

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675897	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER Franklin Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Hearne St Franklin, TX 77856	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44174</p> <p>Based on observation, interviews, and record reviews, the facility failed to treat residents with respect and dignity and care for them in a manner and in an environment that promoted maintenance or enhancement of their quality of life for one (Resident # 53) of eight residents reviewed for resident rights.</p> <p>The facility failed to treat Resident #53 with respect and dignity when the staff was standing while feeding Resident #53 on 08/13/2024.</p> <p>This failure could place residents at risk for decreased quality of life, increased anxiety, and unmet needs.</p> <p>Finding included:</p> <p>Record review of Resident # 53's Face Sheet, dated 08/14/2024 reflected a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of down syndrome (a genetic condition that can affect how their brain and body develop), anxiety disorder (a condition in which a person has excessive worry and feelings of fear. Symptoms may include irritability, dizziness, fast heartbeat and/or restlessness), cognitive communication deficit (mental process of thinking, learning, problem-solving. Can affect both verbal and non-verbal communication such as speaking, listening, and social interaction skills), and need assistance with personal care (hands-on services that assist a person with critical day-to day activities that they are unable to perform on their own such as dressing, bathing, eating, and maintaining their appearance).</p> <p>Record review of Resident # 53's MDS Quarterly Assessment, dated 05/19/2024, reflected Resident #53 had a BIMS score of 0 indicated her cognition was severely impaired. Resident #53 required assistance with eating, dressing, toileting, bathing, and personal hygiene.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #53's Comprehensive Care Plan, dated 07/15/2024, reflected Resident #53 had impaired visual function. Intervention: Resident #53 utilizes glasses. Resident used anti-anxiety medication for diagnosis of anxiety. Intervention: Monitor/ record occurrence for target behavior symptoms such as: pacing, wandering, aggression towards staff/others and inappropriate response to verbal communication. Resident had impaired cognitive function related to downs syndrome (a genetic condition that can affect how their brain and body develop), anxiety disorder (a condition in which a person has excessive worry and feelings of fear. Symptoms may include irritability, dizziness, fast heartbeat and/or restlessness). Intervention: Use the residents preferred name her first name), identify yourself each interaction. Face the resident when speaking and make eye contact. Reduce any distractions such as turn off television and radio. Resident #53 understands, consistent, simple , directive sentences. Keep her routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Resident #53 had a communication problem. Intervention: be conscious of resident position when in groups, activities, dining room to promote proper communication with others. Resident #53 had an ADL Self Care Performance Deficit.</p> <p>Observation on 08/13/2024 at 12:40 PM reflected Resident #53 was sitting at the feeders table in the dining room. Staff delivered her meal tray to her. LVN J walked toward Resident #53 and stood partially behind Resident #53 and partially beside Resident #53's right side. She was not facing Resident #53. LVN J began to feed Resident # 53 at an angle. Resident #53 attempted approximately 4 times turn her head to see the person feeding her. Resident #53 was unable to see the silverware coming toward her mouth until the silverware was in front of her mouth. Resident #53 began to move more frequently while sitting in the chair. She was moving her head side to side and was attempting to see who was feeding her. LVN J did not introduce herself to Resident #53 or explain she was going to be feeding her.</p> <p>Interview on 08/13/2024 at 1:05 PM LVN J stated she was standing while feeding Resident #53. She stated she did not introduce herself or explain she was going to be feeding Resident #53. LVN J stated she was not facing Resident #53 and it was difficult for Resident #53 to see her where she was standing when feeding her. She stated she was required to sit and face Resident #53 when she was feeding her. LVN J stated she did not feed Resident #53 correctly and she had been in serviced when staff was feeding a resident to introduce yourself, explain what you were going to be doing, and face the resident. She stated this was a dignity issue for someone to stand and feed a resident. LVN J stated Resident #53 may become anxious if she was unable to see who was feeding her.</p> <p>Interview on 08/15/2024 at 7:50 AM the Director of Nurses stated the staff was expected to sit when feeding a resident. She stated if staff was standing when feeding a resident this was a dignity issue for the resident. The Director of Nurses did not respond to any other questions about feeding residents in the dining room such as: Is there a possibility this could have a negative outcome with Resident #53 if she was unable to see who was feeding her.</p> <p>Record review of the Facility Policy on Resident Rights, dated 2003 and revised on 11/28/2016, reflected a facility must treat each resident with respect and dignity of care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884</p> <p>Based on observation, interviews, and record review the facility failed to ensure residents unable to conduct activities of daily living (ADLs) received the necessary services to maintain good grooming and personal hygiene for three of eight (Resident #17, Resident #31, and Resident #46) residents reviewed for ADL care.</p> <p>The facility failed to ensure Resident #17, Resident # 31, and Resident #46 nails were cleaned and smooth around the edges.</p> <p>These failures placed residents at risk of a decline in their hygiene, at risk of skin breakdown, loss of dignity and decline in quality of life.</p> <p>Findings included:</p> <p>1. Record review of Resident # 17's Face Sheet dated, 08/14/2024, reflected a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnoses of type 2 diabetes mellitus with other circulatory complications (high levels of blood glucose can damage the blood vessels and nerves that control the heart), diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified (a metabolic disorder in which the body had high sugar levels for prolonged periods of time and a type of nerve damage that occur if you have diabetes most often damages nerves in the legs and feet), lack of coordination (a problem with movement that can manifest in a variety of ways, such as difficulty with fine motor skills), muscle weakness (when your body can not contract its muscle properly, causing a reduction in strength), and pain in unspecified joint (a general diagnosis that a patient is experiencing joint pain, but the specific joint has not yet been identified).</p> <p>Record review of Resident #17's Quarterly MDS Assessment, dated 06/02/2024, reflected the resident had a BIMS score of 03 reflected his cognition was severely impaired. Resident #17 required assistance with personal hygiene, dressing, transfers, and showers/bathing.</p> <p>Record review of Resident #17's Comprehensive Care Plan, dated 06/05/2024 reflected Resident #17 had an ADL self-care deficit. Intervention: Bathing: check nail length, trim and clean on bath day and as needed. Report any changes to the nurse.</p> <p>Observation on 08/13/2024 at 9:45 AM Resident #17 was lying in bed watching television. His nails were jagged and had blackish substance underneath all nails on his right hand. He also had blackish/ brownish dried substance on the tip of the middle, forefinger, and ring finger on his right hand. The substance did have an odor of feces. There were two small scratches on his left arm.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 08/13/2024 at 9:47 AM Resident #17 stated he asked someone last night to clean his nails and the young lady stated someone would clean them the next day. Resident #17 did not remember the young lady's name. He also stated he had a difficult time trying to eat breakfast today (08/13/2024) due to not wanting to get what smelled like cow manure on his food. He stated he hoped no one could smell the stuff (referring to feces) on his hands. He stated there are sometimes a man had an itch and needs to scratch his bottom. He also stated he his nails needed to be cut or something because he has scratched his arm when it was itching. He stated it did cause a little scratch on his arm; he stated it was this arm (he pointed to his left arm).</p> <p>Record review of Resident # 31's Face Sheet dated, 08/14/2024, reflected a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] diagnoses of : combined forms of age-related cataract, bilateral (a common eye condition that occurs when the lenses of the eyes thicken and cloud over due to aging), muscle weakness (when your body can not contract its muscle properly, causing a reduction in strength), and Alzheimer's disease with early onset (a person's symptoms are often relatively mild and not always easy to notice).</p> <p>Record review of Resident #31's Quarterly MDS Assessment, dated 08/04/2024, reflected Resident #31 had a BIMS score of 15 indicated his cognition was intact. He required assistance from staff with personal hygiene, dressing, transfers, and bathing.</p> <p>Record review of Resident #31's Comprehensive Care Plan, dated 08/13/2024, reflected Resident #31 had impaired visual function related to cataracts (a condition in which the lens of the eye becomes cloudy). Intervention: encourage use of glasses. Resident #31 had impaired cognitive function or impaired thought process related to diagnosis of Alzheimer's (a brain disorder that slowly destroys memory and thinking skills). Intervention: keep Resident #31's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Resident #31 had an ADL self-care performance deficit. Intervention: during bathing check nail length, trim and clean on bath day and as necessary. Report any changes to the nurse. If resident was diabetic the nurse will provide toenail care.</p> <p>Observation on 08/13/2024 at 9:56 AM Resident #31 was sitting on his bed in his room watching television. His fingernails were long and not smooth around the edges on his forefinger, middle finger, and his ring finger on his right hand. His fingernails were long and not smooth on his ring finger and middle finger on his left hand. Resident #31 had blackish/ brownish substance underneath his middle and ring fingernails on his right hand.</p> <p>Interview on 8/13/2024 at 9:58 AM Resident # 31 stated his fingernails was rough on both hands. He stated he scratched his leg over the weekend, and he thought the scratch on his right leg bled a little. Resident #31 also stated he asked a staff worked in nursing on Saturday or Sunday to cut and file his nails. He stated the person told him someone would cut and clean his nails next week. He stated he did not want to scratch himself and cause a big problem with his skin. Resident #31 stated no one had offered to clean or trim his nails and he did not want to ask anyone again because he had already reported his nail concerns to staff. Resident #31 stated he would do it himself, but he couldn't see very well to cut his nails or to make them smooth where he wouldn't scratch himself.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident # 46's Face Sheet, dated 06/01/2024 reflected a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnoses of Parkinson's disease without dyskinesia, without mention of fluctuations (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), need assistance with personal care (personal care for elders is the support and supervision of daily personal living tasks and private hygiene and toileting, along with dressing and maintaining personal appearance such as bathing, hair washing, shaving , oral hygiene and nail care), type 2 diabetes mellitus with other specified complications (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), muscle weakness (when your body can not contract its muscle properly, causing a reduction in strength), and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a mental disorder that causes a person to lose the ability to think, remember, learn, make decisions, and solve problems, but without any symptoms of behavioral disturbances).</p> <p>Record review of Resident #46's Quarterly MDS Assessment, dated 06/01/2024, reflected Resident #46 had a BIMS score of 15 indicated his cognition was intact. Resident #46 required set up or clean up assistance with eating, oral hygiene, toileting hygiene, upper and lower dressing. Resident # 46 required partial/moderate assistance with personal hygiene. He required maximal assistance with showers. Resident #46 required moderate assistance with walking. Resident #46 was assessed to require a manual wheelchair for ambulation.</p> <p>Record review of Resident #46's Comprehensive Care Plan dated 08/13/2024 reflected Resident #46 had diabetes mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel) Intervention: check all body for breaks in skin and treat promptly as ordered by doctor. Monitor, document, and report to MD as needed for any signs or symptoms of infection to any open areas: redness, pain, heat, swelling or pus (a thick yellowish or greenish liquid in infected tissue, consisting of dead white blood cells and bacteria) formation. Resident #46 had impaired cognitive function, dementia (a mental disorder that causes a person to lose the ability to think, remember, learn, make decisions, and solve problems), or impaired thought processes. Intervention: Communicate with the resident regarding residents' capabilities and needs. Keep Resident #46 routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Resident #46 had ADL self-care performance deficit. Interventions: bathing, bed mobility, and walking -needed supervision. He uses a cane for ambulation.</p> <p>Observation on 08/13/2024 at 10:57 AM Resident #46 was in his room lying in bed. His nails were long and not even around the edges on his right and left hand. There was a blackish/ brownish substance on the edge of his ring finger and middle finger on his right hand. Observed the scent of feces when Resident #46 held up his right hand. Resident #46 had blackish hard substance underneath his ring finger, middle finger, and forefinger on his right hand.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 08/13/2024 at 11:00 AM Resident #46 stated he did ask someone over the weekend to clean his nails and trim his nails. He stated the person he asked to clean and trim his nails stated someone would do it next week that they did not do nail care on the weekends. Resident #46 did not recall the name of the person he asked to help him with his nails. He stated he did not want to try and clean his nails because he was afraid he would get his fingernails or skin around his nail infected since he was a diabetic. He stated he tried to clean his nails and cut his nails few years ago and his skin around his nails became infected and he almost lost one of his fingers. Resident #46 stated he did have poop (a word for feces) on his fingers he was trying to clean himself and he did not realize it was on his fingers until someone came in and he saw it and asked for his fingernails to be cleaned and cut.</p> <p>In an interview on 08/14/2024 at 11:10 AM LVN A stated the nurses and the CNAs were responsible for nail care. She stated the nurses were responsible to trim and clean all resident's nails with a diagnosis of diabetes. LVN A stated it was the CNAs responsibility to clean and trim all other residents' nails. She stated if there was a blackish substance underneath the residents' nails, there was a possibility the substance had bacteria underneath the residents' nails. She also stated if a resident swallowed the bacteria there was a possibility a resident may become extremely ill with e coli (a bacteria that is commonly found in the lower intestine of warm-blooded organisms) issues such as diarrhea and vomiting. LVN A stated if a resident scratched themselves with rough nails there was a potential a resident may develop a skin tear and the skin tear had a potential of becoming infected. She stated she was not aware of Resident# 17, Resident # 31 or Resident #46 refusing nail care.</p> <p>In an interview on 08/14/2024 at 11:20 AM CNA B stated the nurses completed all diabetic (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel) fingernails, and the CNAs were responsible for all other residents' nails. She stated the CNAs were responsible to complete nail care such as trimming, filing, and cleaning the nails during showers. CNA B stated if a resident's nails needed to be cleaned, trimmed, or filed and it was not their shower day, the staff were expected to do any type of nail care as needed. She stated if a resident had blackish substance underneath their nails, it was probably some type of bacteria such as bowel movements. She stated if a resident swallowed bacteria it was a potential the resident may become ill with E. coli (a bacteria that is commonly found in the lower intestine of warm-blooded organisms) and may develop major stomach problems such as diarrhea. CNA B stated if a resident became severely ill the resident may need to be transferred to emergency room for more care. She stated she worked with Resident #17 and Resident #31, and she was not aware of them refusing nail care. CNA B stated sometimes Resident #46 would refuse to shave but she was not aware of him refusing nail care. She stated if a resident's nails were rough there was a possibility the resident may scratch themselves and develop a skin tear, or possibly scratch their eye and cause a tear on their eyeball. She stated she had been in-service on nail care but did not remember the date of the in-service. She stated it had been about a year.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 08/14/2024 at 11:43 AM LVN C stated the Treatment Nurse D was responsible for all nail care. He stated if a resident had blackish substance underneath their nails there was a possibility the substance was some type of bacteria. LVN C stated if a resident swallowed the blackish substance, he did not know what type of symptoms the resident may have if the blackish substance was bacteria such as feces. LVN C stated the resident may develop vomiting or diarrhea if they did get sick from the blackish substance according to what type of bacteria. He stated he was not aware of when the residents' nails were to be cleaned or trimmed it was according to the treatment nurses schedule. LVN C stated he did not clean or trim nails. He stated he did not recall if he had or had not been in-service on nail care.</p> <p>In an interview on 08/14/2024 at 11:55 AM CNA E stated the CNAs was responsible for cleaning, trimming, and filing all residents' nails except for the residents with diagnosis of diabetes (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel). She stated the nurses was responsible for all residents' nails with diagnosis of diabetes. CNA E stated residents nails were usually cleaned , filed, and trimmed on their shower days. She stated if a resident had a hang nail or their nails were dirty, nail care was expected to be completed as needed. She stated if a resident had nails that were rough around the edges, there was a possibility a resident may scratch themselves or another resident. CNA E stated the scratch may develop into a skin tear. She stated if there was a blackish substance on the residents' fingertips or underneath their nails and the resident swallowed the blackish substance there was a possibility a resident may become ill with stomach issues such as vomiting or diarrhea. CNA E stated there were also a possibility a resident may become severely dehydrated and may need to be transferred to emergency room to determine what type of bacteria was underneath the residents' fingernails. CNA E stated she had been in-serviced on cleaning, filing and trimming residents' nails but she did not recall the date.</p> <p>In an interview on 08/14/2023 at 12:15 PM Treatment Nurse D stated she did help with trimming and cleaning the diabetic nails; however, she was not responsible for all resident's nail care in the facility. She stated a resident may become ill such as stomach issues if the resident ingested some type of bacteria. The treatment nurse D stated if resident had rough nails around the edges there was a possibility a resident scratch themselves, staff, or other residents. She stated residents' nails were given care during showers and as needed. She stated the CNAs was responsible for all residents' nails except for resident with diagnosis of diabetes and this was the nurse's responsibility. She stated she had been in-service on nail care; however, she did not recall the date of the in-service.</p> <p>In an interview on 08/15/2024 at 7:50 AM The Director of Nurses stated the Treatment Nurse D was not responsible for all the residents' nails in the facility. She stated the Treatment Nurse D was expected to assist with nail care especially the residents with diagnosis of diabetes. The Director of Nurses stated if a resident had rough edges around the nail there was a possibility the resident may scratch themselves and develop a skin tear. Director of Nurses stated if a resident ingested blackish substance on their fingers or underneath their fingernails, there was a possibility the substance may be some type of bacteria. She stated a resident may develop a type of illness. She stated it was according to what the bacteria was to determine if a resident would become ill. The Director of Nurses stated the resident may become ill with hepatitis. She stated all residents was expected to receive nail care during showers and as needed. She stated it was the nurse supervisor responsibility to monitor nail care.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>40884</p> <p>Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals, were in locked compartments and inaccessible to unauthorized staff, visitors , and residents for 3 of 3 medication carts reviewed for medication storage.</p> <p>The facility failed to prevent Medication Cart #1 and Medication Cart #2 being unattended and unlocked near the nurse's desk and one medication cart unlocked and unattended approximately 15 feet away from the right side of nurse's desk on 08/15/2024 between 1:30 AM to 1:43 AM .</p> <p>This failure could allow residents unsupervised access to prescription and over-the-counter medications.</p> <p>Findings included,-:</p> <p>Observation on 08/15/2024 at 1:30 AM LVN H was standing at the entrance door to the facility when Surveyor I was walking toward the door to enter the facility. LVN H opened the door for Surveyor I and when entered the facility. LVN H was walking very fast toward Medication cart #1 on the right side of the nurse's desk and locked the medication cart. She asked CNA J to lock Medication Cart #2 on the left side of the nurse's desk.</p> <p>Observation on 08/15/2024 at 1:35 AM observed Resident #28 walked into the lobby and sat in a chair near nurse's desk.</p> <p>Observation on 08/15/2024 at 1:38 AM observed Resident # 7 was propelling self in her wheelchair to the lobby from 400 hall. She stopped approximately 10 feet from the nurse's desk and sat approximately 5 minutes and propelled self toward her room on 400 hundred hall.</p> <p>Observation on 08/15/2024 at 1:43 AM there was a third medication cart #3 located approximately 15 feet from the nurse's desk toward the hall on the right side of the nurse's station where the activity room was located. Surveyor I opened the medication cart drawers, and the Medication Cart #3 (Med Cart #3) was unlocked.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Franklin Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Hearne St Franklin, TX 77856	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/15/2024 at 1:45 AM LVN H stated she was not aware of the third medication cart being unlocked. She stated she knew the other two medication carts by the nurse's desk was unlocked. LVN H stated she thought she had locked the third medication cart, but she did not recall how long the third medication cart had been unlocked. She stated the two medication carts by the nurse's desk had been unlocked approximately 1 hour. She stated she gave one resident some medications out of the medication cart on the left side of the nurse's desk approximately 40 minutes prior to Surveyor I entered the facility and she forgot to lock the three carts. She stated staff that was not authorized to open medication carts did have access to all medications except for narcotics. She stated the narcotics was locked in a box inside the medication cart. LVN H stated if a resident was wandering during the night the resident would have opportunity to open the medication cart and get any medications out if the cart and swallow the medication or drink some of the liquid medications. She stated there was a potential for a resident to die if the resident ingested a medication, they could be allergic to or it interacted with their own medications. LVN H stated all medications carts were to be locked at all times except when the nurse was dispensing medications from the medication cart to give to a resident. She stated she had been in-service to keep medication carts locked at all times unless administering medications to a resident. LVN H stated she did not follow the facility protocol and she was aware she was wrong not to check the medication carts to ensure they were locked.</p> <p>In an interview on 08/15/2024 at 1:55 AM CNA J stated she was sitting behind the nurse's desk when LVN H walked from the front door toward the medication cart. She stated LVN H asked her to lock the medication cart. CNA J stated the medication cart located to the left of the nurse's desk was unlocked and she did lock the medication cart. She stated only the nurses was allowed to lock and unlock the medication cart. CNA J stated she did not think about asking Nurse H she did not feel comfortable locking the medication cart. She stated LVN H had given a resident some medication approximately 45 minutes prior to Surveyor I entered the facility.</p> <p>In an interview on 08/15/2024 at 7:50 AM the Director of Nurses stated all three medication carts were expected to be locked on the night shift unless the nurse was standing at the cart administering medications. She stated if the medication carts were opened on the night shift there was no possibility of a resident getting any medications. The Director of Nurses stated no residents would be up during the night. She stated if there were residents awake when Surveyor I was in the facility the staff would stop them from taking medications. The Director of Nurses did not respond to any other questions of the possibility if staff was not around the medication carts there was a possibility the residents would have access to the medication carts without the staff knowledge. She stated she did not know the facility policy or protocol for the medication carts. She stated she would find out and inform Surveyor I of the protocol and her opinion after she read the facility medication cart policy. The Director of Nurses did not discuss the medication policy or protocol with Surveyor I prior to exiting on 08/17/2024.</p> <p>In an interview on 08/15/2024 at 8:09 AM the Administrator stated it was ideally for the medication carts to be locked when the nurses were not administering medications from the carts. He stated there was a possibility a resident may get medications out of the medication cart. He stated if a resident did take the medications by mouth there was a possibility a resident may have an allergic reaction and may cause some type of physical harm. He stated he was not a nurse and did not know all the risks of a resident taking another residents medication.</p> <p>(continued on next page)</p>		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Facilities Medication Cart Policy, dated 2003, reflected the medication carts shall be maintained by the facility. The carts are to be locked when not in use or under the direct supervision of the designated nurse. Carts must be secured.		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44174</p> <p>Based on observation, interview and record review, the facility failed to store, prepare, distribute food in accordance with professional standards for food service safety for one of one kitchen reviewed for kitchen sanitation.</p> <p>The facility failed to ensure the Maintenance Supervisor K wore a hair net and beard net and the Administrator wore a hair net while standing over large bowl of approximately 15 uncooked chicken breasts in the sink on 08/13/2024.</p> <p>These failures could place residents who were served from the kitchen at risk for health complications, foodborne illness, and decreased quality of life.</p> <p>Findings included:</p> <p>Observation on 08/13/2024 at 9:15 AM the Administrator and the Maintenance Supervisor K walked into the kitchen without donning (the act of putting on gloves or a hair net) hair net and beard net. The Maintenance Supervisor was checking the temperature of the water in the sink. A large bowl of approximately 15 uncooked chicken breasts being defrosted was in the sink. The Maintenance Supervisor K and the Administrator was standing over the sink without wearing hair net or beard net. The maintenance supervisor K had approximately 8-inch growth of hair on his chin. His hair was twisted; however, his hair was long almost to his shoulders. The Administrator hair was long between his neck and his shoulders.</p> <p>In an interview on 08/13/2024 at 9:25 AM Maintenance Supervisor K stated he was expected to place hair net on his head and a beard net over his hair on his chin. He stated he was standing directly over the chicken. He stated there was a possibility hair could have fallen onto the chicken. The Maintenance Supervisor K stated if a resident did have hair on their chicken there was a potential a resident may become sick with some type of illness from the hair. He stated the hair may have chemicals on it and cause the resident to become ill with stomach issues. He stated had been in serviced on wearing hair net and beard net when entering the kitchen. He did not recall the date of the in-service. He stated the hair net and beard net was available at the door prior to entering the kitchen.</p> <p>In an interview on 08/15/2024 at 8:09 AM the Administrator stated he was expected to wear hair net when entering the kitchen and the Maintenance Supervisor K was also to wear a hair net and a beard net. He stated the both of them maintenance supervisor K) did enter the kitchen without wearing hair net and the Maintenance Supervisor did have hair on his chin and he was to wear a beard guard. The Administrator stated the Maintenance Supervisor K was standing directly over the uncooked chicken being defrosted in the sink. He stated he was standing toward the side, however, there was one time he was standing over the same chicken as Maintenance Supervisor K. He stated there was a possibility a resident potentially may ingest hair and become ill with some type of foodborne illness. He stated his expectation was any staff entering the kitchen was expected to wear hair net and if males had beard growth, they were expected to wear a beard guard. The Administrator stated he knew he was required to wear hair net prior to entering the kitchen and the hair nets was available at the kitchen door prior to entering the kitchen.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/15/2024 at 11:55 PM the Dietary Manager L stated all staff in the facility was expected to wear a hair net and if a male had a beard the male staff was expected to wear a hair net and beard net prior to entering the kitchen. She stated there was a possibility hair could have fallen onto the chicken being defrosted in the sink. Dietary Manager L stated it would be easy for hair to stick to wet uncooked chicken. She stated hair was considered contaminated and if a resident ate some hair which was located on the chicken there was a possibility the resident may become physically ill from the bacteria on the hair. She stated a resident may become ill with stomach issues such as vomiting and diarrhea. Dietary Manager L stated her staff is in-service on this on a regular basis and the non-dietary staff was verbally informed no one was to enter the kitchen without wearing hair net. She stated the staff was also informed they could not enter the kitchen if the staff had facial hair. They were to place beard guard over their facial hair. She stated the beard guard and hair nets were located at the door entering into the kitchen from the dining room.</p> <p>Record review of the Facility's Policy on Infection Control, dated 2012, reflected clean hair was required. It is to be covered with an effective hair restraint. Facial hair was to be closely trimmed and was to be covered with a hair restraint.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884</p> <p>Based on observations, interviews, and record review, the facility failed to maintain an Infection Control Program designed to ensure hand hygiene procedures were followed by staff in the direct care of one (Resident #1) of four residents reviewed for infection control.</p> <p>The facility failed to ensure CNA F sanitized or washed her hands prior to touching contaminated surfaces (floor and chair) prior to touching Resident #1's food and prior to feeding Resident #1 on 08/13/2024.</p> <p>These failures could place residents at risk of cross contamination which could result in physical illness.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet, dated 08/14/2024, reflected a [AGE] year-old male admitted on [DATE] with diagnoses of transient cerebral ischemic attack, unspecified (a medical emergency that occurs when the blood flow to the brain is temporarily disrupted, causing a lack of oxygen), unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a mental disorder that causes a person to lose the ability to think, remember, learn, make decisions, and solve problems, but without any symptoms of behavioral disturbances), legal blindness, as defined in USA (having central visual acuity of 20/200 or worse in the better eye with the best possible correction, or a visual field of 20 degrees or less), cognitive communication deficit (It can involve problems with cognitive skills such as memory, concentration, reasoning, and problem-solving. These deficits can affect verbal and nonverbal communication, including speaking, listening, reading, writing, and social interaction skills), age-related nuclear cataract, bilateral cataracts (a common eye condition that affects both eyes and causes blurred vision), and muscle weakness (when your body can not contract its muscle properly, causing a reduction in strength).</p> <p>Record review of Resident #1's Admission MDS Assessment, dated 05/07/2024 reflected Resident #1 had a BIMS score of 5 indicated his cognition was severely impaired. Resident #1 required maximal assistance (helper does more than half the effort) of staff with eating, oral hygiene, dressing and personal hygiene. He was dependent on staff for toileting hygiene and showers. Resident #1 required mechanically altered diet.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's Comprehensive Care Plan, dated 05/01/2024 and revised on 08/13/2024 reflected Resident #1 had impaired cognitive function or impaired thought process (It can involve problems with cognitive skills such as memory, concentration, reasoning, and problem-solving. These deficits can affect verbal and nonverbal communication, including speaking, listening, reading, writing, and social interaction skills). Interventions: Keep Resident #1's, routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. He had impaired visual function related to legal blindness; age related nuclear cataract- bilateral. Intervention: arrange consultation with eye care practitioner as required. Ensure appropriate visual aids are available to support resident. Monitor , document, and report to MD the following signs and symptoms of acute eye problems: ability to perform ADLs and sudden visual loss. Resident #1 was at risk for malnutrition (lack of proper nutrition, caused by not having enough to eat, not eating enough of the right foods, or being unable to use the food that one does eat. Resident #1 had an ADL self-care performance deficit. Intervention: Resident #1 required one person staff assistance with eating.</p> <p>Observation on 08/13/2024 at 12:45 PM reflected CNA F bent over and picked up approximately four stacked cups off the dining room floor. Her middle, forefinger, and ring fingers from the knuckle to the tip of the fingers touched the floor when she picked up the stacked cups. She placed the plastic cups on the table near Resident #1. CNA F grabbed the arms of a chair and pulled the chair next to Resident #1 immediately after she placed the plastic cups on the table. She did not sanitize or washed her hands. CNA F sat in the chair and turned Resident #1 plate around between her and Resident #1. When she pulled Resident #1 plate the top part of her middle finger and fore finger touched inside his plate and touched the mashed potatoes. CNA F continued to feed Resident #1 and never sanitized or washed her hands. She picked up the napkin with her small finger, middle finger, and ring finger on her right hand and wiped Resident #1's mouth. She then wiped his mouth her middle finger and ring finger on her right hand from her knuckle to the tip of her finger touched the right side of Resident #1's mouth.</p> <p>In an interview on 8/13/2024 at 1:30 PM CNA F stated she did pick up some cups off the floor and the tip of her fingers did touch the floor. She stated she pulled up a chair and touched the arms of the chairs. CNA F stated she pulled Resident #1's plate around to feed him and she did touch the inside of the plate and she may have touched the mashed potatoes. She stated she did not wash or sanitize her hands. CNA F stated there was a possibility she may have cross contaminated Resident #1's plate and his food with her hands. She stated it was expected to wash or sanitize hand prior to feeding any resident and she did not wash or sanitize her hands. She stated she had been in serviced on sanitizing hands prior to feeding a resident, however, she did not recall the date of the in-service.</p> <p>In an interview on 08/14/2024 at 11:10 AM LVN A stated if staff picked up anything off the floor and their fingers touched the floor the staff was expected to wash or sanitize their hands immediately. She stated if staff touched the arms of a chair while moving the chair to the table next to a resident, the chair was considered contaminated, and the staff was expected to wash or sanitize their hands prior to feeding a resident. LVN A stated if the staff hand touched the resident's food with her hands after she touched the chair and the floor the staff cross contaminated the food from the bacteria on the staff's hands. She stated there was a possibility the resident could become ill such as food borne illness with symptoms of vomiting or diarrhea. She stated she had been in-service on hand hygiene and wash or sanitize your hands prior to feeding a resident. LVN A stated she did not recall when she had been in-serviced on washing hands when in the dining room feeding residents.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/15/2024 at 11:20 AM CNA B who stated if someone picked anything up off the floor and their fingers touched the floor, she stated the staff was to wash or sanitize hands prior to feeding a resident. She stated if staff pulled up a chair and sat in chair the chair would be considered contaminated. She stated the staff must sanitize or wash hands prior to feeding any resident even if they did not touch the floor or chair. She stated there was a possibility if the food was touched the food would be contaminated from the germs from the floor and the chair. She stated a resident could become sick if they swallowed any type of bacteria from the staff hands if the hands were not sanitized. She stated the resident could become ill with vomiting stomach issues and may have diarrhea. CNA B stated she had been in-service on hand hygiene when feeding did not recall the date and had been in-service on feeding residents and during the in-service was discussed to always sit and never stand when feeding she did not recall when this in-service was given.</p> <p>In an interview on 08/15/2024 at 7:50 AM the Director of Nurses stated the staff was expected to sanitize their hands prior to feeding a resident. She stated if the staff touched the floor, or anything contaminated the staff hands were considered contaminated and was expected to sanitize their hands. She stated she did not know what type of illness a resident may get from bacteria. She stated the facility never had a resident to become ill from any type of bacteria. (common infectious diseases caused by bacteria is the following: strep throat (a disease that causes a sore throat), urinary tract infection (an infection in any part of our urinary system: kidneys and/ or bladder), E. Coli (bacteria normally lives in your intestines can get it from the environment, food and water), clostridiodes diffcile (infection of the colon)She stated there was always a possibility of someone becoming ill from bacteria. The Director of Nurses stated the staff had been in-service to wash or sanitize their hands prior to feeding a resident. She stated she did not recall the date of the in-service.</p> <p>Record Review of the Facility Policy on Hand Hygiene, not dated, reflected you may use alcohol-based hand cleaner or soap/water for the following before and after assisting a resident with meals.</p>		