STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675887	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Joseph Manor	2333 Manor Dr Bryan, TX 77802

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a comprehensive assessment within 14 calendar days after admission as required for 2 (Resident #209 and Resident #212) of 5 residents records reviewed for comprehensive assessment accuracy and timing. Resident #209 and Resident #212 did not have completed admission/comprehensive MDS assessments within 14 days following their admissions to the facility. This deficient practice could result in newly admitted residents not receiving the proper care required to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Findings included: Review of Resident #209's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] and had the following diagnoses: acute kidney failure, altered mental status, primary osteoarthritis of knee (degenerative joint disease that results from breakdown of joint cartilage and underlying bones), low potassium, hyperosmolality (loss of water fluid). Review of Resident #209's MDS summary screen in his EHR on 03/26/25 revealed Resident #209's admission MDS was still in progress. It had an ARD date of 3/24/2025 and was noted as being 2 days overdue. Review of Resident #212's undated face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE] and had the following diagnoses: unspecified dementia, diabetes, sleep apnea (breathing disorder caused by repeated interruptions during sleep), high blood pressure, atrial fibrillation (irregular heart rhythm), congestive heart failure, and gastro-esophageal reflux disease. Review of Resident #212's MDS summary screen in his EHR HER on 03/26/2025 revealed Resident #212's admission MDS was still in progress. It had an ARD date of 3/17/2025 and was noted as being 9 days overdue. In an interview on 03/27/25 at 09:42 AM with MDS A she stated that the timeframe for submitting admission MDS assessments was within 14 days after admission. She stated that Resident #209 was a long term admit and his was not one she was working on (the MDS B was assigned to work it), she had been the only MDS person employed at the facility until recently, and she had become overwhelmed with new admissions. (continued on next page)

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

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/27/25 at 10:12 AM with MDS B she stated she started working at the facility on 2/17/2025. She stated that the timeframe for getting an admission MDS assessment submitted was 14 days after admission. She has been trying to orient due to recently starting and was trying to catch up on her workload. Review of the MDS's job description dated 2024 reflected, The MDS Coordinator-RN, under the direction of the DON, accurately develops and completes resident MDS assessments and Care Plans to assure compliance with regulatory practices and accurate representation of residents' plan of care to assure superlative care of [Facility] residents. Develops admitting processes, and related financial and reimbursement functions. Accurately and timely completes (MCR, quarterly, annual, and change in condition) resident MDS and LTCMI assessments, participates in weekly Care Plan meeting to represent nursing on the Care Plan team. An email request to the ADM on 3/27/2025 at 11:58 AM for a policy on timing for completion of MDS was made by the TC of the survey team. A relative policy on this subject was never received. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.19.1 dated last revised October 2024, required OBRA Assessments for the MDS table reflected that the admission (comprehensive) assessment reference date is due no later than the 14th calendar day of the resident's admission (admission date + 13 calendar days).

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to implement a comprehensive care plan to meet the resident's highest practicable physical, mental, and psychosocial well-being of 3 (Resident #13, Resident #53, and Resident #212) of 12 residents reviewed for care plans. The facility failed to develop and implement the comprehensive person-centered care plan for Resident #13's refusal to be weighted monthly. The facility failed to develop and implement the comprehensive person-centered care plan for Resident #53's refusal to sit up out of bed at a 90-degree angle during all meals. The facility failed to develop and implement the comprehensive person-centered care plan for Resident #212's use of a CPAP machine. These failures could place residents at risk for not receiving appropriate care and treatment. Findings included: Record review of Resident #13's Face Sheet reflected an [AGE] year-old female who was admitted on [DATE] with a diagnosis of Nontoxic Multinodular Goiter (an enlarged thyroid gland with multiple lumps that cause the thyroid to produce too much hormone), Muscle Wasting and Atrophy, Cognitive communication Deficit (difficulty communicating needs and thoughts), and Contracture of Muscle Multiple Sites. Record review of Resident #13's Annual MDS dated [DATE], reflected a BIMs score of 15 indicating resident #13 was cognitively intact. The MDS also reflected that Resident #13's weight was dashed out on the MDS. Resident #13 was marked no or unknown for weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. Record review of Resident #13's care plan initiated 11/04/24 and updated 12/13/24 reflected Resident #13 had a had a nutritional problem or potential nutritional problem related to disease processes and co-morbidities. Resident #13's goal was to maintain adequate nutritional status as evidenced by maintaining weight within 5% of baseline and no signs or symptoms of malnutrition through the review date. Interventions included on the care plan were monitor report to medical doctor as needed signs and symptoms of malnutrition including emaciation, muscle wasting, significant weight loss (greater than 3 pounds in 1 week, greater than 5% in 1 month, greater than 7.5% in 3 months or greater than 10% in 6 months). Record review of Resident 13's Progress notes dated 01/27/25 reflected Resident refuses to be weighed, RP and MD aware. Record review of Resident 13's Mini Nutrition Evaluation dated 03/06/25 reflected Resident #13 had had no weight loss during the last 3 months. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #13's Physicians Order Summary for March 2025 reflected an order to weight monthly unless otherwise noted, dated 09/13/24. Record review of Resident #13's Weight Summary Dated March 2025 reflected there were no documented weights since 09/07/24 of 115 pounds. Record review of Resident #53's Face Sheet reflected a [AGE] year-old male who was admitted on [DATE] with a diagnosis of Bartons Fracture of Left Radius (left arm fracture), Diabetes Mellitus (elevated blood sugars), Unspecified Protein Calorie Malnutrition, and Dysphagia (difficulty swallowing). Record review of Resident #53's PPS MDS dated [DATE], reflected a BIMS score of 08 indicating moderate cognitive impairment. The MDS also reflected that Resident #53s had no symptoms of a swallowing disorder and he was on a mechanically altered diet. Record review of Resident #53's care plan initiated 11/23/24 and updated 01/23/25 reflected Resident #53 had a nutritional problem or potential nutritional problem related to multiple injuries after a motor vehicle accident. The goal was for Resident #53 to maintain adequate nutritional status as evidenced by maintaining weight within 5% of baseline and no signs or symptoms of malnutrition through the review date. Interventions included: monitor/document/report as needed any signs or symptoms of dysphagia (pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals). Registered Dietician to evaluate and make diet change recommendations as needed. Record review of Resident #53s Active Physicians Orders dated 3/25/25 reflected an order that Resident #53 must be out of bed sitting at a 90-degree angle for all meals dated 12/08/24. Record review of Resident #53's Speech Therapy Encounter note dated 12/04/24 reflected Patient seen for dysphagia treatment while seated upright in chair with TLSO brace on. He was very upset to be up in chair and required max cueing and education regarding rehab goals to participate. He refused to self-feed but when bites administered, patient showed good tolerance for po with slow mastication and effective pharyngeal swallow. Record review of Resident #53's Speech Therapy Discharge Summary note dated 12/18/24 reflected: Patient initially struggled with motivation to participate but his endurance and participation improved dramatically across the course of treatment, until he was regularly self-feeding while seated upright with brace on and managing a soft bite sized diet without signs or symptoms of aspiration. Resident #53 was discharged with Goals Met. Record review of Resident #53's Medication Administration Record for March 2025 reflected Resident #53 refused to be out of bed sitting at a 90-degree angle for all meals on 3/1/25, 3/2/25, 3/9/25, 3/10/25, 3/11/25, 3/13/25, 3/16/25, 3/22/25, 3/23/25. In an observation and interview of Resident #53 on 03/25/25 at 12:03pm he was in bed with the head of his bed elevated eating his lunch. Resident #53 stated sitting up in his wheelchair makes him dizzy. Resident #53 denied any difficulty swallowing his food. He stated he does not normally sit up in his chair while he eats. He stated the staff did mention sitting up one time but that was the only time he was offered to sit up for his meal. He stated his head of the bed should be a little higher. Observation of meal reflected it was mechanical soft texture with ground meats. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #212's undated face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE] and had the following diagnoses: unspecified dementia, diabetes, sleep apnea (breathing disorder caused by repeated interruptions during sleep), high blood pressure, atrial fibrillation (irregular heart rhythm), congestive heart failure, and gastro-esophageal reflux disease. Record review of Resident #212's care plan initiated 3/04/2025 reflected Resident #212 had congestive heart failure. His interventions included: Check breath sounds and monitor/document for labored breathing. Monitor/document for the use of accessory muscles while breathing. Record review of Resident #212's Active as of 3/04/2025 Physician's Orders reflected an order to observe if Resident #212 exhibits shortness of breath on exertion, shortness of breath at rest, and an order for Albuterol 0.833-0.167mg/ml sol-1 vial every 6 hours as needed for SOB/wheezing. In an observation on 03/25/25 at 11:23 AM of Resident #212 he was observed to be exhibiting labored breathing and was using a nebulizer mask. The resident was unable to verbally answer the surveyors' questions due to labored breathing but was able to nod yes or no. A CPAP machine and nebulizer were both observed to be sitting in a chair next to Resident #212's bed. He nodded yes to confirm which was a nebulizer and which was the CPAP. In an interview on 03/27/25 at 10:12 AM with MDS B she stated that she started working at the facility on 2/17/2025. She confirmed that Resident #212 had a CPAP and a nebulizer and that he should have an order for both. In an interview on 03/27/25 at 10:47 AM with LVN C who was the charge nurse for unit 4, she stated that Resident #212 used the CPAP every night and the nebulizer was to be used prn. She stated that when the residents admit to the facility the nurse on duty or the nurse in the next shift would add the physicians' orders to the residents EHR. She confirmed with the surveyor that an order for a CPAP and an order for a nebulizer machine were not in Resident #212'sEHR , but they just knew the machines were in the resident's room and that he put them on himself and takes them off himself. The resident's FM had recently asked LVN C to find the resident a pulmonologist to get a new CPAP machine, and a new order should be put in the EHR soon. There was no documentation of replacement parts or a cleaning schedule for either machine in the resident's EHR. In an interview on 03/27/25 at 11:00 AM with Resident #212's FM revealed that Resident #212 had always used a CPAP machine and the facility was in the process of getting him a new one due to the resident having had the current one for approximately 15 years. He stated that Resident #212 used a nebulizer as well, when needed, and the resident was able to administer them to himself without help from the staff. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/27/25 at 11:00am MDS Coordinator A stated care plans should be updated to reflect individual needs. She stated responsibility as an MDS nurse is to care plan the areas that trigger after completion of the MDS. She stated the IDT team was responsible for the compressive care plan. She stated all departments put the residents needs into the care plan. She stated MDS was considered more financial resources instead of clinical. She stated MDS is not 100% responsible for the care plan, it is a collaborative effort amongst everyone. She stated if she were to see a concern with a resident at the time of assessment, she would contact the department head and ask if they would like it to care planned. She stated if a resident was refusing care, it should be care planned. If refusals of care were not care planned it could lead to confusion and not meeting the residents needs and wants. In an interview on 3/27/25 at11:45am the DON said the care plan was a collaborative IDT team effort. She stated the MDS nurse initiated the care plan, she stated the department heads meet every day to discuss resident changes, incidents, wounds, and new orders. The DON stated the MDS was responsible for updating the care plan as they see the need . She stated if a resident was refusing services it needed to be care planned. The DON stated the care plan should paint a picture of the residents needs and be individualized. The DON stated not updating the care plan could lead to residents needs not being met. Record review of facility undated policy titled Care Plans, Comprehensive Person-Centered reflected A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living for 1 of 27 residents (Resident #18) reviewed for ADL activities The facility failed to ensure Resident #18 was monitored for assistance needs and failed to ensure she was positioned in a manner that would allow her to feed herself while in bed. This failure could place residents at risk for weight loss, ADL decline and poor self-esteem. Findings included: Review of Resident #18's face sheet dated 03/26/2025 reflected a [AGE] year-old female admitted on [DATE] with the following diagnoses dementia (A group of symptoms that affects memory, thinking and interferes with daily life.), chronic obstructive pulmonary disease (Is a common, preventable, and treatable disease that is characterized by persistent respiratory symptoms like progressive breathlessness and cough.) and anorexia (an eating disorder that can lead to severe weight loss and an intense fear of weight gain.). Review of Resident #18's annual MDS assessment dated [DATE] reflected Resident #18 was assessed to have a BIMS score of eight indicating moderate cognitive impaired. Resident #18 was assessed to require setup or clean up assist with eating. Resident #18 was assessed to not have a swallowing disorder or weight loss. Review of Resident #18's comprehensive care reflected a focus area dated 02/26/2025 reflected Resident #18 has an ADL self-care performance deficit. Interventions included The resident requires assistance with by staff to eat. Observation and interview on 03/26/2025 at 10:20 AM revealed Resident #18 in bed with her breakfast tray in front of her. Resident #18's overbed table was at Resident #18's chin level. Resident #18 had not eaten any of her food. Resident #18 stated she could not see or reach her food. Resident #18 asked if she could be pulled up in bed. In an interview on 03/26/2025 at 10:31 AM the DON stated after seeing Resident #18 the resident could not reach her food and needed to be repositioned in the bed. In an interview on 03/26/2025 at 10:40 AM CNA G stated she was working on Resident #18's hall. CNA G stated she did not put Resident #18's breakfast in front of her. In an interview on 03/26/2025 at 10:42 AM CNA H stated she was working on Resident #18's hall. CNA H stated she did not put Resident #18's breakfast in front of her. CNA H stated she was unsure who put Resident #18's tray in front of her. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/26/2025 at 10:50 AM the DON stated she was not sure who put Resident #18's tray in front of her but it had to be CNA H or G. She stated Resident #18 should have absolutely be positioned so she could reach her food and have her tray set up. She stated she was going to in service the staff to make sure they are setting up the residents' trays and making sure the residents are positioned so they can feed themselves. Review of the facility's policy ADLs dated 08/2024 reflected The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable .Care and services will be provided for the following activities of daily living .Eating to include meals and snacks .A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain personal hygiene for three (Resident #5, Resident #209, Resident #212) of five residents reviewed for bathing. The facility failed to provide showers to Resident #5, Resident #209, Resident #212 in compliance with their shower schedules. This deficient practice could place residents at risk of a decline in their sense of well-being, level of satisfaction with life, and at risk for skin breakdown. Findings included: Review of Resident #5's comprehensive MDS, dated [DATE], reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including non-traumatic brain dysfunction high blood pressure, stroke, high blood lipids, seizure disorder, depression, partial weakness on one side of the body, dysphagia, abnormal posture, muscle weakness. Resident #5 had a BIMS score of 08, which indicated moderately impaired cognition. She was physically dependent on staff for showers/baths. Review of Resident #5's care plan, dated last reviewed 3/23/2025, reflected she had an ADL self-care performance deficit r/t contracture, pressure injury, required assistance with ADL's, with an intervention of requiring assistance with bathing/showering. Review of Resident #5's bathing task in her EHR reflected that she was to receive showers on Mondays, Wednesdays, and Fridays once an evening between the hours of 2:00 PM and 10:00 PM. Review of Resident #5's bathing tasks in her EHR, from 2/26/25 - 3/26/25, reflected the following: 2/28/25-CNA H indicated total dependence at 11:34am. 3/2/24-CNA H indicated total dependence at 10:23am. 3/3/25-CNA H indicated total dependence at 11:51am. 3/6/25-CNA H indicated total dependence at 10:27am. 3/11/25- CNA H indicated total dependence at 9:32am. 3/13/25- CNA H indicated total dependence at 11:01am. 3/16/25- CNA H indicated total dependence at 12:15pm. 3/19/25- CNA L indicated physical help in part of bathing activity at 1:59pm. 3/21/25- CNA L indicated physical help in part of bathing activity at 1:59pm. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/23/25-CNA H indicated total dependence at 11:16am. 3/24/25- CNA H indicated total dependence at 1:43pm. Review of the facility's Unit 3 shower binder reflected no completed shower sheets for Resident #5 for the past 30 days. Observation and interview on 3/25/25 at 11:06 AM revealed Resident #5 laying in her bed covered in a thick blanket. A FM was present at the time and stated that the facility does not bathe Resident #5 as they should, the resident stated that she does not refuse showers when offered. They both informed the surveyor that the resident required a mechanical lift to get out of bed. The resident stated that not receiving her showers made her feel dirty. She was unable to recall her last shower. An interview on 3/26/25 at 10:43 AM with CNA H revealed that the CNA's on unit 3 use shower sheets to document showers as some new residents did not have a shower task in their EHR. She stated that shower sheets are the most accurate form of documentation on that unit. The CNA helped the surveyor look through the binder for the dates where Resident #5 was scheduled to be showered and no shower sheets were found for Resident #5. When CNA H was asked about the documentation in the EHR where she documented total dependence for Resident #5 during her shifts (6-2), she stated that they have to click the bath on ADL or it'll show red as if they didn't do the task, but they do the paper trail as its easier and they won't lose it if the computer shuts down. She stated the RN must sign the sheet at the end of the shift. Their last in-service for showering (how to give them, filling out the shower sheet, and documenting in PCC) was done last week by the DON. She stated that although her name was in the EHR for Resident #5 she did not bathe the resident because she was not scheduled for showers during CNA H's shift. She stated that the CNA on the 2-10 shift can put a shower note in the EHR during their shift as well, but it was most accurate to fill out a shower sheet. An interview on 3/26/25 at 10:45 AM with CNA L revealed that she did not give Resident #5 showers because of the room number the resident was in. She stated that she only showered residents up to a certain number on the unit and Resident #5 was not included in those numbers. She stated that she uses the shower sheets and that her name in the EHR would have been there to remove the red banner from the computer screen. Review of Resident #209's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] and had the following diagnoses: acute kidney failure, altered mental status, primary osteoarthritis of knee (degenerative joint disease that results from breakdown of joint cartilage and underlying bones), low potassium, hyperosmolality (loss of water fluid). Review of Resident #209's care plan date initiated 3/11/2025, reflected he had an ADL self-care performance deficit and required assistance with ADL's, with an intervention of requiring staff participation with bathing/showering. He was totally dependent on staff for repositioning and turning in bed, and totally dependent on staff for getting dressed. Review of Resident #209's bathing task in his EHR reflected that he was to receive showers on Mondays, Wednesdays, and Fridays once an evening between the hours of 2:00 PM and 10:00 PM. Review of Resident #209's bathing tasks in his EHR, from 3/11/25 - 3/26/25, reflected No Data Found for the period selected. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Unit 3 shower binder reflected 1 completed shower sheet for Resident #209, however there was no date present on the shower sheet. An observation and interview on 3/25/2025 at 10:08 AM revealed Resident #209 laying in his bed, he had 2 FM's present who stated that the resident was very hard of hearing. The FM's stated that they were onsite with the resident almost 24/7. When the resident was first admitted they waited a week before the facility gave the resident a shower. They stated it took the PA telling the staff to shower the resident for him to get the shower. The FM stated that the DR visited on 3/24 and observed a yeast infection on the resident's bottom, which had to get treated. Review of Resident #212's undated face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE] and had the following diagnoses: unspecified dementia, diabetes, sleep apnea (breathing disorder caused by repeated interruptions during sleep), high blood pressure, atrial fibrillation (irregular heart rhythm), congestive heart failure, and gastro-esophageal reflux disease . Review of Resident #212's bathing task in his EHR reflected that he was to receive showers on Mondays, Wednesdays, and Fridays once an evening between the hours of 2:00 PM and 10:00 PM. Review of Resident #212's bathing tasks in his EHR, from 3/4/25 - 3/26/25, reflected No Data Found for the period selected. Review of the facility's Unit 4 shower binder reflected 2 completed shower sheets dated 3/19/2025 and 3/26/2025 for Resident #212. Observation on 3/25/2025 at 11:23 AM revealed Resident #212 laying in his bed in his room using a nebulizer. Resident was observed to be breathing heavily and was unable to answer the surveyor's questions. An interview on 3/26/25 at 10:50 AM with CNA I (who is the facility scheduler) she stated that she felt that they needed more CNA's on the 2-10 shift, she said sometimes that the 2-10 shift cannot get to certain tasks like showers when they are shorthanded. She stated the DON oversaw hiring and that she had been made aware of the staffing concerns. CNA I stated that the CNA's are responsible for showering the residents. CNA I stated that not by resident not getting their showers they get frustrated, their families get frustrated, and that no one wants to sit and be dirty, everyone wants to be clean. An interview on 3/26/25 at 11:29 AM with the DON she stated if a CNA went to ask a resident if they wanted a shower and the resident refused, then the RN would need to go offer the shower, if the resident refused to the RN, then it would be documented in the progress notes in the EHR. She stated that Resident #5 had good recall and would be able to say when her last shower was. An interview on 03/26/25 at 2:53 PM with CNA K revealed that she felt that 2 people on 1 floor during a shift would be short staffing, and that showers are one of the tasks that don't get done if the CNA's felt short staffed during a shift. She also stated that when they felt short-staffed attending to residents who want independence was challenging, she felt that 3 CNA's, with 2 RN's on each shift would allow enough time and delegation to complete all tasks needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 03/27/25 at 10:47 AM with LVN C revealed that they use shower sheets to document resident showers, but they had recently started putting the showers in the EHR as well. No shower sheets or EHR documentation was found for Resident #212. An interview on 3/27/2025 at 11:00 AM with Resident #212's FM revealed Resident #212 had a spinal stimulator implanted, so standing was painful for him, and he could only take a couple steps using assistance, so the facility would usually give him a bed bath. The FM stated that 1 particular CNA would give the resident the bed bath and do the showers as well. Review of the facility's undated Resident Showers policy reflected, It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice. 1. Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety. 2. Partial baths may be given between regular shower schedules as per facility policy. Review of the facility's undated Documentation in Medical Record policy reflected, Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. 3. Documentation may be performed manually or as per the facility's specific electronic medical record software program. 6. Corrections to a medical record shall be made to clarify inaccurate information. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Only the individual who made the original entry shall correct the entry. b. The original content shall remain legible, with a notation that the entry has been corrected. c. The date and time of the new entry shall be recorded and annotated as a correction or addendum. 7. Contradictory information may be clarified by a new entry in the medical record. a. Date and time the entry. b. Provide sufficient details to support that the current information is accurate. c. Sign each entry with name and credentials.

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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 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** Based on observation, interview, and record review, the facility failed to provide treatment and care in accordance with professional standards of practice for 1 (Resident #5) of 5 residents reviewed for quality of care. The facility failed to ensure MA F waited for Resident #5 to consume her nighttime medications before leaving the resident's room. This failure could affect residents by putting them at risk of not receiving the therapeutic benefits of their medications. Findings included: Review of Resident #5's comprehensive MDS, dated [DATE], reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including non-traumatic brain dysfunction, high blood pressure, stroke, high blood lipids, seizure disorder, depression, partial weakness on one side of the body, dysphagia (difficulty swallowing), abnormal posture, and muscle weakness. Resident #5 had a BIMS score of 08, which indicated moderately impaired cognition. The assessment stated none of the above under swallowing disorders. Review of Resident #5's physician's orders in her EHR revealed a standing order dated 1/9/2025 stating, May crush crushable medications, and/or open capsules and mix with food or jelly Review of Resident #5's MAR for the month of March 2025 reflected that MA F administered nighttime medications on 3/24/25 and 3/25/25 and CNA J administered morning medications to Resident #5 on 3/26/2025. Observation on 3/25/25 at 11:06 AM revealed Resident #5 laying in her bed covered in a thick blanket. A FM was present at the time and was assisting the resident with an outside meal brought in by the FM. An additional observation and interview on 3/26/25 at 2:10 PM revealed Resident #5 laying in her bed and a different FM was present with her. The FM expressed frustration with the MA not allowing Resident #5 the time to consume her medications without being rushed or ensuring safe consumption. The FM told the surveyor that Resident #5 was unable to swallow her medications on the night of 3/25/2025 and she spit them out and put them in her bedside table. The FM then opened Resident #5 bedside table drawer and revealed 6 pills (1 round white tablet, 1 oblong white tablet, 2 round brown tablets, 2 round red tablets) the resident stated that she spit them out last night when the MA was rushing her to take her medications and she was unable to swallow them. The FM made a call to the FM who was present with Resident #5 on 3/25/25 who confirmed the medications were not present during that FM's visit. An interview on 3/26/2025 at 3:05 PM with LVN D who was the charge nurse on unit 3 she stated she had never been made aware of Resident #5 spitting out medication. She stated she would let the DON know and take the pills out of the resident's room. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation of the medication cart on 3/26/2025 at 3:05 PM with LVN D it was discovered that the medications in Resident #5's room were the following: Senna (2 brown pills) used as a laxative for short term treatment of constipation Cranberry (2 red pills) used to treat/prevent bladder problems Labetalol (1 small round pill) used to treat high blood pressure Atorvastatin (1 large white pill) used to treat high cholesterol In an interview on 3/26/2025 at 3:20 PM with the DON she stated that she was not aware of a history of Resident #5 not being able to swallow her medications. She stated the crush order in the resident's EHR would depend on a swallow assessment . In an interview on 3/26/2025 at 3:45 PM with CNA J she stated that she gave Resident #5 her medication on the morning of 3/26/2025 and she crushed them for the resident. In a telephone interview on 3/27/2025 at 11:04 AM with MA F she stated that she observed Resident #5 swallow her nighttime pills on 3/24/25 and 3/25/25. She stated the process for her administering medication is that she would hand the residents their pills, wait, let them take drinks, have them open their mouth, and then she would look around in their mouth to ensure they were swallowed. She stated she had never had any instances with Resident #5 spitting out pills. She stated she did not crush her medications due to the resident not having had a crush order. The surveyor informed the MA that Resident #5 had a may crush crushable medications order and the MA expressed her unawareness of the order. The MA stated that Resident #5 had no history of refusing medications during her times of administration. Review of the facility's undated Medication Administration policy revealed, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. 17. Administer medication as ordered in accordance with manufacturer specifications. a. Provide appropriate amount of food and fluid. b. Shake well to mix suspensions. c. Crush medications as ordered. Do not crush medications with do not crush' instructions. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	18. Observe resident consumption of medication.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident who needed respiratory care, was provided such care, consistent with professional standards of practice for one (Resident #212) of 5 residents reviewed for respiratory care. The facility failed to have a physician's order and a plan of care for the use of a CPAP machine and a nebulizer for Resident #212 This failure could place residents at risk of receiving incorrect or inadequate treatment and could result in a health decline or infection. Findings included: Record review of Resident #212's undated face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE] and had the following diagnoses: unspecified dementia, diabetes, sleep apnea (breathing disorder caused by repeated interruptions during sleep), high blood pressure, atrial fibrillation (irregular heart rhythm), congestive heart failure, and gastro-esophageal reflux disease. Record review of Resident #212's care plan initiated 3/04/2025 reflected Resident #212 had congestive heart failure. His interventions included: Check breath sounds and monitor/document for labored breathing. Monitor/document for the use of accessory muscles while breathing. Record review of Resident #212's Active as of 3/04/2025 Physician's Orders reflected an order to observe if Resident #212 exhibits shortness of breath on exertion, shortness of breath at rest, and an order for Albuterol 0.833-0.167mg/ml sol-1 vial every 6 hours as needed for SOB/wheezing. In an observation on 03/25/25 at 11:23 AM of Resident #212 he was observed to be exhibiting labored breathing and was using a nebulizer mask. The resident was unable to verbally answer the surveyors' questions due to labored breathing but was able to nod yes or no. A CPAP machine and nebulizer were both observed to be sitting in a chair next to Resident #212's bed. He nodded yes to confirm which was a nebulizer and which was the CPAP. In an interview on 03/27/25 at 10:47 AM with LVN C who was the charge nurse for unit 4, she stated that Resident #212 used the CPAP every night and the nebulizer was to be used prn. She stated that when the residents admit to the facility the nurse on duty or the nurse in the next shift would add the physicians' orders to the residents EHR. She confirmed with the surveyor that an order for a CPAP and an order for a nebulizer machine were not in Resident #212's EHR , but they just knew the machines were in the resident's room and that he put them on himself and takes them off himself. The resident's FM had recently asked LVN C to find the resident a pulmonologist to get a new CPAP machine, and a new order should be put in the EHR soon. There was no documentation of replacement parts or a cleaning schedule for either machine in the resident's EHR. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/27/25 at 11:00 AM with Resident #212's FM revealed that Resident #212 had always used a CPAP machine and the facility was in the process of getting him a new one due to the resident having had the current one for approximately 15 years. He stated that Resident #212 used a nebulizer as well, when needed, and the resident was able to administer them to himself without help from the staff.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, and dispensing of routine drugs and biologicals to meet the needs of each resident for 1of 4 resident reviewed for pharmacy services. (Resident #213) The facility failed to ensure Resident #213 ordered Thiamine (a B1 vitamin) and Ergocalciferol (a prescription strength vitamin D) medication was available for administration on 03/26/25. These failures could place residents at risk for not receiving medications as prescribed and a decline in health status Findings included: Record review of Resident #213's face sheet reflected he was admitted to the facility on [DATE] with diagnoses of Sepsis (a blood infection), Anxiety, Myasthenia Gravis (a chronic autoimmune disorder that affects the neuromuscular junction, the point where nerves meet the muscle) and mild protein calorie malnutrition. Record review of Resident #213's comprehensive care plan dated 03/21/24 reflected he had the potential for nutritional problem and was provided medication supplements including Thiamine. The goal was to maintain adequate nutritional status as evidenced by maintaining weight within 5% of baseline and no signs and symptoms of malnutrition through review date. The interventions included: Obtain and monitor lab/diagnostic work as ordered. Report results to my physician and follow up as indicated. Record review of Resident #213's admission MDS assessment, dated 03/27/25, reflected he had a BIMS score of 0, which indicated severely impaired cognition. The MDS reflected Resident #213 had no behaviors or refusal of care. Record review of the order summary report for March 2025 reflected Resident #213 had an order for Ergocalciferol Oral Capsule 1.25mg to be given every week on Wednesday dated 03/20/25. The order summary report also showed an order for Thiamine 100mg 1 tablet to be given 1 time daily dated 03/20/25. Record review of the Medication Administration Record for March 2025 reflected Resident #213 did not receive his Thiamine and his Ergocalciferol because the medication was on order. During an observation and interview of medication pass on 03/26/25 at 10:35am MA E prepared Resident #213's medications except the Thiamine and Ergocalciferol. MA E stated those medications were not available. She proceeded to administer his medications and document the medications that were not given were on order. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/26/25 at 10:50am MA E stated she had worked at the facility for 1 year. She stated she has received training related for medication administration from her ADON and DON. The MA stated that she had reported to the charge nurse that Resident #213 was out of his Thiamine medication and his Ergocalciferol . She stated she was not sure why the medications had not come into the facility yet. She stated not having medication available to resident could lead to not being able to treat their diseases appropriately. In an interview on 3/27/25 at 10:11am with LVN C she stated she was never told that Resident #213 was out of his medication or did not have it available. LVN C stated verbally the nurses and Medication aides give report to each other and communicate on medications needed. She stated the medication aides were encouraged to ask questions, and they do ask questions when they are uncertain about an order. Negative outcomes for Resident #213 not receiving his medications as order included sickness and getting worse disease progression. In an interview on 3/27/25 at 11:45am he DON stated he MAs should report all unavailable medications to the nurse . The nurse then would look for the medication. She stated if it was an over the counter the nurse can pull it from the stock medications room. If it is a script the nurse would verify it was not delivered check the order and call the pharmacy. The DON stated the nurse would report all unavailable medications to the DON and doctor. She stated negative effects could include the resident not receiving what medications they need leading to prolonged sickness. Surveyor was not provided a policy on medication availability during survey dates of 3/26/25 and 3/27/25.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 7.69% based on 2 out of 26 opportunities, which involved 1 of 4 residents (Resident #213) observed during medication administration reviewed for medication error. The facility failed to ensure Resident #213's ordered Thiamine (a B1 vitamin) and Ergocalciferol (a prescription strength vitamin D) medication was available for administration on 03/26/25. These failures could place residents at risk of not receiving medications as ordered Findings included: Record review of Resident #213s face sheet reflected he was admitted to the facility on [DATE] with diagnoses of Sepsis (a blood infection), Anxiety, Myasthenia Gravis (a chronic autoimmune disorder that affects the neuromuscular junction, the point where nerves meet the muscle) and mild protein calorie malnutrition. Record review of Resident #213s comprehensive care plan dated 03/21/24 reflected he had the potential for nutritional problem and was provided medication supplements including Thiamine. The goal was to maintain adequate nutritional status as evidenced by maintaining weight within 5% of baseline and no signs and symptoms of malnutrition through review date. The interventions included: Obtain and monitor lab/diagnostic work as ordered. Report results to my physician and follow up as indicated. Record review of Resident #213s admission MDS assessment, dated 03/27/25, reflected he had a BIMS score of 0, which indicated severely impaired cognition. The MDS reflected Resident #213 had no behaviors or refusal of care. Record review of the order summary report for March 2025 reflected Resident #213 had an order for Ergocalciferol Oral Capsule 1.25mg to be given every week on Wednesday dated 03/20/25. The order summary report also showed an order for Thiamine 100mg 1 tablet to be given 1 time daily dated 03/20/25. Record review of the Medication Administration Record for March 2025 reflected Resident #213 did not receive his Thiamine and his Ergocalciferol on 03/26/25 because the medication was on order. During an observation and interview of medication pass on 03/26/25 at 10:35am MA E prepared Resident #213s medications except the Thiamine and Ergocalciferol. MA E stated those medications were not available. She proceeded to administer his medications and document the medications that were not given were on order. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/26/25 at 10:50am MA E stated she had worked at the facility for 1 year. She stated she has received training related for medication administration from her ADON and DON. MA E stated that she had reported to the charge nurse that Resident #213 was out of his Thiamine and Ergocalciferol medications. She stated she was not sure why the medications had not come into the facility yet. She stated not having medication available to resident could lead to not being able to treat their diseases appropriately. In an interview on 3/27/25 at 10:11am with LVN C she stated she was never told that Resident #213 was out of his medication or did not have it available. LVN C stated verbally the nurses and Medication aides give report to each other and communicate on medications needed. She stated the medication aides were encouraged to ask questions, and they do ask questions when they are uncertain about a medication order. Negative outcomes for Resident #213 not receiving his medications as order included sickness and getting worse disease progression. In an interview on 3/27/25 at11:45am The DON stated The MAs should report all unavailable medications to the nurse. The nurse then would look for the medication. She stated if it was an over the counter the nurse can pull it from the stock medications room. If it is a script the nurse would verify it was not delivered check the order and call the pharmacy. The DON stated the nurse would report all unavailable medications to the don and dr. The DON stated staff were given constant reminders to lock the cart. She stated nursing staff had skills check off yearly for competency training on medication pass completed by the ADON. She stated MAs were required to participated in the skills check off. She stated the Pharmacists also completes a medication pass with the staff to ensure competency. She stated negative effects could include the resident not receiving what medications they need leading to prolonged sickness. Record review of facility policy titled Medication Administration dated April 2024 reflected: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure medications and biologicals were stored in locked compartments for 1 of 1 medication carts reviewed for medication storage. The facility failed to ensure the medication cart was locked and medications were secure and not accessible to other staff, resident, or visitors while unattended by MA E on 3/26/25 at 10:30am. This failure could have resulted in harm due to unauthorized access to medications, biologicals, and needles. Findings included: Observation on 03/26/2025 at 10:30am MA E left the medication cart unlocked outside of room [ROOM NUMBER] in the hallway over the counter medication Oscal (a calcium supplement) and Vitamin D supplement were left out on top of cart while she administered medications inside of the room. In an interview on 3/26/25 at 10:50am MA E stated she had worked at the facility x 1 year. She stated she has received training related for medication administration from her ADON and DON. She stated the medication cart should never be left unlocked or unattended. MA E stated medications should not be left out on the top of the cart while it is unattended. She stated leaving the medication cart unlocked and medications out on top of it could allow other staff to have access to the medication cart resulting in missing medications. She stated a resident could take medications that were not prescribed to them causing allergic reactions and medication errors. In an interview on 3/27/25 at11:45am the DON stated she expects all staff who use the medication cart to have the cart locked unless they are actively using the cart. The DON stated staff were given constant reminders to lock the cart. She stated nursing staff had skills check off yearly for competency training on medication pass completed by the ADON. She stated MA's were required to participated in the skills check off. She stated the Pharmacists also completes a medication pass with the staff to ensure competency . She stated leaving the medication cart unlocked could allow other staff and resident access to medications causing missing medications or serious injuries related to drug reactions. Review of the facility's undated policy titled Medication Storage reflected: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675887	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Joseph Manor	2333 Manor Dr Bryan, TX 77802

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's nourishment refrigerators for 3 (Nourishment room [ROOM NUMBER], #3, and #4) of 5 nourishment room refrigerators reviewed for food and nutrition services. 1. The facility failed to ensure the nourishment room refrigerator temperature logs were maintained in dining room [ROOM NUMBER], and nourishment refrigerators #3 and #4. 2. The facility failed to ensure the dining room's refrigerator's cleanliness was maintained. 3. The facility failed to ensure the nourishment refrigerator in unit 1 was free of pests. These failures could place residents at risk for health complications, foodborne illnesses and decreased a quality of life. Findings include: Observation of the unit 3 and 4 dining room's refrigerator on 3/25/2025 at 12:18 PM revealed a lone sign posted to the front of the refrigerator notifying residents, families, and staff that the refrigerator was for residents only. No temperature log was visible on the front or either side of the refrigerator unit or on the surrounding countertops. Inside the refrigerator, the shelves were covered in stains, a single human hair was observed on the shelf, and on the inside door, 3 expired (12/2/2024 X2, 3/18/2024) sour cream packets and 4 expired half & half (1/15/23) cups were all in a bottom drawer. Observation of the unit 4 nourishment refrigerator on 3/25/2025 at 12:30 PM revealed a sign notifying residents and staff that no outside food was allowed in the refrigerator or freezer, and a sleeve of 3 blank temperature logs and 2 temperature logs from November and December 2024 were fixed to the front of the refrigerator. Observation of the unit 3 nourishment refrigerator on 3/25/2025 at 12:54 PM revealed a sign notifying residents and staff that no outside food was allowed in the refrigerator or freezer. No temperature log was visible on the front or either side of the refrigerator unit or on the surrounding countertops. Inside the freezer was a multi-use ½ gallon tub of homemade vanilla flavored ice cream with no resident's name or date visible. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/26/25 at 09:30 AM of the nourishment refrigerator in unit 1 revealed sugar ants crawling all along the seal of the freezer door when opened. When LVN C was notified of the bugs she asked the surveyor what she should do. The surveyor advised her to do whatever it was she would do if she noticed the bugs on her own. LVN C stated she would contact the DON and maintenance. Observation on 03/26/25 at 09:35 AM revealed the ADON placing an Out of Order sign on unit 1's refrigerator and she was overheard to be contacting maintenance for service and the contracted kitchen for resident's replacement food and beverages. Interview with the ADON on 3/25/2025 at 9:23 AM revealed that the contracted vendor for dietary is responsible for maintaining the temperature log and disposing of expired or unused foods. The facility was responsible for cleaning them. Interview with the DON on 3/26/2025 at 9:35 AM revealed that the facility was responsible for maintaining the temperature logs, the CNA's were responsible for cleaning, and the night shift would maintain the cleanliness and temperatures. She stated that all residents, unless they have an NPO order, may have food and beverages from the nourishment refrigerators. Interview with the ADM on 3/27/2025 at 10:23 AM revealed that the facility's kitchen would not be up and running for another 60 days. She stated they had gone back and forth between who was responsible for refrigerator cleanliness and maintenance. Originally, the contracted kitchen was responsible for maintaining it, but then the facility was told it would be their responsibility. She stated the contract between the facility and the contracted kitchen shows the facility as being responsible for temperature monitoring, and the contracted kitchen responsible for stock and cleanliness. She stated that overnight staff would be responsible for cleaning the dining room refrigerator. Her last understanding was that nursing staff would be responsible for maintaining temperature logs. Record review of the facility's contract with the contracted kitchen revealed that {The contracted kitchen} will manage nutrition room stock and cleanliness with temperature monitoring to be done by {The facility} with a due date: to be determined by 9/9/24. Record review of the facility's last 3 months of pest control invoices revealed the facility had a pest control company come out and administer various kinds of insect repellant's indoors and outdoors on 1/23/2025, 2/24/2025, and 3/25/2025.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 one of two medication aides (MA E) observed for infection control practices MA E failed to sanitize her hand, put on gloves prior to administration of eye drops to Resident #213 on 03/26/25 at 10:30am. This failure could place residents at risk for healthcare associated cross-contamination and infections. Findings included: Record review of Resident #213's face sheet reflected he was admitted to the facility on [DATE] with diagnoses of Sepsis (a blood infection), Anxiety, Myasthenia Gravis (a chronic autoimmune disorder that affects the neuromuscular junction, the point where nerves meet the muscle) and Glaucoma (an increased pressure inside the eye). Record review of Resident #213's history and physical dated 03/21/25 reflected he had a diagnosis of Glaucoma wore Correction lenses and was prescribed eye drops Timolol Maleate Ophthalmic (eye) Solution 0.5 % (a medication to decrease eye pressure related to glaucoma), Instill 1 drop in both eyes two times a day. Record review of Resident #213's in progress admission MDS assessment, dated 03/27/25, reflected he had a BIMS score of 0, which indicated severely impaired cognition. The MDS reflected Resident #213 visual assessment was not answered. Record review of the order summary report for March 2025 reflected Resident #213 had an order for Timolol Maleate Ophthalmic Solution 0.5 % 1 drop in both eyes two times a day related to Glaucoma. Observation on 03/26/2025 at 10:35am revealed, MA E prepared Resident #213's medications, she knocked on the door, entered the room and proceeded to administer Timolol eye drops 1 drop in each eye. MA E did not wash her hands or put on gloves prior to the administering eye drops. MA E did not wash her hands after administration of eye drops. In an interview on 03/26/25 at 10:50am MA E stated she had worked at the facility x 1 year. She stated she has received training related for medication administration from her ADON and DON. She stated she should have washed her hands and placed gloves on before giving Resident #213 his eye drops. She stated she was just nervous and forgot. She stated not washing your hands could lead to spreading germs and infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/27/25 at 11:45am the DON stated it was her expectation for staff to wash her hands and apply gloves prior to giving eye drops. She stated staff should wash their hands after removing gloves as well. She stated all staff had been educated on handwashing. The DON stated handwashing was part of the nursing competency check offs annually that was completed by all nursing staff. She stated not washing hands could lead to spreading germs or getting germs from resident to resident. Record review of undated facility policy titled Hand Hygiene reflected: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Before performing resident care procedures. Record review of undated facility policy titled Infection Prevention and Control Program reflected: This facility has established and maintains 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 as per accepted national standards and guidelines. 1. Standard Precautions: a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. c. All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE. d. Licensed staff shall adhere to safe injection and medication administration practices, as described in relevant facility policies. e. Environmental cleaning and disinfection shall be performed according to facility policy. All staff have responsibilities related to the cleanliness of the facility and are to report problems outside of their scope to the appropriate department.