurses, and charge nurses were responsible for ensuring physician orders were followed. She stated charge nurses were trained that they were responsible for completing tasks on the LNAR. She stated staff should not chart (document) they completed a task in the EHR task before it was completed, it should be charted afterwards. She stated the TN was responsible for tasks on the TAR not the LNAR. She stated staff were provided this training during orientation and as needed. She stated staff were provided this training when they were getting trained on the floor by other nurses, herself, and the pharmacy nurse. She stated she was not aware staff were not following physician orders and that they were pre-charting. She stated Resident #109's skin treatment was put on the LNAR because he was particular on the times of when his care was done. She stated it was put on the LNAR for charge nurses to do so he would have it when he wanted. She stated Resident #109 gets irate when he did not get things when he wanted them done and he was very particular about his treatment. She stated a potential negative outcome was that it decreases the facility's credibility with the resident and that residents won't get the care they deserve. During an interview on 7/11/24 at 4:28 PM the ADM stated she expected staff to follow physician orders. She stated she did not know exactly what the policy said for following physician orders. She stated a potential negative outcome was that residents may not get the services they need because they think the task was completed. Record review of facility provided policy titled, Quality of Care dated February 2017, and revised January 2023 revealed: Compliance Guidelines: Quality of care is a fundamental principle that applies to all treatment and care provided to community residents. Based on the comprehensive assessment of a resident, the community will ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices, including but not limited to the following: Skin integrity: Pressure ulcers. Based on the comprehensive assessment of a resident, the community will ensure that: A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42515 Based on interviews and record review, the facility failed to ensure residents receiving psychotropic medications had an approved diagnosis and PRN orders for psychotropic drugs were limited to 14 days unless the attending physician or prescribing practitioner believed, and documented, that it was appropriate for the PRN order to be extended beyond 14 days, for 1 of 32 residents (Resident #133). Resident #133 continued to have a PRN order for Doxepin 10mg after 14 days without an evaluation by the physician for continued treatment. This failure could result in residents receiving psychotropic and antipsychotic medications when contraindicated and could also result in residents experiencing adverse drug reactions, decreased quality of life and dependence on unnecessary psychotropic medications. The findings included: Resident #133 Record review of Resident #133's face sheet, dated 07/09/24, revealed an [AGE] year-old-male who was admitted to the facility on [DATE] with diagnoses to include pneumonia (lung infection), unspecified dementia (the loss of cognitive functioning) and major depressive disorder (mood disorder). Record review of Resident #133's comprehensive MDS, dated [DATE], revealed Section N - Medication Section N0415 - Medications Received: A - Antipsychotic and C - Antidepressant were marked - Is Taking. Record review Resident #133's comprehensive care plan, last review completed 05/23/24, revealed a care area I require anti-depressant medication r/t Diagnosis: Depression. Record review of Resident #133's order summary report dated 07/09/24 revealed the following orders: Doxepin HCl Oral Capsule 10mg Give 1 capsule by mouth every 12 hours as needed for anxiety/agitation related to major depressive disorder, with a start date of 05/15/24 and no end date. Record review of Resident #133's medication administration record, undated for the months of May 2024, June 2024 and July 2024 revealed Resident #133 had not received the medication doxepin that was ordered as needed. Record review of Resident #133's medical records revealed no evaluation documentation for the prn Doxepin. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/11/24 at 10:05 AM, LVN A stated she did not know why Resident #133 had a PRN order for doxepin. LVN A stated she had been trained on psychotropic medications needing a 14 day stop date if they were PRN, but she did not think doxepin was one of the medications that needed a stop date. LVN A stated she did not know why Resident #133 had this order for doxepin PRN and stated she was unsure who put the order in. LVN A stated she did not know of a potential negative outcome to the resident. During an interview on 07/11/24 at 11:29 AM, the DON stated her and the Pharmacy LVN were responsible for ensuring residents did not have a psychotropic PRN medication for greater than 14 days without evaluation. The DON stated all of the nurses have been trained on psychotropic PRN medications needing a 14 day stop date, so she did not know why Resident #133 had the order for doxepin PRN longer than 14 days. The DON stated during the daily clinical meetings, psychotropic PRN medications were reviewed but they must have been focusing on other medications. The DON stated Resident #133 probably had this order from when he admitted to the facility, and that was how it was overlooked. The DON stated a potential negative outcome for the resident was no psychotropic medications were recommended to be given to the elderly. During an interview on 07/11/24 at 11:38 AM, the Pharmacy LVN stated all the nurses, herself and the DON were responsible for ensuring psychotropic medications were not ordered PRN for longer than 14 days. The Pharmacy LVN stated Resident #133's order for doxepin PRN was an oversight and she must have missed it. The Pharmacy LVN stated all the nurses were trained on psychotropic PRN medications needing a 14 day stop date, but she was unsure when the training happened. The Pharmacy LVN stated a potential negative outcome to the resident was it could cause falls or increased confusion. During an interview on 07/11/24 at 11:50 AM, the ADM stated the nursing staff was responsible for ensuring psychotropic medications had a 14 day stop date if they were ordered PRN. The ADM stated she expected all PRN psychotropic medications to have a 14 day stop date. The ADM stated it was unknown why Resident #133 had an order for doxepin PRN longer than 14 days. The ADM stated a potential negative outcome to the resident was staff would not be able to limit potential side effects and a risk for unnecessary medications. Record review of the facility policy titled, Psychotropic Medications and Gradual Dose Reduction, dated January 2022 reflected the following: Guideline Statement: Physicians and mid-level providers will use psychotropic medications appropriately working with the interdisciplinary team to ensure appropriate use, evaluation and monitoring . Standards: The community is expected to make every effort to comply with state and federal regulations related to the use of psychotropic medications in the community to include diagnosis, targeted behavior or clinical indications for use, prescribers specified dosage frequency, and duration of therapy . - The facility will make every effort to comply with state and federal regulations related to the use of psychopharmacological medications in the long-term care facility to include regular review for continued need, appropriate dosage, side effects, risks and/or benefits . - Psychotropic medications include anti-anxiety, hypnotic, antipsychotic/neuroleptic and antidepressant classes of drugs

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43150 Based on interviews, and record review, the facility failed to ensure 1 of 1 resident (Resident #106) reviewed for medication administration were free of significant medication errors. 1. The facility failed to administer eye drops (Brimonidine Tartrate Ophthalmic Solution 0.2%) according to physician orders for Resident #106. Findings included: Resident #106: Record Review of Resident #106 face sheet, date retrieved on 07/11/2024, revealed a [AGE] year-old male, admitted on [DATE] with diagnoses of: type 2 diabetes, absolute glaucoma bilateral, (is the final stage of glaucoma in which increased intraocular pressure results in permanent vision loss or blindness) hepatomegaly (enlarged liver), vitamin D deficiency, orthostatic hypotension (is a sudden drop in blood pressure), primary open-angle glaucoma (is a subset of the glaucoma's defined by an open, normal appearing anterior chamber angle and raised intraocular pressure), idiopathic peripheral autonomic neuropathy (damage to the peripheral nerves where cause cannot be determined), esophageal obstruction (narrowed or blocked and can result in damage to the esophagus), acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood), dysphagia (difficulty swallowing), presence of intraocular lens (the presence of a lens implant), cataract extractions status, right eye, and cataract extractions status, left eye. Record Review of Resident 106's Care Plan dated 11/28/2023, revealed: Resident #106 was at risk for vision loss/impairment: Blindness with interventions of: coordinate appointments and transportation to appointments as indicated, ensure glasses were clean and in good repair for use, medications as ordered, and refer to eye doctor as indicated. Record Review of Resident 106's Care Plan no date provided revealed: Resident #106 has a self-care deficit due to diabetes, blindness. Record Review of Resident 106's Care Plan dated 11/28/2023 revealed: Resident #106 was at risk for falls due to blindness, weakness. Record Review of Resident 106's Care Plan dated 11/28/2023 revealed: Resident #106 was at risk for complications associated with diabetes: frequent infections, diabetic wounds, vision impairment, hyper/hypoglycemia, renal failure, and cognitive/physical impairment. Record review of Resident #106's Physician Orders with active orders as of 04/25/2024 indicated that Resident #106 was given orders for Ophthalmology care PRN. Record review of Resident #106's Physician orders, date retrieved 07/11/2024 revealed: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Brimonidine Tartrate Ophthalmic Solution 0.2%, dated 02/10/2024, Instill 1 drop in both eyes two times a day related to primary open angled glaucoma bilateral, severe stage, (Give eye drops at least 5 minutes apart), Start date: 02/10/2024). Dorzolamide HCl-Timolol Mal Ophthalmic Solution 2-0.5 % (Dorzolamide HCl-Timolol Maleate), dated 02/10/2024, Instill 1 drop in both eyes two times a day related to PRIMARY OPEN-ANGLE GLAUCOMA, BILATERAL, SEVERE STAGE (H40.1133) (Give Eye Drops at least 5 Minutes apart) Orders showed to be active. Latanoprost Solution 0.005 %, dated 01/25/2024, Instill 1 drop in both eyes at bedtime related to PRIMARY OPEN-ANGLE GLAUCOMA, BILATERAL, SEVERE STAGE (H40.1133) (Give Eye Drops at least 5 Minutes apart), Orders show on hold. Record review of Resident #1's Medication Administration Record for 07/01/24 - 07/31/24 indicated on 07/07/2024, he was scheduled to receive Brimonidine Tartrate Ophthalmic Solution 0.2% for night shift and did not receive the medication. On 07/08/2024, he was scheduled to receive the medication for the day and night shift and was not given the medication. On 07/09/2024, was scheduled to receive the medication on both the day and night shift and had not received the medication. On 07/10/2024, he was scheduled to receive the medication on day and night shift and did not receive the medication for the day shift but did receive the medication on the night shift. Record review of Resident #1's Medication Administration Record for 07/01/24 - 07/31/24 indicated on 07/08/2024, he was scheduled to receive Latanoprost Solution 0.005%, for night shift and was not administered. On 07/09/2024, he was scheduled to receive the eye drops for the night shift and it was not administered due to being on hold. During an interview on 07/09/24 at 3:10 PM Resident #106 stated that he had not had 2 of the 3 eye drops in several days. Resident #106 stated that he had asked staff about not getting the eye drops and was told that he was out of them. He stated that when he asked when he would get some more the nursing staff would state that they were unsure. Resident #106 stated that if his eye pressures go up then he could go blind, and it could be irreversible. He stated that this was very stressful when they let the medication run out. This failure could cause the resident to go blind if his pressure's in his eye had gotten too high. During an interview on 07/11/2024 at 2:50 PM the DON stated that all medications were expected to be given. She stated staff have been trained on medication administration by computer-based training and in-services, quarterly. She stated that the negative potential outcome of not administrating medication was missed medication. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review the facility policy, labeled, Medication Errors, date not provided, date retrieved 07/11/2024, revealed: Medication Errors: The communities medication management system is designed and managed to ensure that the community is free of medication errors. The nursing team members will report drug errors and adverse drug reactions to the resident's physician in a timely manner, as warranted by an assessment of the resident's condition, and record them in the resident's record. An incident report must be completed. Medication errors include, but are not limited to administering the wrong medication, administering the wrong time, administering the wrong dosage strength, administering by the wrong route, omitting a medication, and/or administering to the wrong resident.

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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. 43150 Based on observation and interview that the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles and included the appropriate accessory and cautionary instructions, and the expiration date when applicable and the facility failed to ensure, in accordance with State and Federal laws. 1. The facility failed to ensure that medication storage was free from expired medications; five expired medications were located in the medication room on hall These failures could place residents at risk of receiving prescribed medications after their expiration date and drug diversions. The findings include: During an observation on 07/10/2024 at 10:30 AM with RN on C wing for medication storage check. Five expired medications were found (aspirin 325 mg, Geri Care, 100 tablets, regular strength, expiration date of: 2/24, aspirin 325 mg, Geri Care, 100 tablets, regular strength, expiration date of: 4/24, Ferrous Gluconate, 240 mg iron supplement 100 tablets with expiration date of 5/24, Gas Relief Geri Care brand, 100 chewable tablets, 80 mg mint flavor, expiration date: 5/24, Gas Relief Geri Care brand, 100 chewable tablets, 80 mg mint flavor, expiration date: 5/24). RN verified by looking at the expiration dates as the Surveyor had found them and she agreed to the expiration dates. RN took the medications and stated that she would destroy the medication by taking them to the ADON. During an Interview on 07/10/2024 at 10:47 AM with RN. She verified the five expired medications that were found. She stated that all staff are responsible for making sure that expired medications are discarded, and they can do that by checking the storage rooms on every shift when they have down time. RN did dispose of expired medications after verifying that they were expired. She stated that she had been trained in medication storage by in-service, monthly. She stated that the negative potential outcome is a possible reaction to the resident or ineffective medications. She stated that the ADON normally goes through all the medications to check the expirations but stated that all staff should do it. She stated she is unsure if other staff members check for expiration dates or not but she had checked them here and there but not routinely. During an Interview on 07/11/2024 at 2:50 PM with Administrator and DON. The Administrator stated that she expects the staff to go through the medication carts and storage rooms to discard of any expired medications. The Administrator stated that it could cause residents in getting ineffective medications. The DON stated that ADON usually goes through all the medications once a month to destroy any expired medications. The DON stated that staff have been trained through in-services, quarterly on medication storage. The Administrator and DON stated that the negative potential outcome is residents getting ineffective medications. No policy was provided for expired medications prior to exit. Made attempts to obtain policy on 07/11/2024.

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Lamun-Lusk-Sanchez Texas State Veterans Home	1809 N Hwy 87 Big Spring, TX 79720

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 49154 Based on observation, interview, and record review, the facility failed to provide food that was palatable, and at a safe, and appetizing temperature for 3 of 3 food forms (Regular, Mechanical Soft, and Pureed) for 1 of 1 meal reviewed for palatability. The facility failed to provide food that was palatable for 3 of 3 food forms served (Regular, Mechanical Soft, and Pureed) at 1 of 1 meal observed (07/10/24 lunch). These failures could place residents at risk of decreased food intake, hunger, and unwanted weight loss. The findings included: Record review of the Resident Council Minutes dated 05/23/24 revealed resident comments related to the food served in the facility. It was documented, cold hamburger, cheese not even melted, eggs are always cold, eggs in the morning are cold. The following confidential responses were provided during the initial pool interview screening process on 7/09/24: A resident stated, The food is always cold and does not taste good when it is cold and supposed to warm. A second resident stated the food tastes terrible, bad, and it is cold and that he does not eat it most of the time. A third resident stated, food is always cold, and that he ate in his room. A fourth resident stated the food that was supposed to be warm was always cold. An additional six residents reported their meals were served cold at every meal. Four of those six residents ate in their room, and the other two ate in the dining room. On 07/10/24 at 9:30 AM the Dietary Manager was informed of a request for a test tray for the meal served at 12:00 PM (lunch) and that the test tray was to be provided after the last tray was served on the secured unit. During a confidential group interview on 07/10/2024, a resident said the food served to the residents was always cold. This resident eats in his room. A second resident stated the food was served freezing cold. This resident ate in the dining room. A third resident stated the food was often cold and that he thought fish patties were taken straight from the freezer and served cold to residents without cooking them first. This resident ate in the dining room. A fourth resident stated the food was often cold. This resident ate in his room. A fifth resident stated the food was always served cold. This resident ate in the dining room. A sixth resident stated her food was cold at every mean. This resident ate in her room. On 07/10/24 at 12:40 PM the test trays arrived at the conference room and sampling began at 12:41 PM with the following results: Regular meal plate - Regular Texture Ham with gravy, peas, sweet potatoes, and dinner roll were all hot. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regular Meal - Mechanical Soft Texture Ham with gravy, peas, sweet potatoes, and dinner roll were lukewarm. Regular Meal - Puree Texture Ham with gravy, peas, sweet potatoes, and dinner roll were lukewarm. During an interview on 7/11/24 at 2:35 PM, the Dietary Manager stated she was aware of recent complaints of the food being cold and tried to correct concerns and complaints when received. She stated they received an induction cooking system about a month ago which had improved the issued with the food being cold. She stated the complaints were mainly from residents who ate in their rooms. She stated the induction system helps keep food hot during transport to the rooms. She stated the induction system was used for delivering trays to rooms and they also use plate warmers on the food distributed in the dining hall. She stated the nursing staff were responsible for transporting to each room. She stated the dietary staff transported the food trays to the halls and then the nursing staff on those halls were responsible to distribute to them to residents. She stated the trays were in a closed insulated food cart. She stated she was not sure if there was a policy or procedure that gave the nursing staff a timeframe of how soon trays should be distributed. She stated the cooks and management staff were responsible to check food temperatures. She stated dietary staff randomly checked temperatures on test trays to monitor temperatures during the meal service. She stated they prepared the food trays in the dining room directly from the steam table to keep food warm. She stated they tempted food on steam table to ensure temperatures were accurate. She stated warm food should be above 135 degrees and cold food should be below 41 degrees. She stated she expected that staff to check temperatures and log temperatures before serving as well as correct temperatures before serving the food by heating food to the proper temperature. She stated she had received training on food palatability online and she also ensured staff completed those online trainings. She stated the potential negative outcome of serving cold food to residents were that residents could get sick or a bacterial infection from the food being under temperature. During an interview on 7/11/24 at 4:20 PM, the ADM stated she expected that food served to residents was appealing visually, tasteful, and served at the appropriate temperatures. She stated she was not aware of complaints of cold food recently but was aware there have been complaints in the past and she addressed it with dietary. She stated staff served meals directly from the steam tables to residents that ate in the dining room and food trays were transported in insulated carts and taken to the halls of the residents that ate in their rooms. She stated they also put lids on plates to keep food warm. She stated the dietary staff received a list of residents that would eat in their rooms and dining and served those trays were served first. Then the food trays were made for the left-over tickets of residents who did not show up to the dining room and taken to their rooms, and they were served last. She stated the last meal was served at 5:30 PM in the main dining room. She stated people in the dining room were served first because they were waiting for their food. She stated staff were trained by the dietary manager on palatability and temperatures as needed and annually. She stated a potential negative outcome of serving cold food was that the resident would not eat it and have weight loss or a decline in health. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's, policy titled Food: Quality and Palatability, revised September 2017, revealed the following documentation, Policy Statement: Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature. Food and liquids are prepared and served in a manner, form, and texture to meet resident's needs. Definitions: Food attractiveness refers to the appearance of the food when served to the residents. Food palatability refers to the taste and/or flavor of the food. Proper (safe and appetizing) temperature Food should be at the appropriate temperature as determined by the type of food to ensure resident's satisfaction and minimizes the risk for scalding and burns. Procedures: 1. The Dining Services Director and Cook(s) are responsible for food preparation. Menu items are prepared according to the menu, production guidelines, and standardized recipes. 2.The Cook(s) prepare food in a sanitary manner utilizing the principles of Hazard Analysis Critical Control Point (HACCP) and time and temperature guidelines as outlined in the Federal Food Code.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49154 Based on observations, interviews, and record review, the facility failed to ensure, in accordance with accepted professional standards and practices, maintained medical records on each resident that were complete and accurately documented for one (Resident #109) of thirty-two residents reviewed. The facility failed to ensure the LNAR was accurately documented for physician ordered skin treatments that were not provided. This failure could place residents at risk for complications including skin break down, infection, or decreased physical and mental functioning. Record review of Resident #109's undated face sheet reflected Resident #109 was an [AGE] year-old male whose admitted to the facility was on 1/18/24. Resident #109 had the following diagnoses: chronic obstructive pulmonary disease (airflow blockage and breathing-related problems), type 2 diabetes mellitus with unspecified complications (inability for the body to use insulin properly), chronic kidney disease stage 3B (moderate to severe loss of kidney function), essential primary hypertension (high blood pressure), chronic pain syndrome (symptoms beyond pain alone that interferes with daily life), hypothyroidism (underactive thyroid), mood disorder (mental health condition), anxiety disorder (mental health condition), and hyperlipidemia (excess of fat in the blood). Record review of Resident #109's clinical record reflected his comprehensive MDS assessment was completed on 2/1/2024 listing him with a BIMS score of 13, which indicated he was cognitively intact. Record Review of Resident #109's Care Plan, dated 1/18/24, revealed Resident #109 had an actual or would've been at risk for skin impairment: Pitting and weeping edema. Interventions were to apply treatment as ordered. Record review of Resident #109's physician active orders dated 7/10/24 revealed an order dated 7/05/24 to cleanse bilateral lower extremities with normal saline/wound cleanser, or soap and water, pat dry. Apply moisturizing lotion to bilateral lower extremities and wrap with Kerlix (dressing for wounds to secure and prevent movement of primary dressing) daily from 0700 to 1900 one time a day for edema. Record review of Resident #109's licensed nurse medication administration record (LNAR) dated 7/1/24 - 7/31/24 revealed to cleanse bilateral lower extremities with normal saline/wound cleanser, or soap and water, pat dry. Apply moisturizing lotion to bilateral lower extremities and wrap with Kerlix (dressing for wounds to secure and prevent movement of primary dressing) daily from 0700 to 1900 one time a day for edema, with a start date of 7/06/24 at 0700. Furthermore, on this order revealed documentation on 07/10/24 by LVN B that the ordered skin treatment task was completed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 7/9/24 at 3:34 PM, Resident #109 stated he arrived at the facility on 1/18/24 and had issues with his legs prior to entering the facility. He stated the facility was not consistent with the skin treatments on his legs which caused discomfort and itching. He stated he was frustrated with these inconsistencies and felt this caused the condition of his legs not to improve. During an interview on 7/10/24 at 5:34 PM, LVN B stated she was the charge nurse for Resident #109's hall. She stated there were physician orders for staff to clean, apply lotion, and wrap Resident #109's legs daily at 7:00 AM and remove at 7:00 PM. She stated she believed the skin treatment on Resident #109's legs were completed today. She stated she did not know where the notes of the completion of the treatment was documented in the EHR. During an interview on 7/10/24 at 5:48 PM, the ADNS stated the TN was responsible to complete those orders and she believed the skin treatment was completed today. She stated she was not sure where the skin treatment task was documented in the EHR and would provide that information after she had spoken to the TN. She stated staff were supposed to document any refusal of care in the EHR, report it to the NP, and to hospice. During observation and interview on 7/11/24 at 1:19 PM, Resident #109 stated staff never completed the skin treatment yesterday. During observation and interview on 7/11/24 at 1:34 PM, the TN stated she was trained that her duties as the TN were to complete the orders listed on the TAR. She stated Resident #109's orders were listed on the LNAR, which were the responsibility for the charge nurses on duty to complete. During an interview on 7/11/24 at 2:45 PM, LVN B stated she was the charge nurse for halls 400 and 500 and worked from 6:00 AM to 6:00 PM. She stated charge nurses were responsible to complete physician orders listed on the LNAR and TN's completed orders listed on the TAR. She stated on the LNAR the task would turn green on the screen when the task was completed and would turn red if the task did not get completed. She observed the LNAR and verified that her initials were on the LNAR on 7/10/24, which indicated that she completed the skin treatment task for Resident #109. She stated she had not completed that task but did not know how her initials showed that she had completed it. She stated she had not recalled documenting that, but she could have accidentally marked it as completed when she was checking other boxes of other tasks, she had done that day. She stated she must use her login credentials in order to login to the EHR and document her initials. She stated she had received training on how to chart (document) in the EHR where the LNAR. She stated she was trained on her 2nd day of working at the facility. She stated she did not think pre-charting was best nurse practice. She stated she was trained that items on the LNAR were her duties. She stated a potential negative outcome of pre-charting or not documenting accurately was that the staff may not remember to go back and change the task if it was not done or if the resident refused it. She stated another negative outcome was that the staff may not remember what exactly happened in that situation. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/24 at 3:20 PM, the ADNS stated there were physician orders to wrap Resident #109's legs daily. She stated charge nurses were trained that they were responsible to complete tasks on the LNAR. She stated she was able to confirm the skin treatment for Resident #109 was not completed yesterday because she observed that his legs were not wrapped, and she asked him, and he said they were not. She stated staff were not trained to chart a task on the LNAR before the treatment had taken place and they should not have done that. She stated herself, the TN, and charge nurses train other staff. She stated she expected for staff to document tasks completed on the LNAR after the task had been completed. She stated they use the EHR as their system for tracking when tasks were due, completed, or not completed. She stated the screen would show the item as yellow for tasks that were scheduled to be done. She stated the screen would show green when completed and red when it was not completed and past due. She stated a potential negative outcome was that the resident's EHR would be inaccurate because you don't know what the outcome would be, the order could get missed, and the resident would not get the care they were supposed to get. This could prevent wounds from healing and cause them to worsen. She stated she observed LVN B's initials were documented on the LNAR for Resident #109's skin treatment task on 7/10/24, which indicated the skin treatment was completed by LVN B. During an interview on 7/11/24 at 4:28 PM the DON stated charge nurses were trained that they were responsible for completing tasks on the LNAR. She stated staff should not chart (document) they completed a task in the EHR task before it was completed, it should be charted afterwards. She stated staff were provided this training during orientation and as needed. She stated staff were provided this training when they were getting trained on the floor by other nurses, herself, and the pharmacy nurse. She stated she was not aware staff were pre-charting. She stated tasks initialed on the LNAR indicated that the task was done. She stated a potential negative outcome was that it decreases the facility's credibility with the resident and that residents won't get the care they deserve. During an interview on 7/11/24 at 4:28 PM the ADM stated she did not know exactly what the policy said for accurate documentation. She stated a potential negative outcome was that residents may not get the services they need because they think the task was completed. Record review of facility provided policy titled, Quality of Care dated February 2017, and revised January 2023 revealed: Compliance Guidelines: Quality of care is a fundamental principle that applies to all treatment and care provided to community residents. Based on the comprehensive assessment of a resident, the community will ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices, including but not limited to the following: Skin integrity: Pressure ulcers. Based on the comprehensive assessment of a resident, the community will ensure that: A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. During an email on 7/23/2024 at 3:07 PM the ADM stated facility did not have a policy regarding documentation.

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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** 49305 Based on observation, interview and record review the facility failed to 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 4 of 31 residents (Resident #30, Resident #16, Resident #84, Resident #54) and 5 of 5 staff (CNA A, CMA A, LVN B, MA A, Laundry staff member A) reviewed for infection control. 1. CMA A failed to wash her hands or use hand sanitizer prior to medication preparation or medication administration to Resident #30 during observation of medication pass. 2. LVN B failed to wash her hands or use hand sanitizer prior to medication preparation or medication administration to Resident #16 during observation of medication pass. 3. MA A failed to wash her hands or use hand sanitizer prior to medication preparation or medication administration to Resident #84 during observation of medication pass. 4. Laundry staff member A failed to wash her hands prior to folding clean laundry and after touching dirty laundry. Laundry staff member A failed to fold clothes utilizing the folding table by resting the clean clothes against her body and dragging the clothes against the floor while trying to fold them. 5. CNA A failed to sanitize her hands between glove changes during incontinent care for Resident #54. These failures could place residents at risk for spread of infection and cross contamination. Findings included: Resident #30: Record Review of Resident #30's face sheet reflected he was a [AGE] year-old male who was admitted to the facility on [DATE] with a diagnoses of: Parkinson's disease (a disorder of the central nervous system that affects movement often including tremors), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), type 2 diabetes, bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), depression, hyperlipidemia (a condition in which there are high levels of fat particles in the blood). Record review of Physician orders for Resident #30, dated 12/05/2021, revealed: amlodipine besylate tablet 10 mg, give 1 table by mouth one time a day related to essential primary hypertension. Record review of Physician orders for Resident #30, dated 02/04/2020, revealed: Fluoxetine HCl Tablet 20 mg, give 1 tablet by mouth one time a day related to Major depressive disorder, recurring without psychotic features. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Physician orders for Resident #30, dated 02/04/2020, revealed: Loratadine Tablet 10 mg, give 1 tablet by mouth one time a day for allergies. Record review of Physician orders for Resident #30, dated 02/11/2020, revealed: Lubricant eye drops solution 0.4-0.3%, instill 1 drop in both eyes four times a day for dry eyes. Record review of Physician orders for Resident #30, dated 3/11/2021, revealed: Metformin HCl tablet 1000 mg, give 1 tablet by mouth two times a day related to type 2 diabetes mellitus with other diabetic arthropathy (joint damage). Record review of Physician orders for Resident #30, dated 10/06/2022, revealed: Benztropine Mesylate Tablet 0.5 mg, give 1 tablet by mouth two times a day related to neuroleptic induced parkinsonism. Record review of Physician orders for Resident #30, dated 12/14/2022, revealed: Gabapentin Capsule 100 mg, give 1 capsule by mouth two times a day related to neuroleptic induced Parkinsonism. Record review of Physician orders for Resident #30, dated 08/09/2023, revealed: Tramadol HCl oral tablet 50 mg, give 1 tablet by mouth in the morning related to type 2 diabetes mellitus with other diabetic arthropathy. Record review of Physician orders for Resident #30, dated 11/23/2023, revealed: Glipizide Tablet 5 mg, give 1 tablet by mouth two times a day related to type 2 diabetes mellitus with other diabetic arthropathy. Record review of Physician orders for Resident #30, dated 11/28/2023, revealed: hydralazine HCl oral tablet 25 mg (hydralazine HCl), give 2 tablets by mouth three times a day related to essential primary hypertension. Record review of Physician orders for Resident #30, dated 11/28/2023, revealed: Losartan Potassium oral tablet 25 mg, give 1 tablet by mouth one time a day related to essential primary hypertension. During an observation of medication pass on 07/10/2024 at 7:04 AM with CMA A. CMA A failed to wash hands or use hand sanitizer prior to medication administration for Resident #30. CMA A administered medications as listed: gabapentin 100 mg (1 tab), cholecalciferol 25 mg (3 tabs), glipizide 5 mg (1 tab), hydralazine HCl 25 mg (2 tabs), amlodipine besylate 10 mg (1 tab), losartan 25 mg (1 tab), benztropine mesylate 5 mg (1 tab), metformin 1000mg (1 tab), fluoxetine HCl 20 mg (1 tab), loratadine 10 mg (1 tab), tramadol 50 mg (1 tab), Systane 0.3% solution (1 drop in each eye). CMA A prepared medications in a small medication cup and administered medications to Resident #30 without using gloves, washing hands, or using hand sanitizer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/10/2024 at 7:20 AM with CMA Ashe stated that she did understand that she failed to wash her hands or use hand sanitizer before medication preparation or administration for Resident #30. She stated that she had been trained in handwashing by in-services approximately quarterly. She stated that she should have use hand sanitizer or washed her hands prior to medication preparation or administration but was running behind because she was working 2 halls. She stated that the policy stated that staff should wash their hands or use hand sanitizer before medication preparation and administration. She stated that the negative potential outcome for not washing hands would be the transference of germs. Resident #16: Record Review of Resident #16's face sheet reflected he was a [AGE] year-old male who was admitted to the facility on [DATE] with a diagnoses of: type 2 diabetes, osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wears down), hyperlipidemia (a condition in which there are high particles of fat in the blood), cellulitis (a potentially serious bacterial skin infection), congestive heart failure (a chronic condition in which the heart doesn't pump as well as it should), post-traumatic stress disorder (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), depression, acid reflux, dysphagia (difficulty swallowing), anxiety, peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), lymphedema (swelling, most often in an arm or leg caused by a lymphatic system blockage), spinal stenosis (the spaces inside the bones of the spine get too small) Record review of Physician orders for Resident #16, dated 1/14/2024, revealed: Lantus Solution 100 UNIT/ML (Insulin Glargine), Inject 30 unit subcutaneously one time a day related to type 2 diabetes mellitus with other specified complication. During an observation of medication pass on 07/10/2024 at 7:29 AM LVN B looked at orders for insulin and double-checked medication for Resident #16. LVN B took supplies out of the treatment cart to prepare to administer insulin shot for Resident #16. LVN B failed to use hand sanitizer prior to medication preparation. LVN B drew the insulin up in the needle and it was verified for 30 units of glargine-YFGN and locked the needle. LVN B carried the syringe down the hall to Resident #16's room. LVN B failed to wash hands or use hand sanitizer prior to medication administration. LVN B used an alcohol pad to prep Resident #16 to clean the arm to administer the insulin. LVN B administered the insulin and failed to wash hands after administering the medication. During an interview on 07/10/2024 at 7:31 AM with LVN B. She stated that she does know that she failed to wash her hands or use hand sanitizer before medication preparation or administration of insulin administered to Resident #16. She stated that she was not thinking and was caught off guard. She stated that the policy stated that you should wash your hands or use hand sanitizer before medication preparation or administration and after giving insulin. She stated that she had been trained in handwashing by in-services recently within the last few months. She stated that she was unsure of how often the training was held. She stated that the negative potential outcome for not washing hands is spreading germs from one person to another. Resident #84: (continued on next page)

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Lamun-Lusk-Sanchez Texas State Veterans Home	1809 N Hwy 87 Big Spring, TX 79720

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #84's face sheet reflected she was a [AGE] year-old male who was admitted to the facility on [DATE] with a diagnoses of: type 2 diabetes, bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to Manic highs), anxiety, hyperlipidemia (a condition in which there are high levels of fat particles in the blood), polyneuropathy (is damage or disease affecting the same areas on both sides of the body), high blood pressure, atherosclerotic heart disease (the buildup of fats, cholesterol, and other substances, in and on the artery wall), acid reflux, osteoarthritis (types of arthritis that occurs when flexible tissue at the ends of bones wears down), schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), depression, Record review of Physician orders for Resident #84, dated 09/28/2022, revealed: Lactobacillus Bifidus Capsule, give 1 tablet by mouth in the morning for probiotic. Record review of Physician orders for Resident #84, dated 09/28/2022, revealed: Gabapentin Capsule 300 mg, give 1 capsule by mouth four times a day for nerve pain. Record review of Physician orders for Resident #84, dated 09/28/2022, revealed: Lisinopril Tablet 10 mg, give 1 tablet by mouth one time a day for hypertension. Record review of Physician orders for Resident #84, dated 09/28/2022, revealed: Metoprolol Succinate ER Tablet extended release 24-hour 25 mg, give 0.5 tablet by mouth in the morning for hypertension. Record review of Physician orders for Resident #84, dated 12/05/2022, revealed: Glipizide-metformin HCl tablet 2.5-500 mg, give 1 tablet by mouth two times a day related to type 2 diabetes mellitus without complications. Record review of Physician orders for Resident #84, dated 12/19/2022, revealed: Rybelsus Tablet 3 mg (Semaglutide), give 1 tablet by mouth in the morning related to type 2 diabetes mellitus without complications. Record review of Physician orders for Resident #84, dated 1/29/2023, revealed: Calcium + Vitamin D3 oral tablet 600-10 mg-mcg, give 1 tablet by mouth two times a day for supplement. Record review of Physician orders for Resident #84, dated 05/31/2023, revealed: Alprazolam Tablet 1 mg, give 1 tablet by mouth two times a day related to generalized anxiety disorder. Record review of Physician orders for Resident #84, dated 10/25/2023, revealed: Topiramate Tablet 200 mg, give 1 tablet by mouth two times a day for nerve pain, headaches. Record review of Physician orders for Resident #84, dated 11/10/2023, revealed: Buspirone HCl tablet 5 mg, give 1 tablet by mouth three times a day related to generalized anxiety disorder. Record review of Physician orders for Resident #84, dated 03/28/2024, revealed: Zoloft Oral Tablet 50 mg (Sertraline HCl) give 1 tablet by mouth in the morning related to Major depressive disorder, recurrent. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of medication pass on 07/10/2024 at 7:40 AM with MA A. Resident #84 was standing by the nursing station where MA A had her cart, waiting for MA A to administer his medication. MA A pulled all of the medication that she needed to prepare for Resident #84 and placed them on top of the medication cart. MA A failed to wash her hands or use hand sanitizer before preparing medication for Resident #84. The medications that were prepared were : alprazolam 1 mg (1 tab), buspirone HCl 5 mg (1 tab), gabapentin 300 mg (1 tab), glipizide metformin 2.5/500 mg (1 tab), lisinopril 10 mg (1 tab), metoprolol 25 mg (1 tab), sertraline HCl 50 mg (1 tab), topiramate F/C 100 mg (2 tabs), daily vitamin (1 tab), acidophilus with pectin (1 tab), calcium D3 600mg/10mcg (1 tab), Magnesium oxide 400 mg (1 tab), vitamin B-12, Rybelsus 3 mg (1 tab). During an interview on 07/10/2024 at 7:51 AM with MA A. She stated that she understands that she failed to wash her hands before medication preparation or administration for Resident #84. She stated that she knew that she dropped the calcium pill for Resident #84 on the medication cart, picked it up with her bare hands and administered to Resident #84. She stated she is unsure why she did this and did not think about it. She stated that they are trained regularly in handwashing by in-services. She stated that she should have discarded the medication instead of administering it to the resident. She stated that the policy stated that she should wash her hands prior to medication preparation and administration. She stated that the negative potential outcome is cross contamination or the passing of germs. During an observation and interview on 07/11/2024 at 7:40 AM with Laundry staff member A who was describing to Surveyor the process for doing soiled laundry. There were bins of clean laundry on the floor full of laundry. Laundry staff member A did not wash her hands prior to beginning to fold clothes in front of Surveyors. Laundry staff member A began folding clothes and resting the clean clothes against her body touching her scrubs. Laundry staff member A was observed dragging a clean sheet against the floor as she rested the top portion of the sheet against her body, attempting the fold the sheet. Laundry staff member A stated, I'm too short so it just touches the floor, and I don't know how else to fold it. Laundry staff member A was observed folding many different clean clothes by resting the clothes against her body to fold. Observed Laundry staff member A's scrubs were dirty with specks of debris on them. Laundry staff member A was observed touching dirty clothes and then directly to folding clean clothes without washing her hands or using hand sanitizer. During an interview on 07/11/2024 at 3:09 PM with Corporate District Manager. She stated that she expects staff when handling laundry that is soiled or laundry that had been exposed to diseases or illness, to use PPE or sorting linens and always wash hands prior to folding clean laundry. The Corporate District Manager stated that the staff should never drag clean clothes on the floor at any time and should use the folding table to fold the clothes and not fold the clean clothes against their body. She stated that staff had been trained in infection control practices by in-services just this morning on processing, folding, handling laundry, and infection control practices. She stated that the negative potential outcome for not using infection control practices is the spread of germs and the facility is here to prevent the spread of germs and take good care of the residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/11/2024 at 3:49 PM with Laundry staff member A, she stated that she should have washed her hands but did not because she was just showing the process. Laundry staff member A stated that she is short and that is why she was dragging the clean sheet on the floor. Laundry staff member A stated that she does normally use her body to fold clothes and had done it like that for many years. She stated that she does know that she is supposed to wash her hands constantly but unsure when. She stated that the policy stated that she should wash her hands, every time. She stated that the negative potential outcome for not using infection control practices would be cross contamination and the spread of germs. She stated that she had been trained in infection control practices/ handwashing by in-services approximately two to three times a month. She stated that she had been trained by another employee that is no longer in the facility to fold the clothes by resting it against her body. She stated she does see how it is not good to fold the clean clothes against her body and how it might get the clean clothes dirty or spread germs. During an interview on 07/11/2024 at 2:35 PM with Administrator and DON. The Administrator stated that she does expect staff to wash their hands or use hand sanitizer before medication preparation and administration. The Administrator stated that she does also expect staff to fold clothes immediately and not just leave them in the dryer to wrinkle and to wash their hands prior to folding clean clothes especially when going from handling dirty clothes to clean clothes. The Administrator stated that she expects staff to not drag clean clothes on the floor while trying to fold them or not to fold the clothes against their own clothes or rest the clean clothes against their uniforms while folding. The DON stated that staff is trained in handwashing and infection control practices through in-services, computer-based training, competency skills check annually and as needed. The DON stated that she is responsible for providing training for infection control practices. The Administrator stated that that the laundry department should have been trained and it is the responsibility of the housekeeping manager and the laundry supervisor to train them, and they do in-services and computer-based training annually and as needed. The Administrator stated that the negative potential outcome for not following infection control practices would be the spread of germs. Resident #54 Record review of Resident #54's face sheet reflected he was an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses of: type 2 diabetes, atherosclerotic heart disease (the buildup of fats, cholesterol, and other substances, in and on the artery wall), hyperlipidemia (a condition in which there are high levels of fat particles in the blood), high blood pressure, anxiety, bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), depression. Record review of Resident #54's care plan dated 03/22/2024 reflected the resident is incontinent of bladder and requires assistance with incontinent care every shift and as needed. (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 observation of incontinent care for Resident #54 on 07/10/2024 at 4:05 PM, observed CNA A wash her hands prior to beginning procedure and set up supplies on bedside table. CNA A explained procedure to resident and verbal permission was obtained for Surveyor to observe. CNA A observed the resident's privacy by closing the door, pulling the curtain and closing the blinds. Observed CNA A don (put on) gloves and removed resident's brief. CNA A performed male incontinent care using incontinent wipes, then assisted the resident to roll to his right side and perform incontinent care to buttocks area and apply barrier cream to buttocks and coccyx (tailbone) area. Observed CNA A change gloves and apply a new draw sheet and clean brief to Resident #54 then replace the sheet over the resident. CNA A did not sanitize her hands between glove changes or between clean and dirty aspects of incontinent care. Observed CNA A remove her gloves and wash her hands following the procedure. During an interview on 07/10/2024 at 4:19 PM, CNA A stated she did not perform hand hygiene between glove changes or between clean and dirty aspects of resident care. CNA A stated she was nervous and did not think to use sanitizer between gloves changes. She stated she has been trained on hand hygiene during incontinent care via videos, in-services and skills checks. She stated she was trained approximately monthly while working at the facility. She stated a potential negative outcome of failing to perform proper hand hygiene during incontinent care would be spreading infection to other residents or to herself. During an interview on 07/10/2024 at 4:24 PM, the DON stated the Infection Preventionist was responsible for training staff on proper hand hygiene. She stated the Director of Clinical Education does staff in-servicing and staff have been trained on proper hand hygiene as well as periodic skills checks. She stated her expectation is that all staff observe proper hand sanitizing during care. She stated a potential negative outcome of failure to perform proper hand hygiene would be increased infection rates. During an interview on 07/11/2024, the administrator stated that nursing administration is responsible for training staff on proper hand hygiene. She stated her expectation is that staff follow the guidelines for proper hand hygiene at all times. She stated a potential negative outcome of failure to perform proper hand hygiene would be the potential transmission of organisms to others. Record review of facility provided policy titled, Handwashing/Hand Hygiene, dated 2019 and revised January 2023: Guideline This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation 1. All personnel should be trained and regularly in-serviced on the importance of band hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel should follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non antimicrobial) and water for situations such as this (including but not limited to): (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Before and after direct contact with residents; Before handling clean or soiled dressings, gauze pads, etc.; Before moving from a contaminated/soiled to clean care or procedures; Between patient care encounters After contact with blood or bodily fluids; After handling used dressings, contaminated equipment, etc.; Between glove changes/ After removing gloves; After doffing PPE; hand hygiene is the final step after removing and disposing of personal protective equipment. 8. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 43150 Based on observation, interview and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition in 1 of 1 laundry room in that: 1. The facility failed to maintain clean lint traps in all 3 dryers in the laundry room by failing to clean the lint traps per policy. These failures could place residents at risk for receiving cold meals/coffee and at risk for fire emergencies. The findings included: Observation on 07/11/2024, at 1:50 PM with Laundry Manager. The Laundry Manager was asked to pull out the lint traps in all three dryers to check for compliance. All three dryers were deeply covered with lint underneath the lint baskets on the bottom of the dryers and all around the fan motor. When Laundry manager began to clean the lint from the bottom of the dryers, she had to sweep it all together and it filled a five-gallon bucket. Laundry Manager had gotten a shop vac to finish cleaning the lint traps in all three dryers due to the amount of debris left from the lint. The laundry Manager stated that she could not believe that the lint traps had not been cleaned because they have been taught to clean after every load. The Laundry Manager stated that the process for checking and cleaning the lint traps is that staff is supposed to clean after every load or after every hour. During an interview on 07/11/2024 at 2:54 PM with Administrator. She stated that she expects staff to clean per policy. She stated that the policy stated that the lint traps should be cleaned after every load and every hour. She stated that the staff have been trained by in-services quarterly. She stated that the negative potential outcome is a fire could start. During an interview on 07/11/2024 at 3:08 PM with Corporate District Manager. She stated that she expects staff to clean the lint traps every hour and every two hours at the most. She stated that it is a potential fire hazard. She stated that staff is aware to make sure that lint traps are cleaned every hour. She stated that the staff all have been trained through in-services. She stated that during the in-services they went over lint trap, how and when to clean them. She stated if it needs it, then get the vacuum between every, nook and cranny. She stated that the negative potential outcome is that a fire could start and endangering the residents safety. She stated, 'It's a big concern and probably the biggest. During a record review of facility provided in-service, labeled, Lint Trap Cleaning, dated 07/11/2024, revealed: (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Purpose: To teach laundry personnel the proper way to clean dryer lint screens, how often they should be cleaned, and how to properly document their maintenance. A lint screen is installed in the bottom compartment of all commercial dryers. The air that leaves the dryer passes through the filter, catching lint prior to coming in contact with the filter, catching lint prior to coming in contact with the heating element as it exists the machine. If the lint is not removed frequently, it can result in extended dry times and, more importantly, create a potential fire hazard. It is highly important that the lint scree is brushed and cleaned every 2 hours. Always defer to State and Local regulations as they supersede these guidelines. To Clean Lint Screens-this should be done every 2 hours. 1. Ensure dryer is turned off. 2. Unlatch and open lint collection area of the dryer (on some models remove the lint screen). Using a broom or brush, clean the accumulated lint from the screen and surrounding areas (undercarriage of drum/bottom of lint trap area). 3. Discard accumulated lint cleaned from the dryer in the nearest trash receptacle. 4. Upon completion, return the lint screen to the lint trap area if removed and always secure the lint trap door. 5. Document the time and date on the Lint Screen cleaning log. During a record review of portion of facility provided policy, no title listed, dated 09/05/2017, revealed: Lint: A lint screen is installed in the bottom compartment of all commercial dryers. Lint that falls from the linen as it dries is caught by the lint screen, preventing lint from moving directly through the vent and blowing all over the outside of the building. These lint screens must be brushed and cleaned after every load and every hour. If not, the screen will become packed with lint. When this occurs, the warm air moving through the system is blocked, raising the temperatures in the basket and causing a potentially dangerous situation, i.e., where one spark on lint can cause a fire. Torn or improperly fitted screens must be reported to the facility-to-facility maintenance personnel via work order for immediate repair. Lint may also: a). Build-up between the drum and the side of the dryers is the root cause for many dryer fires. This may cause a problem because in many dryers there is a heat sensor there. This sensor reads the heat of the basket and is programmed to shut the dryer down if the temperature gets too hot. If this sensor is covered with lint, the lint acts as insulation and fools the sensor into thinking the basket is not as hot as it really may be. So, instead of shutting the dryer down. It allows heat to continue to pour in. It is extremely important that you remove the entire front of the dryer and vacuum the entire interior. b). Build-up on the top compartment of the dryer. This is dangerous because the heat source is here.