STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675909	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harker Heights Nursing & Rehabilitation	415 Indian Oaks Dr Harker Heights, TX 76548

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on observations, interviews, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality and failed to protect and promote the rights of the residents for 4 of 10 (Resident # 30, Resident #50, Resident #108, and Resident #190) residents observed for dignity. 1. The facility failed to ensure Resident #30, Resident #50, and Resident #108 were assisted with feeding in a dignified manner. 2. The facility failed to promote Resident #190's dignity while dining when staff did not serve her lunch tray for approximately 45 minutes after tablemate was served. These failures could place residents at risk of experiencing humiliation, degradation, and a decreased quality of life. The findings included: 1. Resident #30 Review of Resident #30's face sheet, dated, 02/05/2025, reflected a [AGE] year-old female who was admitted on [DATE] and readmitted on [DATE]. Resident #30 had diagnoses which included Alzheimer's disease, unspecified (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), need assistance for personal care (assistance with basic daily activities like bathing, dressing, eating, toileting, and grooming), dysphagia (swallowing difficulties), dysphagia oral phase (problems using the mouth, lips, and tongue to control food or liquid), memory deficit following nontraumatic intracerebral hemorrhage (a significant impairment in memory function that occurs after a brain bleed inside the brain tissue), and unspecified lack of coordination (uncoordinated movement due to a muscle control problem that causes an inability to coordinate movements). (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #30's Annual MDS Assessment, dated 12/26/2024, reflected the resident had a BIMS score of 0, which indicated her cognition was moderately impaired. Resident #30 required supervision or touching assistance with eating - helper provides verbal cues and/or touching/ steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. Review of Resident #30's Comprehensive Care Plan, with a completion date of 01/14/2025, reflected Resident #30 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits (problems with a person's ability to think, learn, and remember). Resident #30 had a self-care deficit related to cognitive impairment, weakness (a lack of muscle strength, where you feel like you need extra effort to move your arms, legs, or other muscles), and debility(general weakness that may be result of an outcome of one or more medical conditions that produce symptoms such as pain or tiredness, and physical disability, or deficits in attention, concentration, and/or memory) Intervention: may need to prepare my tray, food and drinks. Resident #50 Review of Resident #50's face sheet, dated 02/06/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #50 had diagnoses which included Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), gastro-esophageal reflux disease without esophagitis (a burning sensation in the chest or throat, a dry cough, and difficulty with swallowing), and neurocognitive disorder with Lewy bodies (a progressive form of dementia that affects a person's ability to think, reason, and process information). Review of Resident #50's Quarterly MDS Assessment, dated, 01/25/2025, reflected Resident #50 rarely/never understood others. Resident #50 had poor short- and long-term memory recall. Resident #50 decision making ability was severely impaired (she rarely/never made decisions). Resident #50 was dependent on staff for eating, oral hygiene, showers, dressing, personal hygiene, transfers, and bed mobility. Review of Resident #50's Comprehensive Care Plan, with a completion date of 01/14/2025, reflected Resident #50 had a self-care deficit related to cognitive impairment. Interventions: Resident #50 required one staff assistance with eating. Resident #50 was at risk for nutritional deficits and/or dehydration risks related to prescribed therapeutic altered diet. Intervention: Therapeutic diet as ordered. Educate Resident #50 and/or family regarding nutritional needs, recommended diet and offer care choices as indicated. Resident # 108 Review of Resident # 108's Face Sheet, dated 02/06/2025, reflected Resident #108 a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #108 had diagnoses which included Alzheimer's disease, unspecified (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), cachexia (a complex syndrome characterized by muscle wasting- loss of strength, and fatigue- feeling extreme tiredness or lack of energy), and anxiety disorder (excessive worry, and fear). (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #108's Quarterly MDS Assessment, dated 11/19/2024, reflected Resident #108 had a BIMS score of 1, which indicated her cognition was severely impaired. Resident #108 required supervision or touching assistance with eating (helper provides verbal cues and/or touching/ steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently). Review of Resident #108's Comprehensive Care Plan, with a completion date of 12/5/2024, reflected Resident #108 had a self-care deficit related to cognitive impairment (decline in a person's ability to think, learn, remember and/or make decisions). Intervention: Resident #108 required set up assistance with eating and drinking. Resident #108 was usually able to feed self but may require more physical assistance by one staff. Resident #108 required assistance by one staff with grooming, dressing, hygiene, transfers, bed mobility, and incontinent care. Observation on 02/04/2025 at 12:10 to 12:16 PM, Resident # 30 was sitting at a table with another resident and was staring at her food. She was not attempting to eat her food and did not pick up any silverware. Observation on 02/04/2025 at 12:18 to 12:40 PM, CNA I sat on a rolling chair at a square table to feed Resident #108 and Resident #50. CNA I assisted Resident #30 to the table with Resident #108 and Resident #50. CNA I began to feed Resident #50 and gave her one spoonful of food, CNA I would push herself while sitting on the rolling chair to Resident # 30 (sitting across the table from Resident #50). CNA I would give Resident #30 a spoon full of food and would roll herself to Resident #108. CNA I would pick up spoon from Resident #108's plate and give her a spoonful of food and she sat for a few seconds before rolling to Resident # 50 to feed her some food. This continued throughout the meal service. There were other staff in the dining room and LVN M was standing in the dining room. CNA F was sitting at another table assisting another resident. Interview on 02/04/2025 at 1:05 PM, CNA I stated there was several staff in the dining area and they could have assisted with feeding. She stated it was difficult to feed three residents at the same time. She stated Resident #30, Resident #50, and Resident #108 sometimes could feed themselves but today (02/04/2025) all these residents required assistance and supervision with eating. CNA I stated the residents needed encouragement to eat and when staff not feeding them one on one the residents would lose interest with eating. She stated she did not know what a negative outcome could be if feed 3 residents at the same time. She stated she had been in-service on feeding residents, and it was discussed to feed only one resident. Interview on 02/04/2025 at 1: 16 PM, LVN M stated it was ideally for one CNA to feed one resident instead of three at the same time. She stated there was staff on the 600 hall who could have assisted with feeding. LVN M stated she was not going to make any excuses of why one CNA was feeding three residents at the same time. She stated it was a dignity issue and an issue where the resident may lose interest in eating if they had to wait for the CNA to feed other residents before they received their next bite of food. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #190's face sheet, dated 02/06/2025, reflected an [AGE] year-old female who was admitted [DATE] and readmitted on [DATE]. Resident #190 had diagnoses which included unspecified symptoms, and signs involving cognitive functions and awareness (mental processes such as attention, learning, and reasoning), need assistance with personal care (assistance with basic daily activities like bathing, dressing, eating, toileting, and grooming), and cognitive communication deficit (a communication issue caused by difficulties with thinking processes rather than speech issues). Review of Resident #190's Admission MDS Assessment, dated 01/11/2025, reflected the resident had a BIMS score of 13, which indicated her cognition was intact. Resident #190 was independent with eating, and upper body dressing. Resident #190 required supervision or touching assistance (helper provides verbal cues and /or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or as needed) with the following: oral hygiene, showers, and personal hygiene. Review of Resident #190's Care Plan, dated 01/07/2025 and revised on 01/16/2025, reflected Resident #190 had a self-care deficit related to generalized weakness, and decreased cognitive status. Intervention: Resident #190 required set up assistance with dressing, grooming and hygiene. She required one person assistance with toileting, transfers, and bed-mobility. Resident #190 was at risk for psycho-social issues (having to do with the mental, emotional, and social effects of a disease) such as emotional distress or behaviors. Interventions: Calm and re-assure resident is safe. Keep environment calm, quiet, and avoid loud noises as much as possible. Refer to mental health providers as needed. Observation on 02/04/2025 at 12:10 PM, to 12:48 PM Resident #190 was sitting with Resident #44 at a square table. Resident #44 received her meal tray at 12:10 PM. Resident #190 sat and watched other residents in the dining room eating their meal until she received her meal tray at 12:48 PM. Interview on 02/04/2025 at 12:42 PM, Resident #190 stated she was hungry, and she was getting a little nervous. She stated she was afraid she was not going to get her food. Observation on 02/04/2025 at 12:48 PM, LVN M spoke to Resident #190 and looked in the meal cart and did not remove any meal tray. Interview on 02/04/2025 at 12:55 PM, LVN M stated Resident #190 meal tray was not in the meal cart, and someone went to the kitchen and obtained a meal tray for Resident #190. LVN M stated she did not know what happened to Resident #190 meal tray, however, she believed her tray never came to the 600 hall. She stated the staff was expected to ensure all residents received their trays and if the staff was expected to immediately check on a resident's meal tray if the staff observed any resident without any food. She stated it was a dignity issue for a resident to watch other residents eat and they did not have anything to eat. Interview on 02/07/2025 at 1:15 PM, The Director of Nurses stated it depended on the residents if a CNA was capable of feeding more than one resident at the same time. She stated there was a possibility if a resident had a diagnosis of dementia and staff stopped feeding a resident with dementia to feed another resident the resident with dementia may lose interest in eating and will not want to finish their meal. The Director of Nurses stated it was not unusual for one staff to feed more than one resident. She stated there was enough staff to feed residents in the facility, however, sometimes it was easier to feed more than one resident at mealtime in dining room. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/07/2025 at 1:45 PM, The Administrator stated the expectation was ensure all residents received meals and assistance with their meals. She stated her expectation was one CNA feed only one resident and not two or more residents at the same time. She stated she could not determine if there was any negative outcome if a CNA fed more than one resident at the same time. The Administrator stated if a resident waited approximately 50 minutes before the resident received their meal that was too long, and the nurses and CNAs was expected to ensure every resident received their meal tray when the dietary staff delivered the meal carts to the dining rooms and on the halls for the residents eating in their rooms. Requested Policy on serving meals in dining room and a policy was not provided at time of exit.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on observations, interview and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for two of eight residents (Resident # 30, and Resident #80) reviewed ADL care. 1. The facility failed to ensure Resident #30 and Resident #80 nails were cleaned, trimmed, and did not have any rough edges. This failure could place residents at risk for poor hygiene, dignity issues, and decreased quality of life. Findings included: 1.Review of Resident #30's face sheet, dated, 02/05/2025, reflected a [AGE] year-old female who was admitted on [DATE] and readmitted on [DATE]. Resident #30 had diagnoses which included Alzheimer's disease, unspecified (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), need assistance for personal care (assistance with basic daily activities like bathing, dressing, eating, toileting, and grooming), and unspecified lack of coordination (uncoordinated movement due to a muscle control problem that causes an inability to coordinate movements). Review of Resident #30's Annual MDS Assessment, dated 12/26/2024, reflected the resident had a BIMS score of 0, which indicated her cognition was severely impaired. Resident #30 required supervision or touching assistance with eating and personal hygiene- helper provides verbal cues and/or touching/ steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. Review of Resident #30's Comprehensive Care Plan, with a completion date of 01/14/2025, reflected Resident #30 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits (problems with a person's ability to think, learn, and remember). Resident #30 had a self-care deficit related to cognitive impairment, weakness (a lack of muscle strength, where you feel like you need extra effort to move your arms, legs, or other muscles), and debility(general weakness that may be result of an outcome of one or more medical conditions that produce symptoms such as pain or tiredness, and physical disability, or deficits in attention, concentration, and/or memory) Intervention: Resident #30 required 1 staff assistance with showers, dressing, grooming, and hygiene. Observation and interview on 02/04/25 at 10:07 AM, revealed Resident #30 were in the dining room sitting with other residents. She had a blackish/ brownish substance underneath the middle ring and fore fingernails on her right hand. Resident #30's ring and middle fingernail on her right hand were uneven around the edges. Resident #30 was not interview able. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.Record review of Resident #80's face sheet, dated 12/04/2024, reflected an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #80 needed assistance with personal care (someone required assistance with basic daily living activities such as: bathing, dressing, eating, toileting, grooming due to physical, mental, or cognitive limitations that prevent them from preforming these tasks independently), and dementia in other diseases classified elsewhere, moderate, with psychotic disturbance (the loss of cognitive functioning such as: thinking, remembering, and reasoning to the extent that it interferes with a person's daily life and activities and a set of symptoms that indicate a person has lost touch with reality. Record review of Resident #80's Quarterly MDS Assessment, dated 09/30/2024, reflected Resident #79 had a BIMS score of 2, which indicated her cognition was severely impaired. Resident #79 required substantial/maximal assistance (helper does more than half the work) with personal hygiene, upper body dressing, showers, oral hygiene, and eating. She was total dependent on staff for transfers, lower body dressing, and toileting hygiene. Record review of Resident #80's Comprehensive Care Plan, with a start date of 10/03/024 and completed on 10/16/2024, reflected Resident #80 had an ADL self-care performance deficit related to dementia. Interventions: Check nail length, trim, and clean on bath day and as needed. Report any changes to the nurse. Observation and interview on 02/04/2025 at 10:37 AM, revealed Resident #80 was sitting in the dining room on 600 hall. Her nails on her right hand were not smooth around the edges. She had a blackish brownish substance underneath her middle and ring fingernails on her right hand. Resident #80 was not interview able. In an interview on 02/04/2024 at 11:14 AM, CNA F stated the CNAs were responsible for cleaning, trimming, and filing all residents' nails except for the residents with a diagnosis of diabetes. She stated the nurses were responsible for all the residents' nails with a diagnosis of diabetes. CNA F stated the residents nails were usually cleaned on their shower days and as needed. 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 such as vomiting and diarrhea. She stated a resident may cause a skin tear if their fingernails were not smooth. CNA F stated she was in-serviced on cleaning, filing, and trimming residents' nails but she did not recall the date. She stated she had given care to Resident # 30 and Resident #80, and she was not aware of these residents refusing nail care. Interview on 02/06/2024 at 8: 44 AM, CNA G stated she was not aware of Resident #30 or Resident # 80 refusing nail care. She stated she had given care to these two residents numerous times per month. CNA G stated a resident may scratch themselves or someone else if their nails were not even. She stated it was a possibility a resident may develop a skin tear if their nails were not correctly filed such as having rough nails. She stated it was CNAs responsibility to clean and trim all residents' fingernails except resident with diagnosis of diabetes. She stated nurses trimmed and cleaned residents with diabetes fingernails. CNA G stated if a resident had blackish/brownish substance underneath their nails and if they swallowed the substance, it was a possibility the resident may become ill with stomach issues such as nausea and diarrhea. She stated she had been in-serviced on nail care but did not recall the date. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/06/25 at 09:25 AM, ADON B 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. She stated it was the CNAs responsibility to clean and trim all other residents' nails during showers or as needed. She stated if there was a blackish substance underneath the resident's nails, there was a possibility the substance had bacteria. ADON B stated if a resident swallowed the bacteria there was a possibility a resident may become ill with stomach problems and may develop a stomach infection. ADON B stated she was not aware of Resident # 30 or Resident # 80 refusing nail care. ADON B stated she was in-serviced on nail care; however, she did not recall the date. In an interview on 02/05/24 at 08:36 AM, the Director of Nurses stated if a resident ingested the blackish substance on their fingers or underneath their fingernails, there was a possibility the substance may be some type of bacteria. She stated unless she knew what type of bacteria it was difficult to determine if a resident would become physically ill. She stated all residents were expected to receive nail care during showers and as needed. The Director of Nurses stated the CNAs completed nail care on all residents except for the residents with diagnosis of diabetes. She stated all residents with a diagnosis of diabetes, the nurse was responsible for their nail care. The Director of Nurses stated she expected the CNAs to report any changes in all residents' nails to the nurse supervisor. She stated if a resident had rough nails, there was a potential a resident may scratch themselves. She stated it was the nurse supervisor's responsibility to monitor ADL care. Review of Facility Policy on Activities of Daily Living, dated February 2017, reflected each resident's abilities to perform activities of daily living will not diminish unless the individual's clinical condition demonstrates that diminution was unavoidable. Activities of Daily Living include: 1. personal hygiene 2. ambulation and transportation 3.eating and dining 4. toileting 5. use of speech, language, or other functional communication systems.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 49099 Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, for 2 of 7 residents (Resident #400 and Resident #188). 1. ADON A observed Resident #400 sliding out of the bed and walked out without aiding the resident with bed mobility. 2. The facility failed to ensure a qualified staff fed Resident #188. These deficient practices could place residents at risk for injury, harm, and low sense of self-worth. The findings included: 1. Review of Resident #400's face sheet dated [DATE] reflected am [AGE] year-old female admitted to the facility on [DATE] with a diagnosis that included cerebral infarction (stroke- occurs when blood supply to part of the brain is blocked or reduced), acute pulmonary edema (condition caused by fluid in the lungs), acute kidney failure, history of falling, muscle weakness, unsteadiness on feet, and epilepsy. The face sheet also reflected Resident #400 was discharged on [DATE]. Review of Resident #400's quarterly MDS assessment dated [DATE] reflected a BIMS score of 5 indicating severe cognitive impairment. Section GG- functional abilities indicated lying to sitting on the side of the bed Resident #400 required supervision or touching assistance while sit to lying and sit to stand required partial/moderate assistance. Review of Resident #400's care plan revealed I have a self-care deficit related to need for assistance with ADL care related to history of CVA with interventions that included bed mobility: x1 person assistance as well as turning and repositioning: on rounds as needed, x1 person assistance. Review of Resident #400's transfer/lift status assessment dated [DATE] reflected transfer/lift screening: no lift needed. Review of Resident #400's nursing progress notes reflected a nursing noted dated [DATE] resident discharging with family member, resident has no skin issues noted at this time and neuros done with resident alert and denies pain at this time. Resident able to stand with family for transport. An observation of surveillance video footage provided on [DATE] at 09:25 AM by Resident #400's family member, surveillance video inside Resident #400's room revealed: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* time stamp of [DATE] at 03:47 PM showed Resident #400 in her room lying in bed, an alarm was heard and resident #400 was observed swinging her legs and getting her feet to the floor with her upper body still on the bed lying on her back facing up. ADON A was then observe entering the room saying, they are checking the fire alarm and I am making sure everyone is safe. Currently, as ADON A was communicating with Resident #400, the resident was observed reaching her arm out to ADON A requesting assistance to sit up. ADON A was observed walking completely in the room and looked at Resident #400 before walking back out without providing assistance to Resident #400 to either sit up in bed or get her body completely back in the bed. *time stamped [DATE] at 03:51 PM, Resident #400 was seen with both feet on the floor with her upper body on the bed, her right hand on the bed rail, her walker directly in front of her and she was heard on video calling for assistance. Resident #400 appeared to need assistance sitting up in bed. In an interview on [DATE] at 09:03 AM with Resident #400's family member, he stated that he observed the video surveillance as the events occurred on [DATE] and said he had to call the nurses station to speak to someone that would go in to assist Resident #400. He stated that the total time it took for someone to return to assist Resident #400 back into bed was 10 minutes. Resident #400's family stated that she was ambulatory and can move around but it was difficult for her to go from lying to sitting on her own at times. Resident #400's family stated that he was upset that staff did not assist when going into her room, and that he believed it took too long for them to give her the attention she needed. He stated he had been in the process of moving Resident #400 out of the facility and said no complaint or grievance was given to the facility about the incident he witnessed on the camera until the very last day on discharge when he mentioned it to staff on the way out. In an interview on [DATE] at 04:31 PM with the DON, after seeing the surveillance video she stated the individual in the video was ADON A. The DON stated that it was her expectation that if a resident was observed needing assistance in any manner that assistance if provided to them. She stated that failure to provided assistance to a resident who needs help sitting up or was sliding off the bed could potentially result in the resident having a fall. The DON stated that Resident #400's family member did not immediately file a complaint or make staff aware of ADON A not providing assistance until days later. She stated that he only mentioned it briefly and would not provide details because he already made up his mind about moving the resident. The DON stated the video footage was not provided to them, so they were unaware of the full details. The DON stated she remembered typing a statement during that time to document . In an interview on [DATE] at 05:00 PM with the ADM, after seeing the surveillance video she stated the individual in the video was staff member ADON A. She stated it was her expectation that all staff provided assistance to residents when asked or if they see they need help with repositioning to assist. She stated a potential negative outcome of not assisting would be that there would be the potential for the resident to have a fall. The ADM stated that Resident #400's family member brought up the concern to staff but refused to provide details and did not provide the surveillance video to them at the time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 05:23 PM with ADON A she stated it was her expectation that if a resident required assistance that staff assist. She stated a potential negative outcome of not assisting a resident with repositioning would be the resident could slide off the bed and break something. After seeing the surveillance video from Resident #400's room, she stated she does not recall what was happening at the time but believed she may have gone out to get someone else because she believed the resident was a 2 person assist (documentation shows the resident was only x1 assist). She stated that having the resident wait over 10 minutes for assistance was unacceptable. Review of the DON letter documentation dated [DATE] reflected: Family member did not want to tell writer about the situation at first but began to inform writer about a situation that he was concerned about during Resident #400's stay related to a team member that did not provide Resident #400 assistance. He informed writer that he did not want the individual to get in trouble, but that he had enough incidents with Resident #400 at this facility that he decided to discharge her at this time. Writer asked family member to elaborate on any incidents and he did not want to elaborate. He said that he decided to discharge. The letter was electronically signed by the DON. 2. Review of Resident #188's face sheet, dated [DATE], reflected a [AGE] year-old female who was admitted on [DATE] with diagnoses including type 2 diabetes mellitus with diabetic neuropathy, unspecified (high blood sugar can injure nerves throughout the body), Alzheimer's disease with early onset (progressive brain disorder that gradually destroys memory, thinking skills, and the ability to carry out daily tasks), and panic disorder (a sudden wave of fear or discomfort or a sense of losing control even when there is no clear danger). Review of Resident #188's Admission MDS, dated [DATE] was in progress. Review of Resident #188's Baseline Care Plan, dated [DATE], reflected Resident #188 had a self-care deficit related to generalized weakness and decreased in cognitive status (decline in a person's mental abilities, including memory, thinking, decision-making, and problem-solving). Intervention: Eating and Drinking- Set up assistance as needed; Resident #188 was able to feed self but may require more physical assistance at times. Resident #188 may need one person assistance with feeding and drinking. Observation on [DATE] at 11:05 AM Activity Assistant was standing in the dining room located on the 600-hall feeding Resident #188. There was not any other staff in the dining room. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 11:50 AM the Activity Assistant stated she had not received any training to feed a resident. She stated she was not a CNA and was not a paid feeding assistant. Activity Assistant stated she was not qualified to feed any resident and she was trying to help Resident #188 eat her cherry dessert that was served during an activity. Activity Assistant stated she was wrong to feed a resident. She stated there was a potential she may not feed a resident correctly and a resident may choke. Activity Assistant stated there was a possibility if a resident choked and she could not find a nurse the resident may die. She stated there was not any other staff in the dining room and if a resident began to choke, she would need to leave the dining room and find a nurse or someone with CPR (Cardiopulmonary resuscitation- an emergency treatment that's done when someone's breathing, or heartbeat has stopped) certification. The Activity Assistant stated anytime resident were eating in the dining room safety precaution needed to be in place such as a nurse in the dining room to help a resident if they choked. The Activity Assistant stated she did not have her CPR certification. She stated she had not been in-service or trained by anyone in the facility on feeding residents. Interview on [DATE] at 1:10 PM the Director of Nurses stated she was not aware of Activity Assistant being qualified to feed residents. She stated if a staff was not qualified to feed a resident there was a potential a resident may not be feed correctly and a resident had a potential for aspiration. She stated she expected all staff to be qualified to feed all residents. The Director of Nurses stated qualification included being a CNA, Nurse, or Speech Therapy. She stated staff had been in serviced on feeding residents but only the staff with the qualifications. The Director of Nurses stated she did not know the qualifications of the Activity Assistant. Interview on [DATE] at 1:45 PM The Administrator stated the Activity Assistant was not qualified to feed a resident. She stated her expectations was only CNA's, Nurse or Speech Therapist was the only qualified staff to feed residents. She stated if someone not qualified to feed a resident there was a possibility a resident may aspirate. She stated anytime a resident was being fed in the dining room the nurse was expected to be present. The Administrator stated the nurse would need to be present to ensure if there were any issues with resident during feeding a nurse could intervene immediately. The Administrator did not elaborate of what type of issues may occur during feeding a resident. Interview on [DATE] at 2:30 PM requested from the Administrator qualifications protocol for feeding residents and it was not provided at time of exit. Review of Activity Assistant Personnel record reflected she was hired on [DATE]. She was not a certified nurses assistant and did not have any training on feeding residents. Review of the facility policy titled Quality of Care last revised on ,d+[DATE] reflected: Quality of care is a fundamental principle that applies to all treatment and care provided to community residents. Based on comprehensive assessment of a resident, the community will ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: Mobility: a resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Statement of Residents Rights last revised on ,d+[DATE] reflected: The community should educate, encourage, and honor the rights of those we serve. Further the community should assist a resident to fully exercise their rights as applicable. Resident rights include: - To all care necessary for them to have the highest possible level of health. - To be treated with courtesy, consideration, and respect

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49099 Based on observation, interviews, and record reviews, the facility failed to ensure a resident's environment remained free of accident hazards and a received adequate supervision and assistance devices to prevent accidents for 1 of 1 resident (Resident #1) reviewed for assistance devices in that: NAIT T did not provide Resident #1 with an assistive device (modified cup with lid) when serving coffee to prevent an avoidable accident from occurring. NAIT T served Resident #1 coffee in a standard mug which resulted in Resident #1 spilling the coffee onto her left hand and the table due to her tremors and spastic movements in both arms. The facility failed to ensure NAIT T was knowledgeable on how to locate the Kardex to determine what assistive devices were required during meal services to prevent accidents. An IJ was identified on 02/04/25. The IJ Template was provided to the facility on [DATE] at 06:09 PM. While the IJ was removed on 02/7/25 , the facility remained out of compliance at a scope of isolated and a severity with no actual harm due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of harm and/or injury and contribute to avoidable accidents. Findings included: Review of Resident #1's face sheet dated 02/04/25 reflected a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis that included unspecified psychosis not due to a substance or known physiological condition (mental health condition characterized by a disconnection from reality), personal history of traumatic brain injury, seizures (sudden, uncontrolled electrical disturbance in the brain which can cause changes in behavior, movements, feelings, and consciousness), convulsions, epilepsy, muscle weakness, unspecified mental disorder due to known physiological condition, and cognitive communication deficit. Review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 09 indicating moderate cognitive impairment. Review of Resident #1's care plan last revised 01/06/25 revealed a focus on risk for nutritional deficit and/ or dehydration risks related to diagnosis heart disease and dysphagia with intervention that included modified cup with lid and encourage/offer/assist me to drink fluids during care time opportunities, ask my nurse if you have any questions. The care plan also identified the resident as being PASARR positive for IDD (intellectual and developmental disabilities). Interventions included coordinate plan of care with service coordinator as indicated, report any need to reevaluate specialized services and/ or plan of care to service coordinator and responsible party, and specialized services: Durable medical equipment approved mattress, wheelchair, and pad. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's IDT: care plan conference and advanced care planning review dated 10/16/24 reflected PASARR meeting/ care plan meeting held with notes that included diet regular with cup with lid. Review of Resident #1's Dietary Nutritional Risk assessment dated [DATE] reflected diet/Tube Feed order: regular, cup with lid. Review of Resident #1's physician orders reflected a dietary order with a start date of 12/28/17 regular texture, thin/regular consistency, **NON-SPILL CUP WITH MEALS**. Review of Resident #1's hot liquid evaluation dated 02/04/25 reflected this evaluation identifies if the resident is at risk for injury while handling and drinking hot liquids. Resident #1 was marked for Difficulty holding onto a cup or glass due to weakness or tremors, altered voluntary movement and/or sensation of feeling, such as neuropathy, hemiplegia, or hemiparesis to dominant side. The document showed a focus for I have the potential for injury related to hot liquid spill; may benefit utilizing a lid on hot liquid cup and interventions refer to therapy to screen and/ or eval as indicated and team members will apply/encourage use of a lid to the hot liquid cup when served. In an observation on 02/04/25 at 12:02 PM in the dining room, Resident #1 was observed sitting at a table with 4 other residents. Resident #1 had a plastic reusable cup with a screw on lid filled with cranberry juice, meal trays had not yet been brought out. An observation was made of Resident #1's need for the modified cup with a lid, as Resident #1 was seen to have tremors/ altered movement, she was seen at times shaking her plastic cup around and banging the cup on the table. NAIT T was observed passing out coffee from the coffee cart, Resident #1 saw her and was heard saying coffee. NAIT T was then heard saying oh you want some coffee, I will get you some and then handed Resident #1 hot coffee in a standard mug, no lid. At 12:15 PM Resident #1 was then observed grabbing the coffee mug and due to the altered movements and tremors of her arms and hands she swung the mug around causing the hot coffee to spill on her left hand and all over the table. 2 staff members observed the spill approximately 2-3 minutes later and cleaned the coffee and removed the tablecloth. No assessment was observed completed on Resident #1. In an interview on 02/04/25 at 01:04 PM with NAIT T she stated she will review the meal tickets to determine if a resident requires an assistive device. She stated she had not previously worked with Resident #1 and stated it was only her 3rd day of work and she was still in training. NAIT T stated she has not previously read Resident #1's meal ticket or gotten to know her. She stated she did not know where else to look aside from the meal tickets to determine a residents' needs with assistive devices. She stated she did not know where to look for the Kardex. After discussing Resident #1's requirement for a modified cup with a lid NAIT T stated she should not have given Resident #1 hot coffee in a standard mug and said, she could have burned herself. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 02/04/25 at 12:57 PM with DCE, she stated Resident #1 does require an assistive device for all fluids. The DCE stated that if Resident #1 wants coffee, she was allowed to have it as long as it is in a sealed container with a lid or modified cup with lid. DCE stated that a negative outcome of not providing Resident #1 with a cup with a lid was the resident could burn herself. Upon discussing the observations, DCE stated that Resident #1 could have burned herself and should not have been provided hot coffee in a regular cup. The DCE stated that the meal tickets will contain information about a residents' assistive device needs, however, she stated it was also her expectation that staff look on the Kardex to determine a residents' needs with assistive devices as well if they do not know. An observation on 02/04/25 at 01:23 PM of Resident #1's meal ticket on her table reflected Diet order regular, thin/regular liquids. Notes: ADAPTIVE CUP WITH COVER/LIDS. An observation on 02/04/25 at 01:25 PM by nurse surveyor observation made of Resident #1's hands, no burns, redness, or blistering noted. No signs of pain indicated. An observation on 02/04/25 at 01:37 PM the temperature of the coffee pulled from the coffee carafe into a mug and checked registered at 128.8 degrees Fahrenheit. In an interview and observation on 02/04/24 at 01:46 PM with the DON, she was observed reviewing Resident #1's EMR and she stated Resident #1 does require a cup with a lid for all fluids. She stated it was her expectation that staff ensured they look on the meal tickets to verify assistive devices needed and to ensure those devices are available. The DON stated a negative outcome of not providing Resident #1 her assistive device (modified cup with lid) was that she would spill it which could result in a burn, and she would not be able to drink her drinks. The DON stated that if staff do not know whether a resident required an assistive device, she expected them to ask questions. She stated her expectation with all staff and with trainees was for them to also be looking at the Kardex if the meal ticket was not yet available. In an interview on 02/05/25 at 08:42 AM with the DOR she stated that based on her knowledge Resident #1 has always required a modified cup with a lid since her admission in 2014. She stated Resident #1's condition has only progressively gotten worse and therapy was provided to her as maintenance. She stated based on her condition she should be provided hot liquids in a cup with a lid due to her tremors. In an interview and observation on 02/05/25 at 03:40 PM the DM was observed taking temperatures of coffee in different containers. The readings were as followed: (followed by interview) *Temperature in the carafe 145.2 degrees Fahrenheit. *Temperature in a cup poured from the carafe 136.8 degrees Fahrenheit. *Cup of coffee from the coffee brewing for residents' dinner registered at 150.6 degrees Fahrenheit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An observation of a coffee log dated 02/2025 on the side of the coffee machine with dates 1-3 for the month of February were blank for AM and PM temperatures and 02/04 for AM was left blank and PM was marked 145 degrees Fahrenheit. The DM stated that she began to log coffee temperatures 02/04/25 beginning with dinner and that there were no temperatures logged prior for the month of February. The DM stated it was her expectation that coffee was served between 125-130 degrees Fahrenheit. In an interview on 02/07/25 at 05:00 PM with the ADM she stated it was her expectation that NAIT's always worked with a certified nurse aide and were supervised by nursing staff during meal services. She stated failure to provide the required assistance to residents or necessary devices could result in injury. Review of the Accident Prevention policy last revised 01/2023 reflected: The community ensures that the resident environment remains as free of accident hazards as possible. Accident hazards are defined as physical features in the environment that can endanger a resident's safety. Adequate supervision and assistance devices to prevent accidents: The community identifies residents who may be at risk for accidents and or falls. An accident is an unexpected, unintended, event that can cause a resident bodily injury. It does not include adverse outcomes associated with consequences of treatment or care. Assessments and care plans are used to develop and implement procedures to prevent accidents. Review of the facility Hot liquid/ Food spills policy last revised 01/2023 reflected: Residents are at risk of having any hot liquid /food spilled on their person. Examples of hot liquids/food are coffee, tea, hot soup, oatmeal, or any other dietary substance that could cause injury. - Should the IDT deem the resident unsafe to handle hot liquids, educate, encourage, assist, and provide lidded cups as resident tolerates or allows and may apply other appropriate interventions necessary to promote safety. - If a staff member observes a resident spill a hot liquid or food on themselves or another resident the staff member may attempt to dissipate the heat of the item spilled with at least a liquid that is at temperature of room or below by pouring the room temperature or cooler liquid directly on the affected area. - The charge nurse/designee should be immediately notified so that the skin assessment of the area can be completed. - The charge nurse should notify the attending physician and responsible party of any injury and initiate any further physician orders. - An incident report and investigation should then be completed and determine if the resident needs further interventions such as screening by therapy department to prevent future occurrences. - Update the plan of care as indicated. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Nurse Aide non-certified position agreement dated 07/01/20 reflected: To support the community by providing premier care to each resident through direct care to residents in accordance with community policies and procedures. - Completes resident feeding training and assists with meal service when directed. - Address concerns immediately and reports them to supervisor. - All issues are reported to a licensed nurse immediately- under the supervision of a licensed nurse. - No violations of community procedures for delivering care and elevation protocol. - No safety infractions of residents under your supervision. The ADM and DON were notified on 02/04/25 at 06:09 PM that an IJ was identified due to the above failures and the IJ template was provided. The Plan of Removal was accepted on 02/05/25 and included: Plan of Removal Problem: F689 Free from Accident Hazards/ Supervision/ Devices The facility failed to provide assistance devices necessary to prevent an avoidable accident from occurring. Immediate Response: Licensed nurse assessed Resident #1 No injury noted at this time. Risk management/Incident Report completed. Date completed: 2/4/2025. Physician notification by licensed nurse Date completed: 2/4/2025. Responsible party notified by licensed nurse. Date completed: 2/4/2025. Occupational Therapist will evaluate Resident #1 for safety on 2/4/2025. Date completed: 2/4/2025. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Director of Clinical Operations /Director of Nursing Services/Assistant Director of Nursing Services, and administrative nurses conducted a 100% Audit of all residents who reside in the community to re-evaluate the need for Hot Liquid Assessments. Resident involved in the incident care plan was reviewed and updated. All residents identified had assessments completed.\ Date completed: 2/4/2025. Resident #1 care plan was reviewed and updated by Licensed Nurse Date completed: 2/5/2025. Director of Clinical Operations /Director of Nursing Services, and administrative nurses provided immediate education to the nurse aide in training involved in the incident and all other nurse aides in training and certified nurse assistants on Abuse Neglect, Residents Rights, Kardex Use prior to providing care to the residents. All nurse aide in training and certified nurse aides will be monitored by Director of Clinical Operations/Designee during meal service to ensure they are following appropriate protocol for residents needing assistance devices. Date completed: 2/4/2025 and ongoing. The Director of Clinical Operations/Director of Nursing/Administrative Nursing is responsible for ensuring compliance and oversight of monitoring and education to ensure compliance. All Nursing Team Members to include Agency/Prn/[NAME] Hires were educated on providing care to residents and were re-educated/re-trained by the Director of Clinical Operations /Director of Nursing Services/administrative nurses. o Direct care educated on review of the Kardex before providing care to all residents assigned to them to ensure proper assistance and interventions are utilized according to the resident's need and adherence to the resident's plan of care. Reporting any concerns or inaccuracies to the charge nurse/licensed nurse for additional direction prior to care provided. Nurse aides are not limited. There may be incidents where a resident not assigned to them will need assistance. The expectation for the nurse aide and all direct care staff is the review the Kardex prior to providing care. o Licensed nurse will review tray card accuracy to validate dining information to include diet, adaptive devices and use of a lid for hot liquids as indicated prior to resident receiving a meal or beverage. o Education provided to all Nursing Department including PRN/Agency/New Hires in Preventing Accidents/Hot Liquids/Promoting a Safe Environment: identifying risk, reducing risks, and promoting an accident-free environment indicated in the plan of care by the o All nursing staff will receive the in-service prior to working next shift. o All newly hired nursing staff will receive in-service training prior to assuming shift responsibility during orientation process. o All agency nursing staff will receive in-service training prior to assuming shift responsibility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Director of Clinical Operations /Director of Nursing Services/administrative nurses conducted 100% skills validation all nurse aides in training and certified nurse assistants of accessing the Kardex by the Director of Clinical Operations /Director of Nursing Services/administrative nurses. Date completed: 2/4/2025. Community will ensure all staff on leave/agency staff /PRN/new hires staff are in serviced prior to working their shift. No licensed nurse, nurse aides in training and certified nurse aide will assume an assignment of patient care until they have passed skills validation of accessing the Kardex. Community will ensure administrative nursing staff in the community to provide in-service/education prior team members working their assigned shift. These trainings will also be conducted with new hires. To include licensed nurses, nurse aide in trainings and certified nurse aides. Risk Response: All residents who currently reside in community potentially can be affected by the deficient practice. Systemic Response: Director of Clinical Operations /Director of Nursing Services/administrative nurses conducted a 100% Audit of all residents who reside in the community to re-evaluate for the need for Hot Liquid Assessments. Date completed: 2/4/2025. Director of Clinical Operations /Director of Nursing Services/administrative nurses provided immediate education was provided to the nurse aide in training on: Abuse Neglect/Residents Rights, Kardex Use prior to providing care to the residents. Date completed: 2/4/2025. o The Director of Clinical Education/Director of Nursing Services/Administrative Nurses is responsible for ensuring compliance and oversight of monitoring and education to ensure compliance of education. All Nursing Team Members including PRN/Agency/New Hires were educated on providing care to residents and were re-educated/re-trained by the Director of Clinical Operations/Director of Nursing/administrative nurses on the following: o Review of the Kardex before providing care to all residents assigned to them to ensure proper assistance and interventions are utilized according to the resident's need and adherence to the resident's plan of care. Reporting any concerns or inaccuracies to the charge nurse/licensed nurse for additional direction prior to care provided. o Licensed nurse will review tray card accuracy to validate dining information to include diet, adaptive devices and use of a lid for hot liquids as indicated prior to resident receiving meal or beverage. (continued on next page)

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Harker Heights Nursing & Rehabilitation	415 Indian Oaks Dr Harker Heights, TX 76548

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Education provided to all Nursing Department Preventing including PRN/Agency/New Hires on: Accidents/Hot Liquids/Promoting a Safe Environment: identifying risk, reducing risks, and promoting an accident-free environment indicated in the plan of care by Director of Nursing Services/Designee. o Temperature for coffee/hot beverages will be taken twice daily prior to serving residents by dietary/designee. This will be recorded on the document in the kitchen and kept in a monitoring binder to be kept by the Director of Clinical Operations/Administrator. The Administrator/Dietary Manager will review 3 days a week for 2 months to ensure compliance of the temperature checks. o 100% skills validation of accessing the Kardex. Date completed: 2/4/2025 and ongoing. Community will ensure all staff on leave/agency/PRN staff /new hires are in serviced prior to working their shift. No licensed nurse, certified medication aide or certified nurse aide will assume an assignment of patient care until they have passed skills validation of accessing the Kardex. Community will ensure administrative nursing staff in the community to provide in-service/education prior team members working their assigned shift. These trainings will also be conducted with new hires. Monitoring Response: o The ADM/ DON/ designee will conduct weekly rounds to validate interventions related to Hot Liquid/Accident and Supervision are in place 1-7 days a week for 2 months. o The DON/Designee will conduct random skills validations regarding Kardex use 3-7 days a week for 2 months to ensure direct staff is compliant with the use of the Kardex. o Temperature for coffee/hot beverages will be taken twice daily prior to serving residents by dietary/designee. This will be recorded on the document in the kitchen and kept in a monitoring binder to be kept by the Director of Clinical Operations/Administrator. The Administrator/Dietary Manager will review the temperature checks 3 days a week for 2 months to ensure compliance of the temperature checks. o Policies are followed to ensure the safety and wellbeing of our residents. Additional education will take place based on needs observed during this process. All findings will be reported to the QAPI committee during monthly meeting until there is 100% compliance observed during observations. On 02/06/25 and 06/07/25 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by the following: 02/06/25: Review of Resident #1's total body skin assessment dated [DATE] reflected good elasticity, normal skin color, warm temperature, normal moisture, normal condition, and no new wounds observed. Review of Resident #1's nursing progress notes reflected a late entry nursing progress note dated 02/04/25 writer notified MD and MDR of incident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's Occupational therapy (OT) evaluation 02/05/25 reflected new goals that included assess safety and management of self-feeding adaptive equipment to ensure of self-feeding independence and OT to provide education to caregiver staff in management of self-feeding adaptive equipment to ensure of good carryover/ competence in caregiving skills for patient. OT Evaluation and Plan of Treatment 02/05/25 dx include muscle wasting and atrophy, muscle weakness, lack of coordination, and need for personal assistance with personal care. Review of Resident #1's updated care plan revised 02/04/25 reflected I have the potential for injury related to hot liquid spill, may benefit from lid on hot liquid cup with intervention team members will apply/ encourage use of lid to hot liquid cup when served. Review of QAPI dated 02/04/25 reflected meeting was held, document shows Purpose of the meeting is to discuss the following concerns- F689 the facility must ensure that residents are provided assistive devices necessary to prevent an avoidable accident from occurring. The document stated meeting was attended by ADM, MD, MDR, DON, ADON B, and other key leadership. Review of Adaptive Equipment Tally Report dated 02/05/25 revealed 6 residents who had adaptive equipment updated on their Kardex to include Resident #1 - 1 cup with lid for all liquids. Review of the coffee temperature log reflected coffee temperatures being taken with the following dates and temperatures observed in new process beginning 02/05/25: 02/04/25: 145 PM (no location specification) (in degrees Fahrenheit) 02/05/25: Back Hall 130, Front 125 AM/ Back Hall 130, Front 127 (in degrees Fahrenheit) 02/06/25: Back Hall 130, Front 130 AM/ Back Hall 130, Front 130 (in degrees Fahrenheit) Review of 22 resident hot liquid evaluations reflected each had identified concern related to individual diagnosis, focus to include potential for injury related to hot liquid spill and interventions that included referral to therapy for screening and apply/encourage use of lid to hot liquid cup. Review of in-service dated 02/04/24 titled Kardex contained 6 signatures. Review of in-service dated 02/04/25 titled Feeding- all staff need to have training before feeding anyone including non-clinical management. The document contained 21 staff signatures which included CMAs, CNAs, and Admin staff. Review of in-service dated 02/04/25 titled adaptive tools- any resident who has an adaptive tool for meals (ex. Spoon, fork, plate, cup) must be at every meal. Signed by 25 staff members. Review of in-service dated 02/04/25 titled resident rights contained 16 signatures. ANE, resident rights, Kardex, respect and dignity, accidents, hot liquids, tray card accuracies text status 02/04/25 Review of in-service sheet dated 02/04/25 contained 12 signatures from kitchen/ dietary staff that reviewed tray card accuracy. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of in-service specific to NAIT on Kardex and adaptive tools signed off on 02/04/25. Review of 34 Kardex locating competency checks completed by facility and signed off by direct care staff dated 02/05/25. Review of 3 additional Kardex locating competency checks completed by facility and signed off by staff dated 02/06/25. An observation on 02/06/25 between 12:00 PM and 01:00 PM of lunch services, 2 nurses were observed in the dining room checking all meal tray tickets and supervising CNA's and NAIT's. Staff that required assistive devices were observed provided with their assistive device. NAIT T observed, and knowledge check completed. In an interview on 02/06/25 at 01:43 PM with RN CC, she stated she works PRN (as needed) and stated she also helps to check meal trays before delivery to the residents' rooms. She stated she has been trained on Kardex and safe environment. She stated she would verify diet is correct and check for allergies on the meal trays and would determine if a resident required an assistive device by looking at the Kardex. She stated that if she found a concern related to an inaccurate meal ticket or question about the assistive device, she would report it to ADON A. She stated it was important to provide an assistive device and failure to do so could result in harm to the resident. In an interview on 02/06/25 at 01:59 PM with CNA S, she stated she received training and inservices that included abuse and neglect, resident rights, locating the Kardex, preventing accidents/ hot liquids, and promoting a safe environment before the start of her shift by ADON A. CNA S was asked to locate the Kardex on a resident and surveyor observed competency. CNA S stated it was important to provide the required assistive devices to resident or it could result in spillage and injury such as burns. 02/07/25: A binder of in-services and training was provided: it contained a log documenting the following training: On 02/04/25 and 02/05/25 training was completed on Resident Rights, Kardex, Respect and Dignity, Accidents and Prevention, Hot Liquids, Tray Card Accuracy, and Abuse and neglect. The trainers involved in completing the training of staff included RDBD, DON, ADM, DCE, CR, and ADON A. Of 131 staff members 105 were marked as educated which accounted for 80 percent of the staff, and the remained is ongoing. In an interview on 02/07/25 at 09:10 AM with VPO She stated a care feed system (a system that communicated with all staff via text) in-services facility wide to all staff related to Resident Rights, Kardex, Respect and Dignity, Accidents and Prevention, Hot Liquids, Tray Card Accuracy, and Abuse and neglect was sent to all staff. She stated the staffing list was then divided and each of the leadership trainees was in charge of educating staff either in person or via phone. Staff was asked questions in regard to the topics listed above and after they successfully verbalized understanding and competence in the subject they were marked as completing the training. Sign in sheets were also provided and reviewed with staff signatures for training that was completed in person. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/07/25 from 12:00 PM through 04:00 PM surveyor reached out to care staff with a focus on CNAs and NAITs, to include PRN staff and a mixture of different shifts. Of the 15 staff members contacted, 8 responded and confirmed competency on the trained subjects and knowledge checks were completed over the phone- 2 of which were also observed in person accessing the Kardex and being able to identify and locate assistive devices. During these interviews staff stated they received various inservices which included Kardex and meal tickets, accidents, hot beverages, abuse and neglect, and assistive devices. Staff stated that knowledge was assessed by leadership staff through the employees verbal understanding and competency checks as well as in person verifications with locating the Kardex. Staff provided the surveyor verbal understanding of locating the Kardex, described where to locate information regarding assistive devices, and gave examples of negative outcomes that could occur when assistive devices are not provided. Staff verified for this competency included: - NAIT U (day shift) - CNA V (night shift) - CNA W (night shift and PRN) - CNA X (day shift) - CNA Y (works both day and night shifts) in person competency verification also completed. - CNA Z (PRN) in person competency verification also completed. - CNA AA (new hire) - CNA BB (new hire) **NAIT T was interviewed to confirm understanding during a meal services observation prior to these interviews. In an interview on 02/07/25 at 04:31 PM with DON, she stated the training completed by leadership and knowledge verifications with 80% of staff, stating education began immediately on 02/04/25 after notification of the incident. She stated that staff are required to check meal tray tickets and Kardex for the use of assistive devices and encouraged to ask questions if they do know something to prevent an injury from occurring. She stated retraining was immediately completed for NAIT T on 02/04/25 and said that through this experience they have modified their practices and licensed nurses are to supervise all CNAs and NAIT's during meal services. She said all residents who require assistive devices should and will be provided them to include modified cup with lid, weighted spoons, special plates etc. she stated training and implementation of corrective processes are also ongoing. In an interview on 02/07/25 at 05:00 PM with the ADM she stated it was her expectation that NAIT's always worked with a certified nurse aide and were supervised by nursing staff during meal services. She stated failure to provide the required assistance to residents or necessary devices could result in injury. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The administrator was notified the IJ was removed on 02/07/25 at 04:30 PM, however the facility remained out of compliance, at a scope of isolated and a severity level of no actual harm that is not immediate jeopardy due to the facility's need to continue to monitor the implementation and effectiveness of their corrective systems.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50360 Based on Observation, Interview and Record Review, the facility failed to determine that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled (a system of recordkeeping that ensures an accurate inventory of medication by accounting for controlled medications that have been received, dispensed, administered, and/or, including the process of disposition) for)4 of 6 Narcotic Count Sheets reviewed for Change of Shift Narcotic Counts. The facility failed to ensure all controlled medications were accurately reconciled at the start and end of each shift. This failure could place residents at risk of misappropriation by drug diversion and could result in diminished health and well-being. Record Review of the Change of Shift Narcotic Counts for the 100 Hall on 02/05/2025 at 2:20pm, of the Change of Shift Narcotic Counts for the 100 Hall revealed missing documentation for 02/04/2025 for the night shift. Record Review of the 200/300 Hall count sheet on 02/05/2025 at 2:20PM revealed missing documentation for night shift on 02/03/2025 and the day and night shifts for 02/04/2025. Record Review of the 600 Hall count sheet on 02/05/2025 at 11:52AM revealed missing documentation for night shift on 02/01/2025. Record Review of the 700 Hall count sheet on 02/05/2025 at 11:58AM revealed missing documentation for night shift on 02/01/2025, and night shift on 02/03/2025. During an interview with the DON on 02/06/2025 at 9:52AM, she stated it is was the expectation that the off-going nurse and the on-coming nurse count the narcotics together and both sign on the Narcotic Count sheet in the appropriate column. She further stated the staff are trained via the online training avenue and during their 3 day in-person orientation. The DON stated to ensure compliance for narcotic counts ,that at the end of the month the sheets are gathered and reviewed. The DON stated if there are missing signatures, the individual staff are retrained. The DON stated the Pharmacy consultant also audits the sheets and this helps identify trends. The DON stated that a negative outcome of not consistently following the narcotic count expectations was a possibility of a drug diversion. During an interview with the WFM on 02/07/2025 at 4:00PM, she stated CMAs and nurses are oriented to the change of shift narcotic count expectation during their three-day orientation period. Record Review of Competency check off sheets on 02/07/2025 at 4:00PM demonstrates the narcotic count competency expectation. Record Review of the State Operations Manual at S483.45(b)(3) stated The facility, in coordination with the licensed pharmacist, provides for: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	o A system of medication records that enables periodic accurate reconciliation and accounting for all controlled medications;

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 49099 Based on observation, interview, and record review, the facility failed to ensure each resident received and the facility provided food and drink that was palatable, attractive and at a safe and appetizing temperature for residents who consumed foods orally from the only kitchen in the facility in that: 1. a) The test tray of the lunch meal on 02/06/25 was lukewarm, unappetizing in appearance (no seasoning observed, and soggy roll on the plate), not cooked well (related to beef and pasta noodles) and lacked seasoning and flavor. b) The facility failed to provide palatable food that was attractive or appetizing to residents' who complained the food did not look or taste good. 2. The facility failed to follow the puree diet recipe. The puree scramble eggs recipe required three tablespoons and one teaspoon of food thickener. There was not a recipe for oatmeal. This failure could place residents at risk of decreased food intake, hunger, unwanted weight loss, and diminished quality of life. The findings include: 1. An observation on 02/06/25 at 01:34 PM, a lunch test tray was sampled. The test tray consisted of beef stroganoff pasta noodles, green beans, roll, tea, and water. Initial observation and appearance of the meal, no seasoning was observed on the green beans, the roll appeared soggy as it was placed on the same plate with the beef stroganoff pasta noodles and had soaked up the fluids from the pasta water and gravy. The beef gravy had an oily/fatty appearance. In tasting the meal, the pasta noodles texture was overcooked and felt mushy and dissolved in mouth. The gravy with the beef had very little flavor, felt greasy and watered down in taste; the beef mixed in the gravy was tough. The green beans did not have seasoning observed and did not taste like they had any seasoning. The top of the roll was a good texture, but the bottom was soggy as it has soaked up juices from the pasta noodles and gravy. The overall temperature of the meal was lukewarm. Review of Resident #3's face sheet dated 02/07/25 reflected a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis that included cerebrovascular disease (condition that affects blood flow to brain), chronic obstructive pulmonary disease (ongoing lung condition caused by damage to the lungs), major depressive disorder (mood disorder characterized by persistent feelings of sadness and loss of interest), pneumonia (infection of the air sacs in one or both lungs), and bed confinement status. Review of Resident #3's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 11 indicating moderate cognitive impairment. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #3's physicians orders reflected an order with a start date of 05/09/24 for RCS (reduced concentrated sweets) diet, regular texture, thin/regular consistency, divided plate. In an interview and observation on 02/06/25 at 03:32 PM in Resident #3's room, she was observed with a fast-food bag and eating a fried chicken sandwich, waffle fries, and 32 oz drink. Resident #3 stated that she was served and ate the lunch meal consisting of the beef stroganoff noodles. Resident #3 stated she did not like the gravy on the noodles and the meat saying, it had no flavor. She stated the green beans had no seasoning and she could not eat the roll because it was soaked from the fluids coming from the pasta and gravy. She stated she had the meal in her room and when it arrived to her it was cold. Resident #3 stated she was left hungry and that is why she ordered the fast food that she was observed eating. Review of Resident #39's face sheet dated 02/07/25 reflected a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis that included type 2 diabetes without complications (condition resulting from insufficient production of insulin causing high blood sugar), essential (primary) hypertension (high blood pressure), polyneuropathy (damage to peripheral nerves throughout the body), and age-related debility. Review of Resident #39's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 12 indicating moderate cognitive impairment. Review of Resident #39's physicians orders reflected an order dated 05/09/24 for a RCS (reduced concentrated sweets) diet, regular texture, thin/regular consistency. In an interview on 02/06/25 at 03:37 PM with Resident #39, she stated the beef stroganoff was not appealing to her, so she ordered a hamburger from the always available menu. Resident #39 stated she felt the hamburger was undercooked and sent it back and requested a new one. Resident #39 stated the new burger was still not hot enough or appetizing and was only semi-warm she stated she ate only enough to be able to take medications so she wouldn't have to take them on an empty stomach. Review of Resident #19's face sheet dated 02/07/25 reflected a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis that included type 2 diabetes mellitus without complications (condition resulting from insufficient production of insulin causing high blood sugar), generalized muscle weakness, contracture of the right hand (type of scarring or fibrosis that stiffens and tightens tissues reducing range of motion), and personal history of traumatic brain injury. Review of Resident #19's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 15 indicating cognition intact. Review of Resident #19's physicians orders reflected an order dated 05/09/24 for a RCS (reduced concentrated sweets) diet, regular texture, thin/regular consistency, built up utensils. In an interview on 02/06/25 at 03:41 PM with Resident #19, he stated he was served and ate the beef stroganoff for lunch. He stated the food didn't have good flavor. He stated he had to put salt on the green beans because they didn't have any seasoning, and that the food was lukewarm and not very hot. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #18's face sheet dated 02/07/25 reflected am [AGE] year-old male admitted to the facility on [DATE] with a diagnosis that included type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene (condition resulting from insufficient production of insulin causing high blood sugar with complications), adjustment disorders, dementia-without behavioral disturbance-psychotic disturbance-mood disturbance- and anxiety, and hyperlipidemia. Review of Resident #18's comprehensive MDS assessment dated [DATE] reflected a BIMS score of 12 indicating moderate cognitive impairment. Review of Resident #18's physicians orders reflected an order dated 11/23/24 for a RCS (reduced concentrated sweets) diet, regular texture, thin/regular consistency, for diabetes large protein portions with meals, renal precautions. In an interview and observation on 02/06/25 at 03:49 PM with Resident #18 and his family, an observation was made of Resident #18 in his room with family member at bedside. Resident #18 was being fed breakfast cereal in a cup by his family member. Resident #18 stated he was served the beef stroganoff for lunch and said it was not good and had no seasoning. Resident #18's family member stated that he complained to her about the food, and she tasted it and said it was not good and the noodles were not cooked well. Resident #18's family member stated he was still a little hungry after, so she brought him some breakfast cereal to eat. In an interview on 02/07/25 at 10:07 AM with the DM, she stated it was her expectation that all residents received a fine dining experience. She stated she expected for the food to by flavorful and enjoyed, for the presentation to be good, and for residents to have the meal to their liking. She stated a potential negative outcome of residents not enjoying their food could result in the potential for weight loss. In an interview on 02/07/25 at 05:00 PM with the ADM she stated it was her expectation that the food quality and taste be fit for the residents. She stated she expected the food to be restaurant style, have good presentation, and should be palatable. The ADM stated that a potential negative outcome of poor-quality food is the potential for residents to have poor intake which could result in weight loss. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation and interview on 02/07/2025 at 6:45 AM until 7:15 AM, DC K placed eggs into the puree equipment and proceeded to puree the eggs. When she observed the eggs, she stated she needed to add thickener to the eggs. She reviewed the recipe and it revealed to add 3 tablespoons and 1 teaspoon per 10 servings. DC K was preparing 10 servings. She stated there was not a tablespoon in the kitchen and she had an 8 ounce measuring cup. DC K proceeded to place the thickener in the 8-ounce measuring cup. DC K stated I guessed how much thickener a tablespoon would be when I put the thickener in the 8-ounce measuring cup. The DC K was going to puree the oatmeal and placed the oatmeal into the puree equipment. She walked to the recipe manual and was going to review the recipe to determine how much thickener or if needed milk to put into the oatmeal. When she reviewed the recipe manual, there was not a recipe for oatmeal. The DC K stated I will need to guess if the oatmeal needs milk or thickener. She pureed the oatmeal and placed some thickener and milk into the oatmeal and turned on the puree equipment. She stated she was using her judgement if the oatmeal needed milk or thickener. The DC K also placed 10 blueberry muffins in the puree equipment and proceeded to puree and when she observed the consistency, she reviewed the recipe and she stated she would need to guess how much thickener and milk to place in the puree equipment due to not having the correct measuring cup/spoon to follow the recipe. Observation on 02/07/2025 at 7:00 AM, the Dietary Manager was also attempting to locate the puree oatmeal recipe and she was unable to locate it in her office or in the recipe manual. Interview on 02/07/2025 at 7:25 AM, DC K stated she did not follow the puree recipe for the eggs due to not having the correct measuring cup to measure the milk and the thickener. She stated she needed to review the oatmeal recipe to ensure she was certain exactly how to prepare the oatmeal. She stated if the puree eggs, puree oatmeal and/or puree muffins was not at the correct consistency there was a possibility the residents on puree diet would not receive the correct nutrition they needed. She stated she had been in serviced on how to puree food. She stated she had been a cook over a year. Interview on 02/07/2025 at 7:35 AM, the Dietary Manager stated DC K did not have the proper equipment such as a tablespoon to measure the correct portion of milk and food thickener. She stated DC K did not follow recipe for the eggs and muffin according to the recipe. The Dietary Manager stated the dietary department did not have a recipe for puree oatmeal and it was expected to have all recipes prepared for the residents in the recipe manual. She stated if a resident did not receive the correct consistency with puree food there was a possibility there may be lumps of food. She stated she did observe the puree food and there were no lumps, and it was the correct consistency. Interview on 02/06/2025 at 10:45 AM, the Administrator requested protocol of following recipes and preparing food policy or protocol. This was not provided at time of exit. Interview on 02/07/2025 at 1:45 PM, the Administrator stated the dietary staff was expected to have the correct equipment to measure thickener and milk to ensure the pureed food is prepared correctly. She stated she was not a nurse and could not determine what may happen to a resident if they did not receive the correct consistency of pureed food. Record review of the facility's Diets Offered by the Facility, not dated, reflected: (continued on next page)

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	675909	A. Building B. Wing	02/07/2025

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Harker Heights Nursing & Rehabilitation	415 Indian Oaks Dr Harker Heights, TX 76548

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility is committed to providing the best nutritional care possible to its residents. All residents will receive diets as ordered by the attending physicians. There are many different names for similar diets. Diet order terminology should be standardized to ensure that the correct diets are served. The facility embraces a high liberalized diet philosophy to support health and quality of life and promote food satisfaction levels with the residents. A policy for food palatability was requested from the ADM 02/07/25 at 01:24 PM, she stated there was not a specific policy related to food palatability.

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on observation, interviews and record reviews, the facility failed to provide food that accommodates residents' allergies, intolerances, and preferences for two (2) of ten (10) residents (Resident # 50 and Resident # 241) reviewed for food allergies. The facility failed to honor Resident #50's food preference according to her meal ticket and failed to ensure Resident #50 was not served beef, which her meal ticket reflected she disliked. The facility kitchen failed to honor Resident # 241's food allergies according to her meal ticket and served her products containing gluten (oatmeal, blueberry muffin, dinner roll, and egg noodles) which her meal ticket stated she had an allergy to gluten. This failure placed the resident at risk of consuming a food allergen and of receiving and consuming foods not of their preferred preference which could result in diminished health status. Findings included: 1. Review of Resident #50's face sheet, dated 02/06/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #50 had diagnoses which included Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), gastro-esophageal reflux disease without esophagitis (a burning sensation in the chest or throat, a dry cough, and difficulty with swallowing), and neurocognitive disorder with Lewy bodies (a progressive form of dementia that affects a person's ability to think, reason, and process information). Review of Resident #50's Quarterly MDS Assessment, dated, 01/25/2025, reflected Resident #50 rarely/never understood others. Resident #50 had poor short- and long-term memory recall. Resident #50 decision making ability was severely impaired (she rarely/never made decisions). Resident #50 was dependent on staff for eating, oral hygiene, showers, dressing, personal hygiene, transfers, and bed mobility. Review of Resident #50's Comprehensive Care Plan, with a completion date of 01/14/2025, reflected Resident #50 had a self-care deficit related to cognitive impairment. Interventions: Resident #50 required one staff assistance with bathing, eating, showers, dressing, grooming, hygiene, mobility, toileting, and transfers. Resident #50 was at risk for nutritional deficits and/or dehydration risks related to prescribed therapeutic altered diet. Intervention: Therapeutic diet as ordered. Educate Resident #50 and/or family regarding nutritional needs, recommended diet and offer care choices as indicated. Review of Resident #50's weight records and she did not have a significant weight loss. Observation on 02/04/2025 at 12:16 PM, Resident #50 was sitting at a table being fed by CNA I in the dining room located on the 600 hall. Resident #50's meal ticket reflected she disliked spicy food and beef. Resident #50's meal was pureed taco beef meat. She did not eat very much of the beef. (continued on next page)

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/04/2025 at 1:05 PM, CNA I stated she did not notice Resident # 50's meal ticket. CNA I stated the nurse checked meal ticket prior to meal trays being delivered to Resident # 50. Interview on 02/04/2025 at 1:16 PM, LVN M stated she did compare each resident's meal ticket to their meal. LVN M stated she ensured the residents was receiving the correct diet. LVN M stated she did not notice their likes and dislikes. Interview on 02/04/2025 at 1:30 PM, Resident #50 was not interview able. 2. Review of Resident # 241's face sheet, dated 02/06/25, reflected a [AGE] year-old female admitted to the facility on [DATE]. Resident # 241 had diagnosis of encephalopathy (a brain disease that alters brain function or structure), type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar levels), cerebral infarction (stroke), muscle weakness, respiratory failure, urinary tract infection, influenza (flu), and difficulty walking. Allergies of Codeine, Phenobarbital, Chocolate, Corn, and Gluten. Review of Resident # 241's Comprehensive Care Plan dated 01/23/25, reflected Resident # 241 had allergy to codeine and phenobarbital. No food allergies listed. Interventions of Ensure a list of my allergies go with me to the physician, pharmacy, and hospital. Post allergies on chart and comprehensive orders. Review of Resident # 241's Clinical Physician Orders dated 1/23/25 reflected a diet order of RCS (Reduced concentrated sweets) Soft and Bite sized texture, thin/regular consistency liquids. Review of Resident # 241's Dietary Manager Nutrition Tool dated 01/24/25 reflected diet information of a therapeutic diet type, regular diet texture, and thin fluid consistency. No documentation of food allergies recorded. Review of Resident # 241's RD Nutrition assessment dated [DATE] reflected a diet ordered of RCS Soft/Bite sized with House Shake TID. No documentation of food allergies recorded. Review of Resident # 241's meal ticket slip dated 02/06/25 reflected a diet order of RCS Soft/Bite Sized Regular Thin Liquids. Allergies of Chocolate, Corn, Gluten. Dislikes of Chocolate, All Cheese, All Creamy items, Corn. Observation on 02/05/2025 at 8:45 AM, Resident # 241 in room eating breakfast of scrambled eggs, blueberry muffin, sausage, oatmeal, orange juice, and milk. Observation of Resident # 241's meal slip stated she has allergies to corn, gluten, and chocolate. Dislikes of chocolate, all cheese, all creamy items, corn. Observation on 02/06/2025 at 1:32 PM, Resident # 241 in room of lunch tray being delivered consisting of beef stroganoff over egg noodles, green beans, dinner roll, spiced apples, iced tea, and iced water. Observation of Resident # 241 meal slip stated she had allergies to corn, gluten, and chocolate. Dislikes of chocolate, all cheese, all creamy items, corn. Observation on 02/06/2025 at 4:15 PM, of facility kitchen pantry revealed container of oatmeal and package of egg noodles not to be gluten free. Further observation of kitchen revealed no gluten free food items in kitchen. (continued on next page)

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/04/2025 at 11:57 AM, with Resident # 241's RP revealed no concerns except with the food. RP stated Resident # 241 had allergies that are not being honored as Resident # 241 is allergic to gluten, corn, chocolate. RP stated he had discussed the Resident 241's food allergies with the nursing staff to remind them of the residents' allergies. RP stated sometimes his wife is more forgetful than others and he was unsure if the Resident 241 would remember not to eat products that contain items, she is allergic to. Interview on 02/05/2025 at 8:45 AM, Resident # 241 revealed she did not normally eat oatmeal or muffins when she was at home. Resident # 241 stated she normally ate gluten free products, so it did not upset her stomach. Resident # 241 stated since being in the nursing home she had been eating products that contain gluten since that is what she is being served and she is hungry. Resident # 241 stated that sometimes she has an upset stomach after eating. Interview on 02/06/2025 at 1:43 PM, RN CC stated this was her first shift she had worked at this facility and the first time she had performed meal pass tray check as she normally works at a different facility and normally works the 10:00 pm-6:00 am shift and there are no meals during that shift. RN CC stated that the meal tray check consists of making sure diet is correct and check for allergies or assistive devices needed. RN CC stated the resident information pertaining to diet is in the Kardex for reference if a staff member is unsure of resident needs. RN CC stated if a resident received an item, they are allergic to it can cause harm or possible hospitalization . RN CC stated she was not sure if the meal items Resident # 241 received contained gluten or not. RN CC stated she did not feel the meal tray Resident # 241 received posed a threat to the resident. Interview on 02/06/2025 at 1:59 PM, CNA S stated after the resident meal trays are checked by the nurse then they are passed to the CNAs to pass to the residents and assist with meal set up. CNA S stated staff can look in the Kardex to identify resident needs. CNA S stated if residents receive food items, they are allergic to they can have an allergic reaction or possible require hospitalization . Interview on 02/06/2025 at 4:00 PM, the DM stated the muffin and the dinner roll that Resident # 241 received were not gluten free products. The DM stated the oatmeal and egg noodles that Resident # 241 received was gluten free products. The DM stated staff receive training or in-services when an incident occurs. The DM stated during meal service for residents with allergies and preferences that when the meal trays are being assembled allergies and preferences are called out for each individual meal ticket as that tray is being prepared to ensure accuracy. Interview on 02/07/2025 at 10:55 AM, the Dietary Manager stated the dietary staff will check the meal ticket and compare it to the resident's meal prior to leaving the kitchen. She stated if a resident received something they did not like and it was documented on the meal ticket, there was a possibility a resident may not eat the food and may not receive the nutrients the resident need for the day. (continued on next page)

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/07/2025 at 3:35 PM, the DON stated the nurse checks the resident meal trays for accuracy before handing off to the CNA to pass to the resident. The DON stated if nurse is unsure of something on a tray such as an allergy or an assistive device then the nurse is supposed to check with the ADON or the DM for clarification before passing the meal tray to the resident. The DON stated if the meal tray has an item the resident is allergic to then the nurse is supposed to request a new meal tray for the resident. The DON stated the IDT team meets to discuss each resident needs in the care plan process. The DON stated after the IDT team meets then the information for each resident is communicated with the direct care staff and ancillary staff as pertaining to their job roles. The DON stated the facility has gluten free food items in stock. The DON stated a resident receiving a food item with gluten when they have a gluten allergy could result in an upset stomach. The DON stated the ADON Clinical management responsible for training the nursing staff on how to effectively perform meal tray check this is training conducted in the nursing floor orientation. Interview on 02/07/2025 at 4:30 PM, the ADM stated if a resident receives a meal tray with food items, they are allergic to then the expectation is for nursing to ask for new meal tray. The ADM stated if a resident received food items, they are allergic to then they could suffer a negative health outcome. The ADM stated it is the responsibility of the IDT team and ultimately DM for dietary staff and the DON for nursing staff to ensure meal tray accuracy before the resident receives the meal tray. The ADM stated prior to 02/07/2025 gluten free products were not in the facility and the ADM was not aware of any accommodations being made for the residents' food allergies. The ADM stated she was not aware of prior residents having a gluten allergy. The ADM stated the DM meets with all new residents to acquire likes and dislikes and records this information on the nutrition tool. The ADM stated she was unsure if the nutrition tool form had anything about allergies. 48917 Based on observation, interviews and record reviews, the facility failed to provide food that accommodates residents' allergies, intolerances, and preferences for two (2) of ten (10) residents (Resident # 50 and Resident # 241) reviewed for food allergies. The facility failed to honor Resident #50's food preference according to her meal ticket and failed to ensure Resident #50 was not served beef, which her meal ticket reflected she disliked. The facility kitchen failed to honor Resident # 241's food allergies according to her meal ticket and served her products containing gluten (oatmeal, blueberry muffin, dinner roll, and egg noodles) which her meal ticket stated she had an allergy to gluten. This failure placed the resident at risk of consuming a food allergen and of receiving and consuming foods not of their preferred preference which could result in diminished health status. Findings included: (continued on next page)

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of Resident #50's face sheet, dated 02/06/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #50 had diagnoses which included Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), gastro-esophageal reflux disease without esophagitis (a burning sensation in the chest or throat, a dry cough, and difficulty with swallowing), and neurocognitive disorder with Lewy bodies (a progressive form of dementia that affects a person's ability to think, reason, and process information). Review of Resident #50's Quarterly MDS Assessment, dated, 01/25/2025, reflected Resident #50 rarely/never understood others. Resident #50 had poor short- and long-term memory recall. Resident #50 decision making ability was severely impaired (she rarely/never made decisions). Resident #50 was dependent on staff for eating, oral hygiene, showers, dressing, personal hygiene, transfers, and bed mobility. Review of Resident #50's Comprehensive Care Plan, with a completion date of 01/14/2025, reflected Resident #50 had a self-care deficit related to cognitive impairment. Interventions: Resident #50 required one staff assistance with bathing, eating, showers, dressing, grooming, hygiene, mobility, toileting, and transfers. Resident #50 was at risk for nutritional deficits and/or dehydration risks related to prescribed therapeutic altered diet. Intervention: Therapeutic diet as ordered. Educate Resident #50 and/or family regarding nutritional needs, recommended diet and offer care choices as indicated. Review of Resident #50's weight records and she did not have a significant weight loss. Observation on 02/04/2025 at 12:16 PM, Resident #50 was sitting at a table being fed by CNA I in the dining room located on the 600 hall. Resident #50's meal ticket reflected she disliked spicy food and beef. Resident #50's meal was pureed taco beef meat. She did not eat very much of the beef. Interview on 02/04/2025 at 1:05 PM, CNA I stated she did not notice Resident # 50's meal ticket. CNA I stated the nurse checked meal ticket prior to meal trays being delivered to Resident # 50. Interview on 02/04/2025 at 1:16 PM, LVN M stated she did compare each resident's meal ticket to their meal. LVN M stated she ensured the residents was receiving the correct diet. LVN M stated she did not notice their likes and dislikes. Interview on 02/04/2025 at 1:30 PM, Resident #50 was not interview able. 2. Review of Resident # 241's face sheet, dated 02/06/25, reflected a [AGE] year-old female admitted to the facility on [DATE]. Resident # 241 had diagnosis of encephalopathy (a brain disease that alters brain function or structure), type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar levels), cerebral infarction (stroke), muscle weakness, respiratory failure, urinary tract infection, influenza (flu), and difficulty walking. Allergies of Codeine, Phenobarbital, Chocolate, Corn, and Gluten. Review of Resident # 241's Comprehensive Care Plan dated 01/23/25, reflected Resident # 241 had allergy to codeine and phenobarbital. No food allergies listed. Interventions of Ensure a list of my allergies go with me to the physician, pharmacy, and hospital. Post allergies on chart and comprehensive orders. (continued on next page)

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident # 241's Clinical Physician Orders dated 1/23/25 reflected a diet order of RCS (Reduced concentrated sweets) Soft and Bite sized texture, thin/regular consistency liquids. Review of Resident # 241's Dietary Manager Nutrition Tool dated 01/24/25 reflected diet information of a therapeutic diet type, regular diet texture, and thin fluid consistency. No documentation of food allergies recorded. Review of Resident # 241's RD Nutrition assessment dated [DATE] reflected a diet ordered of RCS Soft/Bite sized with House Shake TID. No documentation of food allergies recorded. Review of Resident # 241's meal ticket slip dated 02/06/25 reflected a diet order of RCS Soft/Bite Sized Regular Thin Liquids. Allergies of Chocolate, Corn, Gluten. Dislikes of Chocolate, All Cheese, All Creamy items, Corn. Observation on 02/05/2025 at 8:45 AM, Resident # 241 in room eating breakfast of scrambled eggs, blueberry muffin, sausage, oatmeal, orange juice, and milk. Observation of Resident # 241's meal slip stated she has allergies to corn, gluten, and chocolate. Dislikes of chocolate, all cheese, all creamy items, corn. Observation on 02/06/2025 at 1:32 PM, Resident # 241 in room of lunch tray being delivered consisting of beef stroganoff over egg noodles, green beans, dinner roll, spiced apples, iced tea, and iced water. Observation of Resident # 241 meal slip stated she had allergies to corn, gluten, and chocolate. Dislikes of chocolate, all cheese, all creamy items, corn. Observation on 02/06/2025 at 4:15 PM, of facility kitchen pantry revealed container of oatmeal and package of egg noodles not to be gluten free. Further observation of kitchen revealed no gluten free food items in kitchen. Interview on 02/04/2025 at 11:57 AM, with Resident # 241's RP revealed no concerns except with the food. RP stated Resident # 241 had allergies that are not being honored as Resident # 241 is allergic to gluten, corn, chocolate. RP stated he had discussed the Resident 241's food allergies with the nursing staff to remind them of the residents' allergies. RP stated sometimes his wife is more forgetful than others and he was unsure if the Resident 241 would remember not to eat products that contain items, she is allergic to. Interview on 02/05/2025 at 8:45 AM, Resident # 241 revealed she did not normally eat oatmeal or muffins when she was at home. Resident # 241 stated she normally ate gluten free products, so it did not upset her stomach. Resident # 241 stated since being in the nursing home she had been eating products that contain gluten since that is what she is being served and she is hungry. Resident # 241 stated that sometimes she has an upset stomach after eating. Interview on 02/06/2025 at 1:43 PM, RN CC stated this was her first shift she had worked at this facility and the first time she had performed meal pass tray check as she normally works at a different facility and normally works the 10:00 pm-6:00 am shift and there are no meals during that shift. RN CC stated that the meal tray check consists of making sure diet is correct and check for allergies or assistive devices needed. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN CC stated the resident information pertaining to diet is in the Kardex for reference if a staff member is unsure of resident needs. RN CC stated if a resident received an item, they are allergic to it can cause harm or possible hospitalization . RN CC stated she was not sure if the meal items Resident # 241 received contained gluten or not. RN CC stated she did not feel the meal tray Resident # 241 received posed a threat to the resident. Interview on 02/06/2025 at 1:59 PM, CNA S stated after the resident meal trays are checked by the nurse then they are passed to the CNAs to pass to the residents and assist with meal set up. CNA S stated staff can look in the Kardex to identify resident needs. CNA S stated if residents receive food items, they are allergic to they can have an allergic reaction or possible require hospitalization . Interview on 02/06/2025 at 4:00 PM, the DM stated the muffin and the dinner roll that Resident # 241 received were not gluten free products. The DM stated the oatmeal and egg noodles that Resident # 241 received was gluten free products. The DM stated staff receive training or in-services when an incident occurs. The DM stated during meal service for residents with allergies and preferences that when the meal trays are being assembled allergies and preferences are called out for each individual meal ticket as that tray is being prepared to ensure accuracy. Interview on 02/07/2025 at 10:55 AM, the Dietary Manager stated the dietary staff will check the meal ticket and compare it to the resident's meal prior to leaving the kitchen. She stated if a resident received something they did not like and it was documented on the meal ticket, there was a possibility a resident may not eat the food and may not receive the nutrients the resident need for the day. Interview on 02/07/2025 at 3:35 PM, the DON stated the nurse checks the resident meal trays for accuracy before handing off to the CNA to pass to the resident. The DON stated if nurse is unsure of something on a tray such as an allergy or an assistive device then the nurse is supposed to check with the ADON or the DM for clarification before passing the meal tray to the resident. The DON stated if the meal tray has an item the resident is allergic to then the nurse is supposed to request a new meal tray for the resident. The DON stated the IDT team meets to discuss each resident needs in the care plan process. The DON stated after the IDT team meets then the information for each resident is communicated with the direct care staff and ancillary staff as pertaining to their job roles. The DON stated the facility has gluten free food items in stock. The DON stated a resident receiving a food item with gluten when they have a gluten allergy could result in an upset stomach. The DON stated the ADON Clinical management responsible for training the nursing staff on how to effectively perform meal tray check this is training conducted in the nursing floor orientation. Interview on 02/07/2025 at 4:30 PM, the ADM stated if a resident receives a meal tray with food items, they are allergic to then the expectation is for nursing to ask for new meal tray. The ADM stated if a resident received food items, they are allergic to then they could suffer a negative health outcome. The ADM stated it is the responsibility of the IDT team and ultimately DM for dietary staff and the DON for nursing staff to ensure meal tray accuracy before the resident receives the meal tray. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADM stated prior to 02/07/2025 gluten free products were not in the facility and the ADM was not aware of any accommodations being made for the residents' food allergies. The ADM stated she was not aware of prior residents having a gluten allergy. The ADM stated the DM meets with all new residents to acquire likes and dislikes and records this information on the nutrition tool. The ADM stated she was unsure if the nutrition tool form had anything about allergies.

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	675909	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harker Heights Nursing & Rehabilitation	415 Indian Oaks Dr Harker Heights, TX 76548

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40884 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. 1. The facility failed to ensure DC K used proper hand hygiene during food preparation. 2. The facility failed to ensure DC L wore a beard guard when standing over food prep table. This failure could place residents who ate food from the kitchen at risk for foodborne illness. Findings included: 1. Observation on 02/07/2025 between 6:40 AM and 7:15 AM, DC K began to prepare puree meal. DC K did not wash her hands prior to preparing puree food. She did not wear gloves or wash hands when she was placing food in the puree equipment. DC K touched the following during the process of preparing puree food: her clothes, menu manual, an empty plastic bag, top of cardboard box, plastic container drawer where utensils were stored, surveyor shirt, and the right side of upper portion of her pants. DC K touched the top of blueberry muffins located on the steam table and the top of blueberry muffins she carried from the steam table to the area where the puree machine was located. DC K's tip of middle finger and forefinger touched the egg pureed food when transferring the eggs from the puree container to the silver container for the steam table. DC K would scoop oatmeal into silver container to puree the oatmeal. When she was scooping the tips of her middle, ring and forefinger touched the oatmeal located inside silver container. DK C did not wash or sanitize her hands between tasks. [NAME] C never washed or sanitized her hands the entire time she was being observed in the kitchen. DC K never washed her hands during the entire process of pureeing eggs, oatmeal, or muffins. In an interview on 02/07/2025 at 7:25 AM, DC K stated she did not wash or sanitize her hands in between tasks and during the entire process of pureeing food. She stated she touched her clothes, recipe manual, plastic bag that was garbage and the top of a cardboard box. DC K stated her clothes, surveyor clothes, cardboard box, plastic bag, and the recipe manual would be considered contaminated. She stated after she touched those items, she did not sanitize or wash her hands and did not wash her hands during the process of puree the muffins, eggs, and oatmeal. DC K stated there was a possibility she contaminated the food. She stated a resident may become ill such as stomach issues such as vomiting if the residents ate food with bacteria. DC K stated she received an in-service on hand hygiene. She stated she did not recall the date or time of in-service. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/07/2025 at 7:35 AM, the Dietary Manager stated all staff was expected to wash hands in between tasks and during preparation of food. She stated the menu binder, a box, clothes, and a plastic bag would be considered contaminated. She stated there was a possibility the food may become contaminated with some type of bacteria. The Dietary Manager stated it would be difficult to determine what type of illness a resident may obtain until knew what type of bacteria was transferred from DK C hands to the food. She stated all dietary staff was in-service on hand hygiene. She did not recall the date of the in-service. The in-service was requested and was not provided at the time of exit. 2. Observation on 02/05/2025 at 1:15 PM, revealed DC L entered the kitchen and his beard guard was located under his chin. He was standing over a food prep table and he did not cover his beard with the beard guard. He had approximately 8 inches of hair growth around his chin and jaw area. Interview on 02/05/2025 at 1:20 PM, DC L stated he was not wearing a beard guard correctly it was located under his chin. He stated there was a potential hair may fall from his face onto the food he was placing on the meal trays. DC L stated if there was hair on the food preparation table there was a potential hair may transfer to a resident plate or food. He stated a resident may become physically ill with stomach issues. DC L stated hair was considered contaminated. DC L stated he was trained to wear beard guards and hair nets when in the kitchen. He did not recall the date or time of the in-service. Interview on 02/07/2025 at 10:55 AM, Dietary Manager stated all male staff with facial hair growth was expected to wear a beard guard. She stated when DC L entered the kitchen, he was not wearing his beard guard correctly. His beard was not covered with the beard guard. She stated there was a possibility hair may fall on food or food preparation table. She stated it depended if there were bacteria on the hair if a resident may become physically ill if a resident had hair on their food and the resident ingested the hair. She stated she was not a nurse and could not determine if a resident may become physically ill from hair being on their food. Dietary Manager stated staff had been in-service on wearing hair nets and beard guards when in the kitchen. She did not recall the date of the hair net and beard guard in-service. Requested copy of the in-service of hair net and beard guard and this was not provided at the time of exit. Interview on 02/07/2025 at 1:45 PM, the Administrator stated anyone who entered the kitchen with a beard was expected to wear a beard net. She stated hair was considered contaminated. She stated the Dietary Manager was responsible to monitor the kitchen and she was over the Dietary Manager. The Administrator also stated she expected the dietary staff to wash their hands in between tasks or when they touched any contaminated item. The Administrator stated if the staff was not washing their hands after touching contaminated items there was a potential the food may become cross contaminated. She stated without knowing the type of bacteria from the hands and from hair it would be difficult to determine if a resident may become physically ill. Review of Facility's Employee Sanitation Policy, not dated, reflected Employee Cleanliness Requirements: Hairnets, headbands, caps, beard coverings or other effective hair restraints must be worn to keep hair from food and food-contact surfaces. Hand Washing: Employees must wash their hands and exposed portions of their arms at the designated hand washing facilities at the following times: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. After touching bare human body parts other than clean hands and clean, exposed portions of arms. 2. Immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles 3. When switching between working with raw foods and working with ready-to-eat foods 4. During food preparation, as often as necessary to remove soil and contamination and prevent cross contamination when changing tasks. 5. After engaging in other activities that contaminate the hands.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50360 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 3 residents (Resident #57) observed for infection prevention. The facility failed to ensure Enhanced Barrier Precautions (EBP) were implemented and used when CNA-G and CNA-J provided perineal and catheter care for Resident #57. This deficient practice could place residents at-risk for spread of infection. Findings included: Record review of Resident #57's face sheet dated 12/09/2023 revealed she was a [AGE] year-old woman, with an initial admitted [DATE], with re-admission on 12/09/2023 and with diagnoses which included: Type 2 Diabetes Mellitus (a chronic condition that affects how the body uses sugar (glucose) for energy), Neuromuscular Dysfunction of Bladder (a condition where the nerves controlling bladder function are damaged, leading to impaired bladder control), Indwelling Urethral Catheter (a thin, flexible tube inserted into the urethra (the tube that carries urine from the bladder to the outside of the body) to collect and drain urine). Record review of Resident #57's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 13, indicating intact cognition. Further review revealed Resident #57 was assessed as having an indwelling catheter. Record review of Resident #57's Active Orders dated 02/07/2025 revealed orders which included: - Enhanced Barrier Precautions start date 02/06/2025. - Foley Catheter care with perineal wipes and/or soap and water q shift and PRN: start date 01/29/2025. - EBP (Enhanced Barrier Precautions); Foley, colostomy, and wound care (until wound healed) Practice EBP as indicated: start date 11/27/2024 and stop date 11/27/2024. Record review of Resident #57's Care Plan dated last reviewed 12/13/2024 revealed a Problem which included I require an Indwelling Catheter, r/t Dx of Neurogenic Bladder, initiated 06/13/2024 and revised 02/06/2025. This problem area included the following interventions: - Catheter Care every shift and as indicated.; initiated 06/13/2024 and - change catheter per my physician's orders; Initiated 06/13/2024 - Check tubing for kinks each shift & during care encounters; Initiated 06/13/2024 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- EBP (enhanced Barrier Precautions); Initiated 06/13/2024. Observation on 02/06/2025 at 09:16 a.m., revealed there was a sign indicating Enhanced Barrier Precautions outside the door to Resident #57's room, and there was no supply of PPE available outside the door/room. Further observation revealed CNA-G and CNA-J put on gloves but did not put on or wear a gown while performing peri-care and foley care for Resident #57 . During an interview with CNA-J on 02/06/2025 at 09:17 a.m., CNA-J stated that she did not think Resident #57 was on Enhanced Barrier Precautions (EBP) because Resident #57's sacral wound had probably healed, and she no longer needed to be on EBP. CNA-J was asked to retrieve the Kardex. CNA-J was able to demonstrate pulling up the Kardex. Record review of the Kardex demonstrated there was no indication of Resident #57 being on EBP. During an interview with the DON on 02/06/2025 at 9:53 a.m., the DON stated staff should know the type of precautions a resident is on by consulting the Kardex. The DON stated a negative outcome of failure to abide by EBPs would be the spread of infection. Record review of facility policy titled Infection Prevention and Control revised 4/1/2024 revealed In addition to isolation practices, Enhanced Barrier Precautions (EBP) may be implemented as an infection control intervention designed to reduce transmission of resistant organisms. The use of PPE, such as gown and glove use during high contact resident care activities. EBP may be indicated as a recommendation by the CDC (when contract Precautions do not otherwise apply) for residents with the following: Wounds or indwelling medical devices, regardless of MDRO colonization status. Infection or colonization with an MDRO. EBP requires the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer o0f MDROs to staff hands and clothing. Residents/Patient with the following clinical indication should be under EBP. Indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO Colonization status EBP should be utilized during high-contact resident care activities. Device care of use: central line, urinary catheter feeding tube, tracheostomy/ventilator o Urinary catheters-during incontinent/catheter care activities.