| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 675907 | A. Building<br>B. Wing | 07/17/2024 |

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| Diboll Nursing and Rehab | 900 S Temple Dr<br>Diboll, TX 75941 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>46273<br><br>Based on interviews and record reviews, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 of 1 resident group (resident council) reviewed for quality of life.<br><br>The facility failed to ensure that staff were not talking on their cell phones while providing care to residents.<br><br>The facility failed to ensure that staff did not speak rudely to residents.<br><br>This failure could place residents at risk of decreased feelings of self-worth.<br><br>Findings include:<br><br>During an anonymous group interview, 6 of 12 residents in attendance of resident council meeting voiced the following concerns:<br><br>1. Staff members had been providing care while using their personal cell phones. One resident said that a staff member had given her a shower recently and was on her cell phone using ear buds the entire time she showered her, and it made her feel very uncomfortable, almost like the person on the other end of the phone could see me. She said she had already reported it to administration but it was still happening. Other residents said that staff would commonly be talking on their phones while providing personal care to them.<br><br>2. Staff members often speaking rudely to them and being disrespectful to them.<br><br>Residents would not give staff member's names.<br><br>(continued on next page) |

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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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 07/16/24 at 03:58 PM Administrator said he was aware of some residents complaining of staff being rude and using cell phones while providing care. He said the Resident Council president had told him. He said staff should not be talking on their phones while providing care. He said it could make the residents feel bad about themselves. He said the residents had not given him specific employee names, but he would be holding in-services because that was unacceptable to him. He said that CNAs being rude to the residents was inhospitable. He said this was their home and they should be treated with respect.<br><br>During an interview on 07/17/24 at 09:55 AM DON said that she would be providing education to staff regarding respect and not talking on their phones while providing care. She said it could make the residents feel bad about themselves.<br><br>Record review of a facility policy titled Cell Phones dated December 2019 read .Use of these devices will be restricted to the employee break room or outside of the facility .<br><br>Record review of a facility policy titled Dignity dated 2001 and revised in February 2021 read .Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem . |

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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273<br><br>Based on interview and record review the facility failed to ensure each resident was informed before, or at the time of admission, and periodically during the residents stay, of services available in the facility and of charges for those services, which included charges for services not covered under Medicare/Medicaid or by the facility's per diem rate for 3 of 3 residents (Resident #9, Resident #22 and Resident #139) reviewed for beneficiary notice.<br><br>The facility failed to ensure Resident #9, Resident #22 and Resident #139 was given a Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) when discharged from skilled services at the facility prior to covered days being exhausted.<br><br>This failure could place the residents who were discharged at risk of not having knowledge of changes to services in a timely manner to allow the resident or their representative the option of appealing the denial of services.<br><br>Findings include:<br><br>Record review of a facility face sheet dated 7/16/24 for Resident #9 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] and subsequently readmitted on [DATE] after a qualifying hospital stay 1/11/24 through 1/16/24 with diagnoses including: metabolic encephalopathy (a change in how your brain works due to an underlying condition. It can cause confusion, memory loss and loss of consciousness), anxiety disorder (intense, excessive and persistent worry and fear about everyday situations), and thrombocytopenia (an abnormally low level of platelets).<br><br>Record review of a facility census report for Resident #9 indicated that she had been admitted to Medicare A skilled services on 1/17/24 and discharged from Medicare A skilled services on 3/17/24. The facility failed to issue a NOMNC or a SNF ABN.<br><br>Record review of a facility face sheet dated 7/16/24 for Resident #22 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] and his last qualifying hospital stay was from 12/29/23 through 1/12/24. His diagnoses included: intestinal adhesions (bands), unspecified as to partial versus complete obstruction (a disease of the intestines and digestive system that can lead to obstructions); hypertension (high blood pressure); and type 2 diabetes (uncontrolled blood sugar).<br><br>Record review of a facility census report for Resident #22 indicated that he was admitted to Medicare A skilled services on 1/12/24 and discharged from Medicare A skilled services on 3/14/24. The facility issued a NOMNC on 3/11/24 indicating that Medicare would not cover services after 3/13/24 but failed to issue a SNF ABN.<br><br>(continued on next page) |

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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of a facility face sheet dated 7/16/24 for Resident #139 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] after a qualifying hospital stay of 10/4/23 to 10/30/23. His diagnoses included: Acute respiratory failure with hypoxia (a condition where the lungs cannot provide enough oxygen to the blood); bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs (mania or hypomania) and lows); and dysphagia (difficulty in swallowing).<br><br>Record review of a facility census report for Resident #139 indicated that he was admitted to Medicare A skilled services on 10/30/23 and discharged from Medicare A skilled services on 2/10/24. The facility failed to issue a NOMNC or a SNF ABN.<br><br>Record review of SNF Beneficiary Notice indicated Residents #9, Resident #22, and Resident #139 remained in the facility at the end of Medicare part A stay and did not receive the SNF ABN notification form.<br><br>During an interview on 7/16/24 at 11:00 am DORC said she did not have the forms required because the facility did not complete them.<br><br>During an interview on 7/17/24 at 9:33 am the Administrator said that Residents #3, #22, and #139 had been on Medicare A and the facility did not have an MDS nurse at the time. He said since they did not use all their 100 days, they should have received the notices. He said it was a lack of education and communication, and he would ensure better education and communication going forward. He said he had hired a new MDS nurse and BOM and they would both be expected to do things correctly going forward. He said residents may not be aware of any benefits remaining if they were not given the appropriate notices.<br><br>Record review of Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123 provided by the facility read .The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily .<br><br>Record review of Form Instructions Advance Beneficiary Notice of Non-Coverage (ABN) OMB Approval Number: 0938-0566 provided by the facility read .The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice .<br><br>Record review of a facility policy titled Medicare and Medicaid Benefits dated 2001 and revised in April of 2021 read .When changes are made to items and services covered by Medicare or Medicaid plans, residents are informed of these changes as soon as possible . |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46436<br><br>Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical, nursing, mental and psychosocial needs for 1 of 7 residents (Resident #6) reviewed for care plans.<br><br>The facility failed to develop a comprehensive care plan that included Resident #6's nutritional status and requirement of a feeding tube.<br><br>This failure could place residents at risk of not having individual needs met and cause residents not to receive needed services.<br><br>Findings:<br><br>Record review of a facility face sheet dated 7/16/24 indicated Resident # 6 was an [AGE] year-old female that admitted on [DATE] with diagnosis cerebrovascular disease (reduction of blood flow in the brain).<br><br>Record review of a quarterly MDS assessment dated [DATE] indicated Resident #6 had a BIMS of 14 indicating intact cognition and required a feeding tube.<br><br>Record review of a physicians consolidated order dated 6/28/24 indicated Resident #6 required Jevity C 1.5 at 65 ml (milliliters) per hour times 12 hours per feeding tube and Jevity 1.5 237 ml bolus feeding daily at noon.<br><br>Record review of a comprehensive care plan dated 7/02/2024 did not reflect Resident #6's nutritional status and requirement of feeding tube for nutrition.<br><br>During an interview on 07/16/24 at 9:34 am the MDS nurse said she started at the facility February 2023 and was new to MDS and care plans. She said she had been trained by the corporate MDS nurse on hire and was still learning. She said that she was responsible for completing the MDS and care plans and Resident #6's care plan should have reflected her nutritional status and requiring a feeding tube. She said she captured the feeding tube on the MDS and was not aware that it did not generate to the care plan. She said by not having the feeding tube care plan it could affect resident care.<br><br>During an interview on 7/17/24 at 9:00 am the DON said she and the MDS was responsible for developing and implementing care plans. She said care plans were developed on admission, quarterly and with any changes that occurred. She said Resident #6 should have had a nutrition care plan to include her tube feeding and expected all care needs to be in the care plan. She said if care plans were not in place, it could affect resident care.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 7/17/24 at 9:30 am the Administrator said he has worked at the facility since November 2023. He said the MDS nurse and DON were responsible for the care plans. He said they had been working on getting all the care plans updated and expected all care plans to be accurate and reflect all the care each resident needed. He said if care plans were not developed and implemented for resident problems it could affect resident care.<br><br>Record review of a facility policy titled Comprehensive Care Plans dated 01/26/24 indicated, .It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the resident's comprehensive assessment . |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46436<br><br>Based on observation, interview, and record review, the facility failed to ensure the residents' environment remains as free of accident hazards as possible for 1 of 7 residents (Resident #3) reviewed for accidents hazards and supervision, in that:<br><br>CNA E and CNA F failed to properly transfer Resident #3 on 7/15/24.<br><br>This deficient practice could result in a loss of quality of life due to injuries.<br><br>Findings:<br><br>Record review of a facility face sheet dated 9/16/2020 indicated Resident #3 was a [AGE] year-old female that admitted on [DATE] with diagnosis of Alzheimer's.<br><br>Record review of a quarterly MDS assessment dated [DATE] indicated Resident # 3 had a BIMS of 11 indicating moderately impaired cognition and required total dependence of two persons for transfers.<br><br>Record review of a facility comprehensive care plan dated 5/07/24 indicated Resident # 3 required a mechanical lift to transfer times two persons.<br><br>During an observation on 07/15/24 at 10:15 AM CNA E and CNA F were observed transferring Resident #3. Both CNAs positioned Resident #3 on the side of the bed and placed the shower chair in a locked position next to the bed. CNA E and CNA F placed their arms under Resident #3's arms, lifted Resident #3 into a standing position and sat Resident #3 in the shower chair.<br><br>During an interview on 7/15/24 at 10:20 am CNA F said she had worked at the facility for 1 year and residents should be transferred either with a gait belt or lift. She said she was assisting CNA E and should have stopped and gotten a gait belt before proceeding because manually lifting a resident could cause injury to the resident.<br><br>During an interview on 7/15/24 at 10:25 am CNA E said she had worked at the facility for 3 months and had been a CNA [AGE] years. She said she was assigned to care for Resident #3. She said Resident #3 was a two person lift and she should have used a gait belt or to transfer her. She said she forgot her gait belt and did not stop and go back for it. She said that each residents transfer ability was on their care plan in the computer but could not recall what Resident #3's care plan said about transfers. She said by manually transferring or transferring by the wrong method she could cause an injury to the resident. She said she had been trained on transfers and safety and was nervous.<br><br>During an interview on 7/15/24 at 10:30 am LVN D said that each resident was care planned for their transfer status and the nurses and CNAs communicate with each other on resident care. She said that Resident #3 was care planned for a lift but did sometimes use a gait belt times two persons if she refused to use the . She said the CNA's will report transfer changes and therapy would evaluate them if needed. She said residents should not be transferred by lifting and pulling on them because of risk for injury.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 07/17/24 at 8:57 am the DON said she was responsible for oversight of all nursing staff to ensure proper transfer technique was used for each resident. She said she completed training with all staff on transfer and safety and the CNAs should have known the proper transfer technique. She said she expected each resident to be transferred safely and follow the care plan to prevent injuries to the residents.<br><br>During an interview on 7/17/24 at 9:28 am the Administrator said that nursing management was responsible for oversight and training of the CNAs on transfers and expected all residents to be transferred safely to prevent injuries.<br><br>Record review of a clinical skills checklist dated 4/03/2024 indicated CNA E had satisfactorily demonstrated competency for lifting and transferring, use of Hoyer lift and gait belt.<br><br>Record review of a clinical skills checklist dated 10/31/2023 indicated CNA F had satisfactorily demonstrated competency for lifting and transferring, use of Hoyer lift and gait belt.<br><br>Record review of a facility policy titled Safe Lifting and Movement of Residents dated 3/31/23 indicated, .in order to protect the safety and well-being of all staff and residents, and to promote quality of care, this facility uses techniques and devices to lift and move residents. 2. manual lifting of residents shall be eliminated when feasible, 4. staff responsible for direct care will be trained in the use of manual (gait belt) and mechanical lifting devices . |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40124<br><br>Based on observation, interview, and record review, the facility failed to ensure that all drugs and biologicals were properly stored and inaccessible to unauthorized staff and residents for one resident (Resident #16) of six residents reviewed for medication storage.<br><br>The facility failed to ensure topical medications and skin cleanser were stored in a manner to prevent possible diversion or contamination.<br><br>This failure could place residents at risk for drug diversion and access to medications that could cause harm, sickness, or hospitalization .<br><br>Findings included:<br><br>Review of Resident #16's face sheet dated 07/14/2024 reflected an eighty-three-year-old female admitted on [DATE] with diagnoses that included: Senile Degeneration of Brain (gradual loss of thinking ability), Diaper dermatitis (skin rash to the diaper area) Pressure-induced deep tissue damage of right ankle, (open skin break on the right foot), and Pressure ulcer of left ankle, stage 3 (open skin break of the left ankle).<br><br>During an observation and interview on 07/15/2024 at 07:00 AM Resident #16 is lying in bed in her room, wound cleanser was on the bedside table, Zinc Oxide tube and 3 small packets of Zinc Oxide were on the bedside table, skin barrier cream and antifungal skin powder on bedside table. All containers are labeled keep out of reach from Children. Resident #16 said the staff use the products on her and they must have left them there after providing her wound care and care to her peri-area.<br><br>During an observation on 07/15/20/24 at 01:26 PM revealed Resident #16, sleeping in her room. Wound cleanser at bedside table. Zinc Oxide tube and 3 small packets of Zinc Oxide are on the bedside table, skin barrier cream and antifungal skin powder on bedside table.<br><br>During a record review of a physician order summary dated 7/15/2024, Resident # 16 had orders with an origin date of 06/24/2024 for Calmoseptine (menthol-zinc oxide) ointment; 0.44-20.6 %; amount- dime size; topical three times a day and apply Zinc Oxide to buttocks & coccyx every shift, origin date 03/01/24 twice a day.<br><br>During an interview on 07/15/2024 at 01:30 PM LVN C, said that medications should not be keep in residents' room, including medications for wound care. He said that he will remove the barrier cream, antifungal powder and zinc oxide ointment and place them in a bag for storage in the wound care cart. LVN C said that the items could harm residents if they used them incorrectly or ingested topicals labeled keep away from children. He said the topical medications could be contaminated if the resident or family opened them with unclean hands.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an Interview on 07/15/2024 01:45 PM the DON she said the residents are not allowed to keep medications at bedside, unless they have a doctor's order and arrangements for safe storage are developed for that specific resident. The DON said it was unsafe to have any medications or substances labeled to keep out of reach from children at bedside and topicals could become contaminated if not handled correctly by the resident or family.<br><br>During an interview on 07/16/2024 03:30 PM the Administrator said the DON is responsible for oversight of medication storage and will start an Inservice for all staff safe storage of medications. The Administrator said leaving topical medications or cleanser at bedside pose a risk to residents for possible ingestion and contamination.<br><br>Record review of a facility policy titled Storage of Medications Policy . The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation<br><br>1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications .<br><br>The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.<br><br>2. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing dressings and biologicals are locked when not in use. Unlocked medication carts are not left unattended.<br><br>Record Review of a facility policy dated 06/01/2022 titled Administrative Procedures for all Medications To administer medications in a safe and effective manner.<br><br>A. Security: All medication storage areas (carts, medication rooms, central supply) are locked at all times unless in use and under the direct observation of the medication nurse/aide. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46436<br><br>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 1 of 1 kitchen reviewed for dietary services.<br><br>1. The Dietary Aide failed to properly wear hair net while in the kitchen on [DATE].<br><br>2. Dietary Staff failed to check and log the dishwasher temperature and sanitation for month of [DATE].<br><br>3. Dietary Staff failed to properly label and dispose of leftovers from the refrigerator.<br><br>4. Facility staff failed to clean Resident #7's water pitcher.<br><br>These failures could place residents at risk for food contamination and foodborne illness.<br><br>Findings:<br><br>During an observation on [DATE] at 6:45 am the dietary aide had hair out of his hair net on his neck and had facial hair with no beard guard net.<br><br>During an observation on [DATE] at 6:50 am there was a dishwasher temperature and sanitation log located on the side of the refrigerator. The log had no temperatures or sanitation levels listed. The log was not dated with the month and only included staff initials.<br><br>During an observation on [DATE] at 7:00 am the refrigerator located in the kitchen had two containers of ready care thickened water dated [DATE] and 1 container of ready care thickened orange juice dated [DATE]. Directions on the ready care container read to use within 7 days of opening. There were leftovers in plastic containers with labels that read: smothered chicken dated [DATE], chicken patties dated [DATE], spiced apples dated use by [DATE], chicken dated [DATE], meatballs dated use by [DATE], rice dated use by [DATE], meatloaf dated use by [DATE], red beans and sausage dated use by [DATE], beef stew use by [DATE], and white gravy dated [DATE].<br><br>During an interview on [DATE] at 6:57 am the dietary aide said he had been at the facility for 5 weeks. He said he initialed the dishwasher log but was not sure about the temperature and sanitizer sections. He said the log posted was for [DATE] and he checked the temperatures and sanitation every day, but he was not sure what temperature the dishwasher needed to be. He said the previous dietary manager may or may not have told him and would make sure the water was steaming when he washed the dishes . He said he thought his hair was short enough on his beard and applied a beard guard and tucked his hair in the back under the hair net. He said that not washing dishes at the proper temperature could cause illness and not having his hair covered was unsanitary.<br><br>(continued on next page) |

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|---|---|---|---|
| | 675907 | A. Building<br>B. Wing | 07/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Diboll Nursing and Rehab | 900 S Temple Dr<br>Diboll, TX 75941 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on [DATE] at 7:10 am [NAME] G said she had been at the facility 1 year. She said all leftovers were to be labeled with name, date and use by date and should be discarded after 3 days. She said the ready care thickened beverages were to be dated when opened and discarded after 7 days. She said the cooks were responsible for checking and removing items from the refrigerator at least every other day. She said if residents were to consume expired foods it could make them sick.<br><br>Record review of a facility face sheet dated [DATE] indicated Resident #7 was an [AGE] year-old female that admitted on [DATE] with diagnosis of Alzheimer's.<br><br>Record review of a quarterly MDS assessment dated [DATE] indicated Resident #7had a BIMS of 04 indicating severely impaired cognition was dependent with all activities of daily living.<br><br>During an observation on [DATE] at 10:05 am Resident #7 had a water pitcher at her bedside with thickened water and on inspection the water had a slimy green substance floating in the water.<br><br>During an interview on [DATE] at 10:20 am CNA F said she had worked at the facility 1 year. She said she passed water to her residents every morning and afternoon. She said Resident # 7 was on thickened liquids and received her hydration in a cup from the kitchen . She said she was not aware there was a water pitcher in her room and would remove it. She said that water pitchers were to be changed out every night on the night shift and washed by the kitchen staff. She said if water pitchers were not cleaned it could cause residents to get sick.<br><br>During an interview on [DATE] at 9:30 am [NAME] G said that the aides were to collect the water pitchers and bring them to the kitchen to wash. She said she was not sure if there was a schedule and could not recall the last time water pitchers were washed. She said that water pitchers that were not cleaned regularly could cause a resident to get sick.<br><br>During an interview on [DATE] at 10:32 am the DON said that Resident #7 was on thickened liquids and the CNAs provide the already thickened liquids in individual cups and was not sure how she got a water pitcher at her bedside. She said the water pitchers should be changed nightly on the evening shift but there was no process in place to ensure the pitchers were being cleaned. She said dirty water pitchers could cause sickness and she expected all water pitchers to be cleaned and changed daily.<br><br>During an interview on [DATE] at 9:10 am the Administrator said he was responsible for oversight of the kitchen and made rounds in the kitchen with staff for training weekly. He said he was between dietary managers and in the process of finding a new manager. He said that the staff were responsible for their daily duties and the dietary aides were to fill out the dishwasher log daily and ensure the temperature and sanitation was appropriate to prevent illness. He said leftovers should be discarded after 3 days because old food could make someone sick if it was served. He said water pitchers should be changed daily but there had not been a monitoring system in place. He said dirty water pitchers could cause illness. He said he expected the kitchen to be always maintained in a sanitary kitchen and water pitchers are cleaned and changed daily.<br><br>Record review of a facility policy titled Mechanical Cleaning and Sanitizing of Utensils and Portable Equipment dated 2018 indicated, . the facility will follow the cleaning and sanitizing requirements of the state. 7. If a machine that uses chemicals for sanitizing is in use, follow these guidelines: a. the temperature of the wash water must be at least 120F.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Record review of a facility policy titled Food Storage dated 2018 indicated, .to ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal, and US food codes and guidelines. 2. Refrigerators e. use all leftovers within 72 hours. Discard items that are over 72 hours old . |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40124<br><br>46436<br><br>Based on observations, interviews, and record reviews the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 12 residents (Resident #6 and Resident #27) reviewed for infection control.<br><br>The facility failed to ensure the COTA (certified occupational therapy assistant) followed enhanced barrier precautions when she provided care to Resident #6 on 07/15/2024.<br><br>The facility failed to ensure LVN (licensed vocational nurse) followed infection control precautions when she administered medications to Resident #27 on 07/26/2024.<br><br>These failures could place residents at risk for cross contamination and infection.<br><br>Findings:<br><br>1.Record review of a facility face sheet dated 07/16/2024 indicated Resident # 6 was an [AGE] year-old female that admitted on [DATE] with diagnosis cerebrovascular disease (reduction of blood flow to the brain).<br><br>Record review of a quarterly MDS assessment dated [DATE] indicated Resident #6 had a BIMS of 14 indicating intact cognition and had a feeding tube.<br><br>Record review of a physician order dated 04/29/2024 indicated Resident #6 required EBP (enhanced barrier precautions).<br><br>Record review of a comprehensive care plan dated 06/21/2024 did not reflect Resident #6's requirement of feeding tube nor EBP.<br><br>During an observation on 07/15/2024 at 10:26 am the COTA was present in Resident # 6's room providing care. Resident #6 requires Enhanced Barrier Precautions (EBP)and the COTA did not have on PPE with providing therapy.<br><br>During an interview on 07/15/2024 10:27 am the COTA said she thought PPE was only required for high-risk task or if care was being provided directly to whatever it was that the resident required the precautions for. She said the DON and ADON had trained her on the new EBP, and she must have misunderstood the requirement. She said by not properly wearing PPE could cause a spread in infections.<br><br>During an interview on 07/15/2024 at 10:29 am the DON said she did not realize that providing therapy required PPE when a resident was in EBP and must have misread the new regulations. She said Resident #6 required EBP due to feeding tube. She said she and the ADON had provided the training to staff and would retrain on the correct use of PPE for EBP. She said she expected staff to follow the EBP to prevent the spread of infections.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Record review of a facility face sheet dated7/16/2024 indicated Resident #27 was a [AGE] year-old female admitted on [DATE] with a diagnosis of end stage renal disease (kidneys no longer filter toxins from the blood), age related decline, and dependence on renal dialysis (the artificial removal of toxins from the blood by machine and filter).<br><br>Record review of a MDS (OSA) optional state assessment dated [DATE] indicated Resident #27 had a BIMS of 14 indicating intact cognition and had a dialysis port.<br><br>Record review of consolidated orders dated 07/16/2024 indicated Resident #27 had no order for EBP (enhanced barrier precautions).<br><br>Record review of a comprehensive care plan revised 07/03/2024 indicated interventions for care of a dialysis port.<br><br>During an observation and interview on 07/16/2024 07:40 AM of medication administration LVN A prepared Resident #27's medications. Signage was posted on doorway of Resident #27 room with indications that Resident #27 required EBP. LVN A said that resident required donning (to apply) with gown and gloves because she had a dialysis port which made her at risk for infection that could be spread to other residents. LVN A sanitized hands with alcohol-based wipes to the palms of her hands only and donned gown and gloves. LVN A administered medications per mouth to Resident #27 and returned to the medication cart with her gown, gloves on and proceeded to touch her pen, medication cart surface and papers on the medication cart. LVN A said she had worked at the facility for approximately 1 and a half years and had received training on the EBP requirements, infection control practices and hand hygiene but she was confused about exactly what she needed to do. LVN A said she should have removed her gown and gloves before exiting the room. She said she should have sanitized her hands before returning to the medication cart. She said by not removing her PPE and sanitizing she could spread infection.<br><br>During an interview on 07/16/2024 at 08:20 AM with the DON and the Regional Nurse Consultant, the DON said she would provide education to the staff on EBP, infection control and hand hygiene. The DON said that not removing PPE after contact with Resident #27 and sanitizing hands before returning to the medication cart the nurse could spread infection. The Regional Nurse Consultant said that LVN A had broken basic infection control process by not doffing (to remove) her PPE and sanitizing before she exited the room.<br><br>During an interview 07/16/2024 at 09:00 AM The ADON said LVN A had been trained on correct procedures for infection control. The ADON said not removing PPE and sanitizing before leaving the room and touching items on the medication cart could spread infection.<br><br>During an interview on 07/17/2024 09:00 AM the Administrator said the DON and ADON/IP are responsible ensuring basic infection control, handwashing, sanitizing and EBP for infection control are followed. The Administrator said that not following guidelines for infection control could spread infection.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of a facility policy titled Enhanced Barrier Precautions dated 04/01/2024 indicated, .enhanced barrier precautions should be followed when working with residents in therapy and while assisting with transfers and mobility d. Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room .<br><br>Record review of a facility policy titled Administration Procedures for All Medications dated 06/01/2022 indicated, .cleanse hands using microbial soap and water or facility- approved hand sanitizer before beginning a med pass, before handling medication, and before contact with resident. |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep all essential equipment working safely.<br><br>46436<br><br>Based on observation, interview and record review the facility failed to maintain all essential equipment in safe operating condition, for 1 of 1 stove in the kitchen reviewed for essential equipment.<br><br>The facility did not ensure the gas stove was in working order. One of six gas stove burners (back right) had excessive carbon buildup and the burner did not fully light on 7/16/2024.<br><br>This failure could place residents who eat out of the kitchen at risk for injury and under cooked food.<br><br>Findings:<br><br>During an observation on 7/16/24 at 10:53 am, 1 of 6 burners on the stove located in the kitchen did not light completely. The burner had carbon build up to the right side of the burner.<br><br>During an interview on 7/16/24 at 10:54 am [NAME] H said she was the cook for the day, and it was her first day back from a month break. She said she was not sure who was responsible for burners on the stove, but the cooks cleaned the covers and grill daily. She said that the burner not lighting correctly could cause an injury,<br><br>During an interview on 7/16/24 at 11:15 am the maintenance director said he was not sure who was responsible for the stove burners and could not recall anyone coming to clean them. He said he was not sure what could happen if the burners did not light correctly.<br><br>During an interview on 7/16/24 at 12:10 pm the administrator said he was not sure who was to clean the burners on the stove. He said the cooks clean daily after meals but the actual removal of carbon buildup he was not sure who was responsible but would get someone to the facility to clean them. He was not sure what could happen if the burners did not work correctly and would advise staff to not use that burner until it was cleaned.<br><br>Record review of a facility a facility policy titled Range and Grill dated 2018 indicated, .the facility will maintain the range and grill in a clean manner to minimize the risk of food hazards . |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>40124<br><br>Based on observations, interviews, and record reviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 2 of 4 hallways (north hallway and south hallway) reviewed for environment, in that.<br><br>1. The nursing supply storage room on the south hallway was open and accessible to visitor or resident tampering/contamination of sterile products and supplies kept in the nursing supply storage room.<br><br>2. The shower room on the north hallway (100 hallway) was open and accessible to residents and staff staff allowing access to toxic cleaners.<br><br>These failures could place residents at risk for unsafe environment resulting in injury or unsafe conditions due access to toxic cleaners and visitor or resident tampering/contamination of sterile products and supplies kept in the shower room and nursing supply room.<br><br>Findings included:<br><br>1. During an observation on 07/15/2024 at 06:55 AM Nursing supply storage room on the end of the south hallway was observed to be open. Upon entrance to the nursing supply storage room there are sterile supplies in the room, sterile foley catheters, lancets for skin punctures, gastric tube feeding supplies, wound cleanser, sterile dressing supplies no staff in area. Resident walking down the hallway nearby.<br><br>2. During an observation on 7/15/24 at 7:30 AM Shower room door on end of north hallway (100 hallway) was observed to be open. Upon entrance to shower room, observation revealed a supply closet in shower room was also open. There was a bottle of spray disinfectant inside supply closet.<br><br>During an interview on 07/15/2024 at 07:30 AM LVN C said he had just gotten to the facility when the surveyors arrived. He was not aware the nursing supply closet was propped open, but he would go shut it. He said the door had a lock and it should be always locked to prevent resident or visitors from accessing to room. LVN C said nursing staff had a key to the door, but the night shift probably left it open for convenience.<br><br>During an observation and interview 07/15/2024 at 07:43 AM, the door to the nursing supply room remained propped open. LVN B said the door should be closed and locked. LVN B said residents and visitors would have assess and could possibly tamper with supplies if the door is left open. She said that if the resident or visitors tampered with supplies include wound supplies and cleansers, sterile foley catheters, lancets glucometer supplies, and supplements they could become contaminated.<br><br>(continued on next page) |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 07/15/2024 at 11:30 AM the DON said she was aware that the supply room was sometimes being left open. The door had a lock, and the nurses have the key. She said she has in-serviced the staff and ordered a punch key lock for the door. The DON said when the lock arrives the maintenance man will install it. The DON said there was a risk of theft or contamination to the supplies if a visitor or resident accessed the supply room and tampered with them.<br><br>During an interview on 07/17/24 09:00 AM the Administrator said a punch lock had been installed on the door to the nursing supply to facilitate easy access for the staff and protect the supplies from contamination or theft.<br><br>Record review of a facility policy titled Storage of Medications Policy .<br><br>The facility stores all drugs and biologicals in a safe, secure, and orderly manner.<br><br>Policy Interpretation and Implementation<br><br>1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications .<br><br>6. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing dressings and biologicals are locked when not in use. Unlocked medication carts are not left unattended.<br><br>Record review of a facility policy revision date February 2021 titled Homelike Environment . Policy Statement:<br><br>Residents are provided with a safe, clean, comfortable, and home environment and encouraged to use their personal belongings to the extent possible.<br><br>Policy Interpretation and Implementation: Staff provides person-centered care that emphasizes the residents comfort, independence and personal needs and preferences.<br><br>2. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting.<br><br>These characteristics include:<br><br>a. clean, sanitary, and orderly environment .<br><br>46273 |