STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675908	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avante Rehabilitation Center	225 N Sowers Rd Irving, TX 75061

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35489 Based on observation, interview and record review, the facility failed to ensure each resident received an accurate assessment, reflective of the resident's status for one (Resident #73) 24 residents reviewed for accuracy of assessments. The facility failed to ensure Resident #73's Significant Change MDS Assessment, dated 06/18/24, did not inaccurately reflect Resident #73 having had a tracheostomy (a surgical opening in the windpipe to allow air into the lungs). This failure could place residents at risk for not receiving care and services to meet their needs, diminished function of health, and regressions in their overall health. Findings included: Review of Resident #73's Admission Record, dated 07/31/24, reflected he was a [AGE] year-old male, admitted on [DATE], with diagnoses of lung cancer, heart disease, asthma, and chronic kidney disease. He was noted to be his own Responsible Party. Review of Resident #73's Significant Change MDS, dated [DATE], reflected he had moderate difficulty hearing, but was able to understand others, and be understood by others. He had a BIMS score of 10, indicating possible moderate cognitive impairment. The document reflected no indication of mood or behavior problems. Resident #73 used a wheelchair, and required substantial staff assistance for most of his ADL's. In the document, the resident was noted to have tracheostomy care while a resident of the facility. The document was electronically signed by Former MDS, and RN K. An interview on 07/30/24 at 12:21 PM with Resident #73 indicated he looked puzzled when asked if he had a tracheostomy. He said he did not have one now, and he did not think he ever did. He showed the surveyor his neck, and there was no tracheostomy, scarring, or bandage. Review of Resident #73's order summary, dated 08/01/24, reflected no order for tracheostomy or the care of one. Review of Resident #73's care plans reflected no care plans for tracheostomy, or the care of one. An interview on 07/30/24 at 12:32 PM with RN J revealed she had never known Resident #73 to have a tracheostomy. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 07/31/24 at 3:01 PM with the Administrator revealed she did not think Resident #73 had ever had a tracheostomy. She explained that Former MDS was not available for interview on the date of this interview. She did not know why the MDS had trach care documented for the resident. She said they had a new MDS Coordinator starting on 08/05/24. An interview on 07/31/24 at 3:19 PM with MDS revealed Resident #73 never had a tracheostomy. She was not the person who did his MDS, and did not know why the mistake occurred, but she felt it was probably just human error, and most likely was a matter of someone meaning to click on the thing above or below it. She said they might have caught it if they ran an 802 (a table of residents with checkmarks in their areas of needed care) but they did not run them very often. She did not think the error would cause any problems for the resident, and she said she would correct it that evening. Review of the facility policy Resident Assessment and Care Planning - Minimum Data Set (MDS) Resident Assessments revised November 2019, reflected: Policy Statement: A comprehensive assessment of every resident's needs is made at intervals designated by OBRA and PPS requirements.; Policy Interpretation and Implementation: 1. The Resident Assessment Coordinator is responsible for ensuring that the Interdisciplinary Team conducts timely and appropriate resident assessments and reviews [.] 11. All persons who have completed any portion of the MDS Resident Assessment Form must sign the document attesting to the accuracy of such information. Review of the facility policy Resident Assessment and Care Planning - Minimum Data Set (MDS)- Certifying Accuracy of the Resident Assessment, revised November 2019, reflected Policy Statement: Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment.; Policy Interpretation and Implementation; [.] 2. Any person who completes any portion of the MDS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of that assessment. 3. The information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment. Different items on the MDS may have different observation periods. 4. The Resident Assessment Coordinator is responsible for ensuring that an MDS assessment has been completed for each resident. Each assessment is coordinated and certified as complete by the Resident Assessment Coordinator, who is a registered nurse.

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F 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a qualified health professional conducts resident assessments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35489 Based on interview and record review the facility failed to submit discharge MDS assessments for five of fifteen residents (Residents #2, #37, #45, #80, and #82) reviewed for discharge MDS submission. The MDS Coordinator failed to successfully submit discharge MDS assessments Residents #2, #37, #45, #80, and #82 when they discharged from the facility. This failure could place residents at risk of communication about a resident's status from not being transmitted to CMS and could interfere with residents receiving needed services after discharge. Findings include: 1. Review of Resident #2's Admission Record, dated 08/01/24, reflected she was admitted on [DATE]. She was 78-years-old, and had a primary admitting diagnosis of myasthenia gravis with (acute) exacerbation (a chronic autoimmune disorder in which antibodies destroy the communication between nerves and muscle). Review of Resident #2's discharge progress note, dated 04/17/24, reflected she was discharged home. Review of Resident #2's census information in the EMR on 08/01/24 reflected her discharge on 04/17/24. Review on 08/01/24 of a list of MDS submissions in the EMR for Resident #2 reflected her admission MDS for 02/20/24 submission was accepted, but no discharge MDS was listed. 2. Review of Resident #37's Admission Record, dated 08/01/24, reflected she was admitted on [DATE]. She was an [AGE] year-old woman with a primary admitting diagnosis of cerebral infarction (stroke). Review of Resident #37's discharge progress note, dated 03/23/24, reflected she was discharged on that day at 1:00 PM. Review of Resident #37's census information in the EMR on 08/01/24 reflected her discharge on 03/23/24. Review on 08/01/24 of a list of MDS submissions in the EMR for Resident #37 reflected her admission MDS for 02/27/24 submission was accepted, but no discharge MDS was listed. 3. Review of Resident #45's Admission Record, dated 08/01/24, reflected he was admitted on [DATE]. He was a [AGE] year old male, with a primary admitting diagnosis of type 2 diabetes mellitus with ketoacidosis (a complication of diabetes in which the body breaks fat down too quickly, which can be potentially life-threatening) without coma. (continued on next page)

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F 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #45's discharge progress note, dated 03/24/24, reflected his discharge, with a family member present. Review of Resident #45's census information in the EMR on 08/01/24 reflected his discharge on 03/24/24. Review on 08/01/24 of a list of MDS submissions in the EMR for Resident #45 reflected his admission MDS for 02/15/24 submission was accepted, but no discharge MDS was listed. 4. Review of Resident #80's Admission Record, dated 08/01/24, reflected she was admitted on [DATE]. She was an [AGE] year-old female, with a primary admitting diagnosis of fracture of unspecified part of neck of right femur, sequelae (broken hip.) Review of Resident #80's progress note, dated 03/26/24, reflected confirmation with the resident's family member that she planned to pick up Resident #80 on 03/27/24, at 1:00 PM. Review of Resident #80's census information in the EMR on 08/01/24 reflected his discharge on 03/27/24. Review on 08/01/24 of a list of MDS submissions in the EMR for Resident #80 reflected her admission MDS for 03/05/24 submission was accepted, but no discharge MDS was listed. 5. Review of Resident #82's Admission Record, dated 08/01/24, reflected he was admitted on [DATE]. He was a [AGE] year-old male, with a primary admitting diagnosis of other acute osteomyelitis (bone infection), left ankle and foot. Review of Resident #82's discharge progress note, dated, reflected his discharge on 03/21/24. Review of Resident #82's census information in the EMR on 08/01/24 reflected his discharge on 03/21/24. Review on 08/01/24 of a list of MDS submissions in the EMR for Resident #82 reflected his admission MDS for 03/09/24 submission was accepted, but no discharge MDS was listed. An interview on 07/31/24 at 3:01 PM with the Administrator revealed their Former MDS, who did the skilled MDS from March 2024 to 07/05/24, was not available for interview; but MDS was currently doing the skilled ones remotely, until their new MDS Coordinator started on 08/05/24. An interview on 08/01/24 at 1:57 PM with MDS revealed that if there had been a discharge MDS done, it would show up in the EMR. She would not have been the person who did the MDS at the time the missing discharge MDS were done, so she was not sure why they were not done. She said she thought Former MDS, who was doing them at that time was behind on them, and had completed a lot before she left, because she noticed about 40 completed ones in the portal, but she may have missed some. She said if they were done, she did not know of any potential consequences for the resident, but it could have an impact on staffing. (continued on next page)

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F 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 08/01/24 at 3:59 PM with the Administrator revealed she did not know why the MDS' were not all completed, but she would be working with their new MDS coordinator to make sure they were all done. She said it would be part of the QAPI process. She was not aware of any direct repercussions to the resident, but thought it could potentially affect staffing levels. Review of the facility policy Resident Assessment and Care Planning - Minimum Data Set (MDS): Resident Assessments, revised December 2019, reflected Policy Statement: A comprehensive assessment of every resident's needs is made at intervals designated by OBRA and PPS requirements.; Policy Interpretation and Implementation: 1. The Resident Assessment Coordinator is responsible for ensuring that the Interdisciplinary Team conducts timely and appropriate resident assessments and reviews according to the following requirements: [.] (5) Discharge Assessment-Conducted when a resident is discharged from the facility.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 8.57 % based on 3 errors out of 35 opportunities, which involved 3 of 9 residents (Resident #9, Resident #35, and Resident #46) reviewed for medication errors. The facility failed to ensure MA C and ADON B administered Resident #9's external pain reliving patch to her right lateral (directional term describing outer side of the body part) hip as ordered by the physician. The facility failed to ensure MA C administered Resident #35's antibiotic eye ointment only in the left eye as ordered by the physician. The facility failed to ensure Resident #46 received his daily Vitamin D tablet as prescribed on 07/31/24. These failures could place residents at risk of not receiving the desired therapeutic effect of their medications, negative side effect and a decline in health. Findings Included: 1. Resident #9 Review of Resident #9's face sheet, dated 08/01/24, reflected a [AGE] year-old female that admitted the facility on 07/01/19. Her diagnoses included lumbar region disc degeneration (back pain caused by loss of cushioning between the discs of the spine), age related osteoporosis (a condition in which bones become weak and brittle) blood clots in vein, unspecified cellulitis (a skin infection that causes inflammation, redness, and burning of skin), lower back pain, generalized osteoarthritis (a joints condition when the flexible tissue wears down at the ends of bones causing pain), uncontrolled blood sugar, high blood pressure, cardiomyopathy without heart failure (a condition of the heart that makes it hard for the heart to deliver blood to the body and can lead to heart failure). Review of Resident #9's admission MDS assessment, dated 07/17/24, reflected a BIMS sore of eight out of fifteen indicating moderate cognitive impairment. Review of Resident #9's care plan on 08/01/24, revealed Resident #9 had age related osteoporosis. The goal was to remain free of injuries and at a level of discomfort acceptable to Resident #9 through review date. Interventions included encouraging physical activity, giving analgesics (pain medication) as needed for pain, giving medications as ordered, monitoring, documenting of side effects and effectiveness. The care plan further revealed focus of acute (immediate) pain, chronic arthritis pain, and degenerative disc disease. The goal was that resident would report satisfactory pain control. Interventions were to administer pain medications per order. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #9s orders , dated 07/30/24, reflected Salonpas [topical analgesics] pain relieving external patch with 4 % lidocaine. The directions were to apply to the resident's right lateral hip topically one time a day for arthritis pain and remove per schedule. Start date 11/18/23. Review of Resident #9's July 2024 MAR reflected Salonpas pain reliving external patch with 4 % Lidocaine was applied topically to right hip from 07/01/24 to 07/19/24. No application on 07/20/24 and 07/21/24. Resumed medication application on 07/22/24 to both knees from 07/22/24 to 07/30/24 at 12:58 PM. Observation of Resident #9 on 07/30/24 at 01:52 PM, revealed Resident #9 was in bed, she appeared sleeping. Resident #9's knees were exposed revealing a medication patch on each knee dated 07/30/24. In an interview with MA C on 07/30/24 at 02:02 PM, she stated that she was in training and the nurse training her told her to ask Resident #9 where she wanted the pain patches placed on her body. MA C stated that Resident #9 indicated that she wanted the pain patches on both knees below the knee cap. MA C did not state the risk to Resident #9's for not following prescribed medication order. MA C stated that she placed the medication patches on both knees as it indicated on the MAR but not according to the physician's orders. In an interview with ADON B on 07/30/24 at 02:05 PM, he stated he was helping train MA C. He stated that the MAR showed Resident #9's pain patch was to be applied to her bilateral (both) knees. He stated he would reach out to the physician and change the orders to reflect the patches to be applied topically to both knees. He stated the risk to the resident not getting the medication was uncontrolled illness . 2. Resident #35 Review of Resident #35's face sheet dated 08/01/24, reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included Cerebral infraction (Stroke) Cerebral ischemia (a condition in which there is insufficient blood flow to the brain), high cholesterol, metabolic encephalopathy, atrial fibrillation (an irregular heart rhythm), unspecified dementia (cognitive decline), unsteady on his feet, and Benign prostatic hyperplasia without urinary tract symptoms (is a condition of an enlarged prostate gland that can cause urination difficulty). Resident #35 was his own RP. Review of Resident #35's admission MDS assessment, dated 04/29/24, reflected a BIMS score of two out of fifteen, indicating severe cognitive impairment. Review of Resident #35's orders , dated 05/01/24, reflected Erythromycin Ophthalmic Ointment 5 MG/GM Erythromycin. Instill 1 ribbon of ointment in left eye in the morning for redness to left eye . Review of Resident #34's MAR for July 2024, reflected Erythromycin Ophthalmic Ointment 5 mg/gm, instill 1 ribbon in left eye in the morning for redness to left eye. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Resident #35 on 07/30/24 at 10:54 AM, revealed Resident #35 was with family at bedside. Resident #35 stated that he was having blurred vision in both eyes. He stated that MA C had put the eye medication in both his eyes instead of only in the left eye. He stated he did not question her because he did not know if his order had been changed. Resident #35's family stated that he saw MA C put the eye medication in both of Resident #35's eyes but it did not dawn on him to ask. The family stated Resident #35 had vision problems due to having numerous strokes and he had seen an eye specialist for his vision problems; therefore, the complaint of blurred vision did not alarm him when Resident #35 started to complain about it after eye medication administration. In an interview with MA C on 07/30/24 at 11:32 AM, she stated it was her third day on the job at the facility. She stated she administered the eye medication in both eyes as ordered in the MAR. Upon review of the MAR, MA C stated she would notify the nurse that she had made a mistake by administering the eye medication in both eyes instead of only in the left eye. MA C left to find the nurse and did not state the risk to the resident. In an interview with RN J on 07/03/24 at 03:00 PM, she stated MA C notified her of the medication error for Resident #35. She said she notified the physician and Resident #35's right eye was washed with normal saline to wash the medication out of his eye. She stated that they would monitor the resident for twenty-four hours for any adverse reactions. She stated the risk to resident getting medication in the wrong eye could cause an adverse reaction. In an interview with ADON B on 08/01/24 at 11:14 AM, he stated he assumed responsibility to train MA C on her last day of training and he should have kept closer monitoring on her medication administration. He stated the resident would be monitored for twenty-four hours and the physician was notified. He stated the risk to the resident was possible adverse reaction. He stated he started an in-service on medication administration. 3. Resident #46 Review of Resident #46's face sheet dated 08/01/24, reflected an [AGE] year-old male that was admitted at the facility on 12/12/23. His diagnoses included Chronic obstructive pulmonary disease (a lung disease that blocks airflow and makes it difficult to breathe), cerebral ischemia (a condition in which there is insufficient blood flow to the brain), major depression, anxiety, wedge compression fracture, constipation, muscle wasting, heart diseases, atrial fibrillation (an irregular heart rhythm), and abnormal walking. Review of Resident #46's quarterly MDS assessment, dated 06/14/24, reflected a BIMS score of seven out of fifteen, indicating severe cognitive impairment. Review of Resident #46 orders , dated 12/12/23, reflected Cholecalciferol [Vitamin D] Oral Tablet 75 MCG (3000 UT). Give 1 tablet by mouth in the morning for supplements. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with MA D on 07/31/24 at 09:09 AM, reveled MA D took Resident #46's medications out of the bubble pack and placed them into a medication cup. She then stated she could not find Resident #46's Cholecalciferol Tablet 75mcg. She asked ADON B to check the medication room for the missing medication. MA D stated she would administer the medications she had taken out and come back for the missing Cholecalciferol Tablet. Resident #46 was seated at the edge of the bed. MA D took his BP and gave him his medications minus the Cholecalciferol Tablet. She told Resident #46 that he was missing his Vitamin D and she would be back to administer the missing medication. MA D stated if there was no more of Resident #46's medication, she would notify the person in charge of ordering the medications to get more. She stated she would notify Resident #46's nurse too. Review of Resident #46's MAR for July 2024, for the Cholecalciferol Oral Tablet 75mcg (3000 UT), reflected a number nine in place of medication administration for 07/31/24 by MA D. Interview with MA E on 08/01/24 at 09:10 AM, she stated MA D was not in the facility. She stated that the number nine on the MAR meant other which was an indication that the resident did not receive medication or was missing a dose of the medication. MA E stated MA D should have looked at the order and paid attention to the 3000-unit part of the order instead of the 75mcg part and she would have seen the house stock of the medication in the med cart. MA E stated that Resident #46 would take 3 tablets of the Cholecalciferol to total up to the ordered 3000 UT of the Cholecalciferol. In an interview with ADON B on 08/01/24 at 11:14 AM, he stated all missing doses of medications should be reported by the MA to the nurse. He said documentation should reflect the missing dose and the nurse should follow up or the MA should follow up and administered medication when it is available. He said he expected MAs to administer medications as ordered. He stated the risk to the resident not getting medication was uncontrolled illness. In an interview with the Administrator on 08/01/24 at 03:58 PM, she stated the pharmacy delivered medication to the facility two times a day in the morning and in the evening therefore they always have medications that they need. She stated nursing staff should reach out to pharmacy for missing medication. She stated she expected staff to slow down and look at the orders and to follow the order as prescribed. She stated if a resident no longer had hip pain, then call the physician and change the order for the correct intervention needed. She expected staff to follow the formal medication error process. She stated the risk to resident getting wrong medication was adverse effects and risk for missing medication was not achieving desired therapeutic outcome. Record review of the facility's Administering Medications revision date April 2019 read in part, . Medications shall be administered in a safe and timely manner, and as prescribed . Policy Interpretation and Implementation . 4. Medications must be administered in accordance with the orders . 9. The individual administering the medication must check the label to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35489 Based on observation, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen. The facility failed to maintain quat sanitizer at a proper level in all three sanitation buckets, having levels of 500 ppm, and sanitation compartment of the three-compartment sink having level of 400 ppm. The facility failed to maintain the chlorine at a proper level in the dishwasher sanitizer cycle, having a level of 200 ppm. These failures could place all residents who eat off facility dishes at risk for exposure to higher than necessary levels of sanitizer chemicals, potentially leading to irritation of the digestive tract, and intestinal symptoms. Findings Included: An observation on 07/30/24 at 8:52 AM revealed the DS used quat test strips to check the levels of quaternary sanitizer in the three buckets used for sanitizing food preparation surfaces in the kitchen, and the dishwashing sink, which also used quaternary sanitizer for sanitizing hand-washed cooking equipment. All three buckets registered as 500 ppm on the test strips, and the sink registered closer to 400 ppm. The DS indicated by pointing at the strip that the level should have been at 400. The DS then checked the sanitizer in the sanitizing step of the dishwasher cycle with the chlorine test strips, and the cycle registered as 200 ppm. The DS again indicated by pointing at the test strip that it was supposed to match the high number (200 ppm). She said that the Dietary Manager had come, and she could not remember the exact date, but she thought it was on 07/05/24 or 07/06/24 and had checked the levels, and the lady from the city had been there, and it had been fine when they checked, and it always had been fine. She said they were supposed to dilute the buckets a little if it was too strong, and it was dispensed from the wall-mounted dispenser. She said having the chemicals too high could be a danger because it could cause some chemicals to be in the food, and residents could get sick. An interview on 07/31/24 at 7:34 AM with HR/DM revealed the sanitizer in the buckets was supposed to be at about 200 ppm, and the dishwasher at 100 ppm. She said she had the vendor come out on 07/30/24 and adjust the levels and she had checked everything today, and the levels were correct. She said it could potentially be hazardous to residents if it had too much chemical, and could also be hard on the staffs hands. She said they did not normally have an issue with it being high in the buckets or the dishwasher. An interview and observation on 08/01/24 at 8:06 AM revealed the DS checked the sanitizer buckets, which were at 200 ppm, and the dishwasher sanitizer cycle, which was at 100 ppm. She said she was normally the one who checked the chemicals every morning. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview on 08/01/24 at 3:59 PM with the Administrator revealed her expectations of kitchen staff were that they checked the sanitizer chemical levels thoroughly and reported any incorrect levels to the DS, or if the DS discovered it, she would report to her manager, so they could immediately look into corrective action. She said levels of chemical too high could be toxic. Review of the sign, provided by the vendor of the company which provided the quaternary sanitizer system, posted above the three compartment sink next to the wall-mounted dispenser reflected a pictorial and text instructions for testing sanitizer levels in the three compartment sink, and food contact surface sanitizer. The sign reflected testing solution should be between 150-400 ppm with a picture of the testing strip package, and the acceptable range bracketed. Review of the MSDS sheet for the quat sanitizer product, issued 02/04/20, reflected only that the product in its diluted state could cause eye irritation. Review of the facility policy Dietary Services- Kitchen Operation: Sanitization, revised October 2008, reflected: Policy Statement: The food service area shall be maintained in a clean and sanitary manner.; Policy Interpretation and Implementation: [.] 3. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions. 4. Sanitizing of environmental surfaces must be performed with one of the following solutions: a. 50-100 ppm chlorine solution; b. 150-200 ppm quaternary ammonium compound (QAC) [.] 8. Dishwashing machines must be operated using the following specifications: [.] Low-Temperature Dishwasher (Chemical Sanitization) [.] b. Final rinse with 50 parts per million (ppm) hypochlorite (chlorine) for at least 10 seconds. [.] 9. Manual washing and sanitizing will employ a three-step process for washing, rinsing and sanitizing: [.] c. Sanitize with hot water or chemical sanitizing solution. Chemical sanitizing solutions may consist of: (1) Chlorine 50 ppm for 10 seconds;

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	675908	A. Building B. Wing	08/01/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35489 48520 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections for 4 (Residents #20, #46, #78 and #83) of 9 residents reviewed for infection control. The facility failed to ensure MA D sanitized blood pressure cuff between use on Residents #20, #46, and Resident #83. The facility failed to implement an infection control and prevention plan that included gastronomy care (G-tube- resident received food through a tube into his stomach) for Resident #78. These failures could place residents at risk of cross contamination and infectious diseases. Findings included: 1. Resident #20 Review of Resident #20's face sheet dated 08/01/24, reflected a [AGE] year-old female that admitted to the facility on [DATE]. Her diagnoses included encephalopathy (loss of brain function due to imbalance), lack of coordination when walking, difficulty walking, cerebral infarction (stroke), unsteady on her feet, hypertension (high blood pressure), type 2 diabetes (uncontrolled blood sugar), and bipolar disorder (a mental disorder). Review of Resident #20's admission MDS assessment, dated 06/19/24, reflected a BIMS score of 15, indicating cognitive intact. Review of Resident #20's care plan on 07/31/24, revealed a focus on hypertension related to heart diseases without heart failure. The goal was for Resident #20 to be free of signs and symptoms of hypertension (Headache, visual problems, confusion, disorientation, lethargy, nausea, and vomiting) through review date 10/16/24. Interventions included Avoiding taking the blood pressure reading after physical activity or emotion distress, giving anti-hypertensive medications as ordered, monitoring for side effects such as orthostatic hypotension [low bp upon standing] and increased heart rate and effectiveness, and monitoring for and documenting any edema [swelling]. Monitor/document abnormalities for urinary output. Report significant changes to the MD. Monitor/record medication side effects. Report to MD as necessary. Review of Resident #20's orders on 07/31/24, reflected: Amlodipine Besylate Oral Tablet 10 MG (Amlodipine Besylate) Give 1 tablet by mouth in the morning Hold for BP < 110/ 60. Lisinopril Oral Tablet 5 MG (Lisinopril) Give 2 tablet by mouth in the morning for HTN GIVE 10 mg po daily. Atenolol Tablet 100 MG Give 0.5 tablet by mouth in the morning for hypertension Hold for BP < 110/60 and HR < 60. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with MA D on 07/31/24 from 08:50 AM to 09:20 AM, revealed MA D stated that she always placed BP medication in a separate cup until after checking the BP. She said if the BP was out of range she would hold the medication and notify the nurse. She then went into Resident #83 room, and she placed the wrist BP cuff on Resident #83's left wrist then walked to the wall with gloves and put a glove on her right hand. Resident #83' BP reading was 122/84, pulse was 61. MA D removed the BP cuff and gave Resident #83 her medication. MA D removed the glove from her right hand and went back to the medication cart and placed the used BP cuff on top of the medication cart. Hand hygiene was performed. MA D did not sanitize the BP cuff. MA D looked up Resident #46';s medication and placed Resident #46's BP medications in a separate medication cup. MA D did not perform hand hygiene after taking all medications and touching keys for control medication and signing the control book. MA D then went into Resident #46's room with the used BP machine and placed the BP cuff on Resident #46's right wrist. Resident# 46's BP reading was 133/82, pulse was 78. After removing the BP cuff off Resident #46 she gave him his medications. MA D then placed the used wrist BP cuff in her right arm pit and went into Resident #46's restroom and washed her hands with soap and water. She then walked out of Resident #46's room with the BP cuff in her arm pit and placed the BP cuff on top of medication cart. The BP cuff was not sanitized after use and before placing it on top of the medication cart. Resident #20 came out of her room to where MA D was in the hallway on her way to an appointment. MA D took Resident #20's medications out including her BP medications. MA D took the used BP cuff off the top of medication cart and placed the BP cuff on Resident #20's wrist. The BP reading was 146/84, pulse was 109. MA D removed the BP cuff off Resident #20 and placed it on top of the medication cart. MA D administered Resident #20's medications. MA D performed hand hygiene after she administered medications to Resident #20. MA D attempted to continue with another resident, but the surveyor intervened and stopped MA D. MA D stated that she forgot to sanitize the wrist blood pressure cuff in between residents. She stated she was expected to sanitize the wrist BP cuff after each resident use. She stated that she was not even thinking about it when she placed the wrist BP cuff in her arm pit. She stated she had been used to working in hospital setting where residents had individualized bp cuffs for each person. She said the risk to the residents for not cleaning the bp machine between each resident use was cross contamination and spread of infection. 4. Resident #78 Review of Resident #78's face sheet, dated 08/01/24, reflected the resident was a [AGE] year-old man, admitted to the facility on [DATE]. His diagnoses included dementia (cognitive decline), dysphagia following cerebrovascular (trouble swallowing after a stroke), a pacemaker (a small device used to treat irregular heartbeat), and gastronomy status (G-tube- resident received food through a tube into his stomach). Review of Resident #78's quarterly MDS assessment, dated 05/10/24, reflected Resident #78 was rarely understood by others, and rarely able to understand others. The staff assessment for mental status reflected he had long and short-term memory problems, and severely impaired daily decision-making skills. He continuously displayed inattention and disorganized thinking. Resident #78 had physical behavioral symptoms directed toward others (for example kicking, hitting, or grabbing others). The document reflected he had one-sided impairment in his upper and lower extremities, was always incontinent, and was completely dependent on staff for all his ADLs. He did not sit up or transfer during the assessment period, due to his clinical condition. Resident #78 received 51% or more of his nutrition through his g-tube. Review of Resident #78's care plans on 07/31/24 reflected: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I have a condition that requires Enhanced Barrier Precautions. EBP are related to G-Tube or PEG Tube, Wound Care Date Initiated: 07/02/2024; Revision on: 07/02/2024 o Infection control intervention to reduce the transmission of multidrug-resistant organisms. Date Initiated: 07/02/2024; Target Date: 08/21/2024 o Resident is not on isolation and should not be restricted to their room or limited from participating in activities. Date Initiated: 07/02/2024 o Staff must don gown and gloves after entering the room to provide high contact resident care activities such as dressing, bathing/ showering, transfers, providing hygiene, changing linens, toileting/ brief changes, device care, med administration vis [sic] enteral tube or central line, trach care and wound care. Observation and interview with RN I on 07/31/24 at 08:10 AM, she stated that Resident #78 was on enhanced barrier precautions and required Personal Protection Equipment (PPE) for G-Tube medication administration. She stated Resident #78 at times hit staff, so she asked CNA F to assist her. Both staff put on PPE and entered Resident #78's room. CNA F went to the right side of Resident #78, and she picked bed remote and lowered Resident #78's head down and lowered Residents #78 covers to expose the abdomen area. CNA F them moved to the left side of Resident #78 and held his right hand. RN I went to the right side of Resident #78 and placed the medication cups and water on the uncleaned bedside table. RN I then went into the bathroom, washed her hands, and put on clean gloves. RN I then stopped Resident #78's feeding and disconnected his feeding from the G-tube. RN I then attached a large syringe to the G-tube entry and poured some water into it. After a few minutes of the water sitting in the syringe not flowing into Resident #78's G-tube, RN I stated that it appeared Resident #78's G-tube to be clogged. CNA F then told RN I to flush the G-tube or to milk (method to dislodge residue) the G-tube. RN I told CNA F to hold the G-tube while she looked for a flush. CNA F did not change her gloves nor wash her hands after touching the bed and the covers and Resident #78's hand, CNA F took hold of Resident #1's G-tube and started milking it a little. RN I then told CNA F to get the ADON. RN I disconnected the syringe, locked the G-tube, and laid it on Resident #78's top sheet covering his hips. ADON A entered Resident #78's room without putting on any PPE on, without gloves and without hand washing. ADON A picked up Resident #78's G-tube and milked it one time. ADON A then stated, Ooh I need to put on some gloves. ADON A then left Resident #78's room to find PPE. Resident #78 had no PPE outside his room or inside his room. In an interview with CNA F on 07/31/24 at 09:39 Am, she stated she did not think to change her gloves and perform hand hygiene before holding Resident #78's G-tube and she stated she should not have touched it nor milk it as that was out of her scope of practice. She stated she was only trying to help RN I do what other nurses have done in the past. CNA F stated that she had done an in-service last week on infection control and hand hygiene. She stated the risk to Resident #78 was passing on germs to him and infection. In an interview with RN I on 07/31/24 at 11:04 AM, she stated that Resident #78's G-Tube was clogged, and they managed to unclog it and administered his medications. RN I stated she had been in-served on G-tube cleaning, medication administration, infection control, and EBP. She stated that all staff were required to wear PPE when administering medication and feeds for Resident #78. She stated that she did not say anything to ADON A when she touched Resident #78's G-tube without gloves or PPE in front of surveyor but she said something afterwards. RN I stated not following proper G-tube care risked Resident #78 to infection. (continued on next page)

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