STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675932	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Terrace Healthcare Center	609 Rio Concho Dr San Angelo, TX 76903

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Based on observations, interviews, and record review the facility failed to provide reasonable accommodation of resident needs and preferences for 1 of 5 residents (Resident #2) reviewed for reasonable accommodations, in that: CNA A and CNA B failed to put Resident #2's call light within reach after performing a transfer. This deficient practice could place residents at risk of not having their needs/preferences met to not being able to use call lights for assistance in to achieve independent functioning, dignity, and well-being. Findings included: Review of Resident #2's Face Sheet dated 2-5-25 revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included stiffness of the right and left knee, abnormal posture, and arthritis. Review of Resident #2's Quarterly MDS assessment dated [DATE] revealed: He had long and short-term memory impairment with severely impaired cognitive skills for daily decision making. He had lower extremity impairment on both sides and used a wheelchair. He was dependent for chair to bed transfers. Review of Resident #2's Care Plan updated 1/14/25 revealed: Falls/Safety risk: resident had a fall out of his wheelchair no injuries noted. Long Term Goal Target Date: Resident will remain free of injuries related to falls and will remain in a safe environment. Approaches included: Keep call light in reach. Review of Resident #2's Care Plan updated 1/14/25 revealed: (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident had multiple problems that affects his ability to walk. He has history of and the potential to fall and at risk for injury related to weakness and depression and mental disorder. The long-term goal was Resident will have no injuries related to fall over the next 90 days. Identified interventions included: Make sure his call light is within his reach and respond quickly. Review of Resident #2's Care Plan updated 1/14/25 revealed: Resident is unable to stand for transfers. The identified the goal was Resident may use a mechanical lift for all transfers and will not have falls related to transfers. Approaches included: resident may use mechanical lift for all transfers. Observation on 02/05/25 at 1:18 PM revealed CNA A and CNA B transferred Resident #2 from his wheelchair to the bed. The aides positioned Resident#2 in bed washed their hands and left the room. The call light remained on the floor behind the nightstand. Interview on 02/05/25 at 03:53 PM the DON stated she expected staff to put a resident's call light within reach once care was completed. Observation on 02/05/25 at 04:21 PM with the DON revealed CNA A and CNA B completed a transfer for Resident #2. Resident #2's call light was draped on the night nightstand but still out of reach of the resident if he was in bed. Review of the facility's policy and procedure on Call Lights dated March 2021 revealed: The purpose of this procedure is to ensure timely responses to the resident's requests and needs. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46641 Based on interview and record review, the facility failed to immediately consult Resident #1's physician for a decision to discharge the resident after a change in condition for one (Resident #1) of three residents reviewed for notification of changes. The facility failed to immediately notify Resident #1's physician regarding an incident with the resident's change of behavior resulting in Resident #1 being discharged from facility. This failure could place residents at risk of not having their physician informed of medical diagnoses not getting treated and a decreased quality of life. Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including sequelae cerebral infarction (pneumonia), diabetes mellitus with circulatory complications (sustained high blood sugar levels), Hemiplegia and hemiparesis (weakness to right dominant side), anxiety disorder due to known physiological condition, type 2 diabetes, acquired absence of left and right leg below the knee. Review of Resident #1's quarterly MDS assessment, dated 11/9/24, reflected a BIMS score of 15, indicating Resident #1 is cognitively intact. Section E-rejects care, GG- manual and motorized wheelchair, impaired on lower extremity both side, H-always incontinent, I-stroke, diabetes, and anxiety. Review of Resident #1's quarterly care plan, dated 11/15/24, behavioral symptoms, exhibits verbally abusive behaviors towards staff. Last reviewed/revised: dated 11/25/24 created by DON J (former DON), category: Physical aggression towards staff causing injury. Record review of incident on 11/25/24 at 9:15pm, Resident #1 physically assaulted CNA. CNA was sent to emergency room and diagnosed with chest wall contusion. Resident #1 was given an immediate discharge notice and was transferred to another nursing facility on 11/26/24 at 3:00pm. Resident #1's primary Physician was not notified of incident on 11/16/24 of Resident#1's change in aggression from verbal to physical aggression. During an interview on 2/4/25 at 2:30pm, the Administrator stated that on 11/25/24 at 9:30pm she was notified by DON J of an incident involving Resident #1. The Administrator stated it was decided by her and DON J that Resident #1 needed to be immediately discharged . The Administrator stated that this was the first time that Resident #1 had physically assaulted staff that she knew of. The Administrator stated that it was Care Planned that Resident #1 was verbally aggressive. The Administrator stated that DON J made a necessary notification and plans for discharge. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/5/25 at 3:10pm, DON J stated that on 11/25/24 at 9:15pm Resident #1 physically assaulted a CNA causing injury. It was decided by her and the Administrator that Resident #1 will be immediately discharged as soon as possible. A nursing facility was found the next morning on 11/26/24 and agreed to take Resident #1 that day. DON J stated that she notified Resident #1, resident's spouse , and resident's Primary Physician that Resident #1 is being discharged . DON J stated she did not notify resident's Primary Physician of the incident on 11/25/24 until the next day on 11/26/24 at 12:05pm. DON J stated she did not think that she needed to notify the Primary Physician on 11/25/24 because the resident was not harmed only staff. DON J stated that Resident #1 had a history of verbal aggressiveness towards staff, yelling, cussing, and threatening but this was the first time resident physically assaulted staff. DON J did agree that becoming physically aggressive could be considered a change in behavior. DON J stated that she did revise Resident #1's Care Plan on 11/25/24 to include physical aggression. During an interview on 2/6/25 at 2:00pm, Resident #1's Primary Physician stated that he was not notified of the incident on 11/25/24 until the next day, 11/26/24. The Primary Physician stated he would expect to be notified if a resident has a change in behavior or condition. Facility Resident's Condition or Status policy, Our facility promptly notifies the resident, his or her attending physician, heath care provider and the resident representative of changes in the resident's medial/mental condition and/or status (e.g., changes in level of care, billing/payments, residents' rights, etc.). Policy Interpretation and Implementation 1. Notifying resident's attending physician, A. accident or incident involving the resident, D. significant change in the resident's physical/emotional/mental condition, G. need to transfer the resident to a hospital/treatment center.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 51011 Based on observations, interviews, and record review the facility failed to protect the confidentiality of personal and medical records for 2 (LVN C and CMA D) of 5 staff reviewed for confidentiality of records. 1. The facility failed to ensure LVN C locked her laptop before she left the treatment cart unattended exposing residents personal and medical records. 2. The facility failed to ensure CMA D locked her laptop while she was in a resident's room administering medication exposing a resident's medication record. These deficient practices could place residents at-risk of loss of dignity due to lack of privacy. The findings included: Observation and interview of a treatment cart on 02/06/25 beginning at 11:30 a.m., revealed the computer on the treatment cart was unlocked and unattended displaying residents' personal and medical records. The computer was unattended for 5 minutes, approximately 25 feet away from the nurse's station and not in a clear line of sight from the nurse's station. Walking to the nurse's station, the surveyor asked which staff member was assigned to the cart. LVN C, standing at the nurse's station, stated the cart belonged to her. Observation of a medication cart in A Hall, on 02/06/25 beginning at 12:38 p.m., revealed the computer on the medication cart was unlocked and unattended which displayed a resident's medication record. The computer was unattended with the computer facing the hall. After 2-3 minutes, CMA D came out of a resident's room. The surveyor asked CMA D if the cart belonged to her. CMA D stated the cart belonged to her. In an interview on 02/06/25 at 11:30 a.m., LVN C stated she knew it (the computer) should be locked and she did not mean to leave it open. LVN C stated she never left it open. LVN C stated that leaving the computer unlocked could give unauthorized people access to private information. In an interview on 02/06/25 at 12:38 p.m., CMA D stated leaving the computer unlocked was not an acceptable practice. CMA D stated This was the first time ever. In an interview on 02/06/25 at 4:47 p.m., the DON stated the staff knew better than to leave their computers unlocked and unattended. The DON stated computers should be locked when unattended. The DON stated she and the ADON's perform random rounds to check for compliance. Record review of the facility's policy entitled Electronic Medical Records, revised in June of 2019, read in part: The facility will make reasonable efforts to limit the use or disclosure of protected health information to only the minimum necessary to accomplish the intended purpose of the use or disclosure.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46641 Based on interview and record review, the facility failed to provide documentation for transfer or discharge by resident's physician for 1 (Resident #1) reviewed for discharge requirements. The facility failed to provide reason for discharge by resident's physician which must include specific resident needs the facility could not meet, the facility's efforts to meet those needs and the specific services the receiving facility will provide to meet the needs of the resident which cannot be met at current facility. This failure placed residents at risk of not having the needed records when transferring care and services. Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including sequelae cerebral infarction (pneumonia), diabetes mellitus with circulatory complications (sustained high blood sugar levels), Hemiplegia and hemiparesis (weakness to right dominant side), anxiety disorder due to known physiological condition, type 2 diabetes, acquired absence of left and right leg below the knee. Review of Resident #1's quarterly MDS assessment, dated 11/9/24, reflected a BIMS score of 15, indicating Resident #1 is cognitively intact. Section E-rejects care, GG- manual and motorized wheelchair, impaired on lower extremity both side, H-always incontinent, I-stroke, diabetes, and anxiety. Review of Resident #1's quarterly care plan, dated 11/15/24, behavioral symptoms, exhibits verbally abusive behaviors towards staff. Last reviewed/revised: dated 11/25/24 created by DON J (former DON), category: Physical aggression towards staff causing injury. Record review of incident on 11/25/24 at 9:15pm, revealed Resident #1 physically assaulted CNA. CNA was sent to emergency room and diagnosed with chest wall contusion. Resident #1 was given an immediate discharge notice and was transferred to another nursing facility on 11/26/24 at 3:00pm. Record review of Resident #1's Physician orders dated 11/26/24 at 12:14pm, stated 'Discharge resident to (other nursing facility). Continue current orders and medications as ordered.' During an interview on 2/6/25 at 2:00pm, Resident #1's Primary Physician stated that he was not notified of the incident on 11/25/24 until the next day 11/26/24. Primary Physician stated he agreed with discharge from the facility for resident's behavior towards staff and in his general order description stated discharge resident. During an interview on 2/4/25 at 2:30pm, Administrator stated that on 11/25/24 at 9:30pm she was notified by DON J of incident involving Resident #1. The Administrator stated it was decided by her and DON J that Resident #1 needed to be immediately discharged . The Administrator stated that DON J made all necessary notification and plans for discharge. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/5/25 at 3:10pm, DON J stated she received a general order from Resident #1's Primary Physician stating to discharge resident. SLP Operations, Transfer and Discharges policy, dated July 2024. Section 12, Emergency Transfer/Discharges,

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** 26221 Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 2 of 2 resident (Resident #2 and #63) reviewed for accidents, hazards, supervision. The facility failed to safely transfer Resident #2 with a mechanical lift transfer by not locking his wheelchair. The facility failed to safely complete a two-person gait belt transfer with Resident #63 by not locking his wheelchair. These failures could place residents at risk for injuries due to not receiving the appropriate level of supervision. Findings included: Review of Resident #2's Face Sheet dated [DATE] revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included stiffness of the right and left knee, abnormal posture, and arthritis. Review of Resident #2's Quarterly MDS assessment dated [DATE] revealed: He had long and short term memory impairment with severely impaired cognitive skills for daily decision making. He had lower extremity impairment on both sides and used a wheelchair. He was dependent for chair to bed transfers. Review of Resident #2's Care Plan updated [DATE] revealed: Falls/Safety risk: resident had a fall out of his wheelchair no injuries noted. Long Term Goal Target Date: Resident will remain free of injuries related to falls and will remain in a safe environment. Approaches included: Keep call light in reach. Review of Resident #2's Care Plan updated [DATE] revealed: Resident had multiple problems that affects his ability to walk. He has history of and the potential to fall and at risk for injury related to weakness and depression and mental disorder. The long-term goal was Resident will have no injuries related to fall over the next 90 days. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Identified interventions included: Make sure his call light is within his reach and respond quickly. Review of Resident #2's Care Plan updated [DATE] revealed: Resident is unable to stand for transfers. The identified the goal was Resident may use a mechanical lift for all transfers and will not have falls related to transfers. Approaches included: resident may use mechanical lift for all transfers. Observation on [DATE] at 1:18 PM revealed CNA B positioned the mechanical lift around Resident #2's chair while CNA A steadied the wheelchair and Resident #2. CNA A steadied Resident #2 as CNA B lifted the chair and the chair moved as Resident #2 came out of it. Once Resident #2 was clear of the wheelchair, CNA A hooked her foot around the wheelchair and pulled it out the way of the lift. CNA A and CNA B then completed the transfer. Interview on [DATE] at 01:35 PM CNA A stated she thought the transfer with Resident #2 went good. CNA A stated she did the transfer as she was trained to do and there was not anything she would do differently. Interview on [DATE] at 01:43 PM CNA B said she thought the transfer with Resident #2 went ok. CNA B said she did not think there was anything she would do differently in the transfer. Interview on [DATE] at 03:53 PM the DON stated her expectation for a mechanical lift was for there to be two people to use it at all times, make sure the sling was positioned under the resident correctly, make sure the wheelchair is positioned the shortest distance from the bed because it was less stress on the resident, one aide holds the resident's arms. The DON explained she expected one aide to stand behind the resident and control the sling while the other aide operated the lift. The DON stated the wheelchair should absolutely be locked. The DON said the last training on transfers the facility did was approximately 6 - 8 weeks ago and it was a joint in-service between therapy and nursing. The DON said the Regional Nurse recently updated the competencies and the facility did them as people hired on. The DON said the agency staff had their own competency check off list at the nurse's station and transfers were on it. Interview on [DATE] at 04:31 PM the Administrator joined the conversation with DON regarding transfers and stated the ADON needed to start an in-service right away on mechanical lifts. Interview and observation with the DON on [DATE] at 04:21 PM revealed CNA A and CNA B completing a mechanical lift transfer with Resident #2. While explaining to the DON the wheelchair was unlocked while the transfer was completed, CNA B stated Did I not lock it the last time? Sorry. Review of in-services provided by the facility revealed the last in-service on mechanical lift transfers was completed on [DATE]. Review of Resident #63's Face Sheet, dated [DATE], revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included stroke with paralysis on the non-dominant side. Review of Resident #63's Quarterly MDS, dated [DATE], revealed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	He had long and short-term memory impairment. He had modified independence with daily decision-making skills. He needed substantial assistance for chair to bed transfer. He used a wheelchair. Review of Resident #63's Care Plan, dated [DATE], revealed: Problem: ADL Function/Rehab potential. Goal: Resident will achieve maximum functional mobility. Approaches included: Ambulation/Transfers amount of assist: Total. Observation on [DATE] at 1:30 p.m. revealed CNA A and CNA B prepared to do a transfer with Resident #63. CNA B put a gait belt on Resident #63. The aides decided they wanted the wheelchair closer to the bed, unlocked the wheelchair, inched the wheelchair closer to the bed. CNA B locked the inside wheel, but CNA A did not lock the outside wheel. The aides completed the transfer from the wheelchair to the bed with the wheelchair unlocked. Interview on [DATE] at 1:35 p.m. CNA A stated she thought the transfer went ok; they took Resident #63's foot pedals off, put the gait belt on, Resident #63 did really well standing, the aides assisted with the pivot and put him to bed. CNA A said there was not anything she would do differently with the transfer. Interview on [DATE] at 1:43 p.m. CNA B stated she insisted on doing the transfer with Resident #63 with two people all the time. CNA B said Resident #63 would not agree to a transfer until there were two people available. CNA B stated she remembered the aide took the foot pedals off Resident #63's wheelchair, moved the wheelchair closer to the bed, put on the gait belt, she (CNA B) got one side while CNA A got on the other side; they (the aides) grabbed the gait belt got under his arms, helped him pivot and helped him sit on the bed. CNA B said there was not anything different she would do with the transfer because she always did a two-person transfer gait belt transfer with him. Interview on [DATE] at 3:53 p.m. the DON stated her expectation for a two-person gait belt transfer was both wheels of the wheelchair be locked. Review of the Clinical Skills Checklist and Competency Evaluation for Transfers from Bed to Wheelchair using Transfer Belt, dated February 2019, revealed: Before assisting to stand, locks wheels on wheelchair. Review of the facility's policy and procedure on Safe Lifting and Movement of Residents, revised [DATE], revealed: In order to protect the safety and well-being of staff and residents, and to promote quality of care, the facility uses appropriate techniques and devices to lift and move residents.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Based on observations, interviews, and record review the facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 1 of 3 residents (Resident #28) reviewed for respiratory care. The facility failed to ensure staff remained with Resident #28 while he received his nebulizer treatment. This failure could place residents at risk for respiratory distress. Findings included: Review of Resident #28's Face Sheet dated 2/6/25 revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis which included pulmonary edema (swelling of the lungs) and Chronic Obstructive Pulmonary Disease (chronic disease affecting the lungs and heart making it difficult to breathe) Review of Resident #28's Quarterly MDS Assessment, dated 1/24/25, revealed: He had a mental status score of 14 of 15 (indicating he was cognitively intact) Review of Resident #28's Continuity of Care Document, dated 2/6/25 revealed he had orders for ipratropium - albuterol 0.5mg - 3 mg solution for nebulization one vial, inhalation four times a day for wheezing and shortness of breath diagnosis of Chronic Obstructive Pulmonary Disease beginning 12/29/24. There was no care plan for the breathing treatments. Observation on 2/4/25 at 2:39 p.m. revealed Resident #28 out of his room. There was a breathing treatment mask on the bed in operation. Review of Resident #28's nurse's notes and Medication Administration Record for the date and time revealed no documentation about Resident #28 refusing the breathing treatment or walking away from it. Interview on 2/6/25 at 1:31 p.m. DON stated if the resident refused a breathing treatment three times in a row the facility notified the doctor. The DON said breathing treatments were administered dependent on the mental status of the resident. The DON explained the nurse would stay with the resident if the resident was actively delusional. The DON said Resident #28's cognition went back and forth. The DON stated Resident #28 did smoke but was not a regular smoker. The DON said if Resident #28 walked away from the breathing treatment in the middle of the breathing treatment it was considered a refusal. The DON stated Resident #28 walking away from breathing treatments was not care planned and the expectation was that nurses would sit with him if there was still medication in the small volume nebulizer. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure on Medication Administration, revised December 2019, revealed: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Resident may actively refuse medications. Medication refusal must be reported to the prescriber after (XX) number of doses are refused and there must be documentation of prescriber notification of such.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675932	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Arbor Terrace Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 609 Rio Concho Dr San Angelo, TX 76903	

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45411 Based on observation, interview, and record review the facility failed to provide pharmaceutical services, including procedures that ensure the accurate administering of all drugs to meet the needs of the residents and failed to ensure medications were disposed of when expired for 2 of 3 nurses carts inspected for medication storage. The facility failed to ensure the medication cart 1 did not contain expired docusate sodium and loratadine. The facility failed to ensure the medication cart 2 did not contain expired loratadine. These failures could place residents at risk of receiving medications that were expired and not produce the desired effect. Findings included: During an observation and interview on 02/06/25 at 11:10 a.m., in the medication cart assigned to LVN E, 1 bottle of docusate sodium 100 mg was found with an expiration date of 01/25 and 1 bottle of loratadine 10 mg was found with an expiration date of 01/25. Surveyor asked LVN E what staff is responsible for checking carts for expired medications. LVN E stated that the nurses and medication aides try to check monthly for expired meds. During an observation and interview on 02/06/25 at 12:49 p.m., in the medication cart assigned to CMA F, 1 bottle of loratadine 10 mg was found with an expiration date of 01/25. Surveyor asked CMA F what staff is responsible for checking carts for expired medications. CMA F stated LVN's and CMA's try to check every few months for expired meds. During an interview on 02/06/25 at 4:47 p.m ., the DON stated all staff assigned to a cart should check for expired medications. The DON stated the contracted pharmacist performs cart inspections monthly and the DON and ADON's perform random cart checks. Record review of the facility's Storage of Medications policy dated 11/20 indicated in part: .Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.

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	675932	A. Building B. Wing	02/07/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51011 Based on observation, interview, and record review the facility failed to ensure that medications were secure and inaccessible to unauthorized staff and residents for 2 of 3 medication carts reviewed for labeling/storage of drugs and biologicals. The facility failed to ensure that medication carts 1 and 2 were not left unlocked and unsupervised. These failures could cause access, loss, diversion, or accidental ingestion of medications. Findings included: During observation on 02/04/25 at 5:13 p.m. an unlocked and unsupervised medication cart (cart 1) was found on F Hall. There was no staff in the line of sight of the cart at the time of this observation. There were two residents observed in sight of the medication cart. During an interview on 02/06/25 at 4:47 p.m., the DON stated that it was her expectation that medication and treatment carts would be locked when not in use. During an observation on 02/06/25 at 8:35 p.m. an unlocked and unsupervised medication cart (cart 2) was noted at the nurses' station. There were no staff in line of sight of the cart at the time of this observation. There were no residents or visitors observed within sight of the medication cart. Record review of the facility's Storage of Medications policy dated 11/20 indicated in part .Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46641 Based on interviews and record review the facility failed to notify hospice of emergency transfer of 1 (Resident #1) of 1 resident reviewed for discharge. The facility failed to immediately notify resident's hospice provider of discharge to another facility. This failure placed residents at risk of not receiving necessary care and services. Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including sequelae cerebral infarction (pneumonia), diabetes mellitus with circulatory, complications (sustained high blood sugar levels), Hemiplegia and hemiparesis (weakness to right dominant side), anxiety disorder due to known, physiological condition, type 2 diabetes, acquired absence of left and right leg below the knee. Review of Resident #1's quarterly MDS assessment, dated 11/9/24, reflected a BIMS score of 15, indicating Resident #1 is cognitively intact. Section E-rejects care, GG- manual and motorized wheelchair, impaired on lower extremity both side, H-always incontinent, I-stroke, diabetes, and anxiety. Review of Resident #1's quarterly care plan, dated 11/15/24, behavioral symptoms, exhibits verbally abusive behaviors towards staff, hospice services. During an interview on 2/6/25 at 10:05am, Hospice RN stated she was notified by DON J that resident had been immediately discharged from facility only after resident had left facility. Hospice RN stated she needed to know about discharge before resident left facility so they can help set-up or coordinate care with the new hospice or facility that resident was going too before resident left facility and make sure resident had at least two weeks supply of medications just to ensure the receiving facility has time to gather needed medications. Hospice RN stated that without this coordination with current facility and receiving facility resident's care could be compromised. During an interview on 2/4/25 at 2:30pm, Administrator stated that on 11/25/24 at 9:30pm she was notified by DON J of incident involving Resident #1. The Administrator stated it was decided by her and DON J that Resident #1 needed to be immediately discharged . The Administrator stated that DON J made all necessary notification and plans for discharge. During an interview on 2/5/25 at 3:10pm, DON J stated that she was responsible for making all notifications to providers of resident's discharge. DON J stated that she had forgot to contact Resident #1's hospice provider before the resident left facility. DON J stated she did contact Hospice RN, but it was after resident was already enroute to receiving facility. Nursing Facility Hospice Services Agreement dated March 20, 2024. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Section 3.6 Notifications. The Nursing Facility must immediately notify Hospice in the event of any of the following: C). There is a need to transfer the Resident Patient from the Nursing facility, and the Hospice makes arrangements for, and remains responsible for, any necessary continuous care or patient care related to the terminal illness and related conditions.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51011 Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 4 (Residents #30, #64, #63 and #331) of 4 residents reviewed for infection control practices. 1. The facility failed to ensure LVN C used appropriate PPE during dressing changes for Residents #30, #64 and #331 who were on Enhanced Barrier Precautions (EBP). 2. The facility failed to ensure CNA G changed her gloves after they became contaminated during incontinent care for Resident #63. 3. The facility failed to ensure LVN C used appropriate infection control principles while performing dressing changes for Resident #331. These failures could place residents at risk for cross contamination and the spread of infection. Finding included: Resident #30 In an observation on 02/06/2025 at 12:30 PM LVN C performed a dressing change on Resident #30's suprapubic catheter (a tube that drains urine from the bladder through a small incision in the abdomen). LVN C did not wear a gown during the dressing change. Review of Resident #30's face sheet dated 02/06/2025 indicated she was admitted to the facility on [DATE] with diagnoses of the presence of urogenital implants-suprapubic catheter, neuromuscular dysfunction of the bladder, and encounter for other orthopedic aftercare (care post-orthopedic surgeries). She was [AGE] years of age. Review of Resident #30's care plan revised 01/22/2025 indicated in part: Focus - Enhanced Barrier Precautions (EBP): Resident #30 requires EBP due to having a wound and catheter. Goal: The resident will have no symptoms of multi-drug resistant organisms (MDRO). Interventions: Staff will wear PPE during high-contact activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, incontinent care, wound care of any type requiring a dressing, device care or use (central line, urinary catheter, feeding tube, trach care, ostomy care, etc.). Review of Resident #30's Quarterly MDS dated [DATE] indicated in part: the BIMS score is 15, indicating Resident #30 is cognitively intact. She had an indwelling catheter and was always continent of bowel. Review of Resident #30's Order Summary Report dated 8/22/24 revealed the following orders: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Clean Suprapubic site with wound cleanser, pat dry, apply T-drainage dressing - every day and as needed (Order Date: 01/13/2025) - Enhanced Barrier Precautions due to the following: Increased risk of MDRO acquisition due to having an indwelling medical device and a wound (Order Date: 01/16/2025) Resident #63 In an observation on 02/05/2025 at 6:33 PM CNA G performed incontinent care for Resident #63. After washing and drying her hands, CNA G donned gloves and proceeded to perform personal care to Resident #63. CNA G used her right hand to wipe and her left hand to hold and move Resident #63's genitals. Not changing gloves, CNA G rolled Resident #63 onto his right side and used her right hand to wipe and her left hand to hold Resident #63's buttocks apart. Not changing gloves, CNA G removed the dirty brief, placed a clean brief on Resident #63, and rearranged his clothing and bedding. CNA G then removed her gloves. Review of Resident #63's face sheet dated 02/06/2025 indicated he was admitted to the facility on [DATE] with diagnoses of cerebrovascular disease (disease impacting the brain's blood vessels and blood supply), hemiplegia (one-sided muscle paralysis or weakness) affecting the left side, and deafness. He was [AGE] years of age. Review of Resident #63's care plan revised 01/28/2025 indicated in part: Focus - ADL's: Resident is incontinent of bowel/bladder related to stroke. Goal: The resident will achieve maximum functional ability. Interventions: Toileting assistance. Review of Resident #63's Quarterly MDS dated [DATE] indicated in part: BIMS not available related to Resident #63 is rarely understood. Bladder and bowel: Always incontinent. Resident #64 During observation on 02/06/25 at 9:30 a.m., LVN C performed a dressing change on Resident #64's cancerous lesion to his middle back without wearing a gown as required for EBP. The EBP sign was visible on Resident #64's door indicating the need for PPE and a PPE station was noted outside of the resident's room. Review of Resident #64's face sheet revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included malignant melanoma (cancer) of the skin and obstructive and reflux uropathy (urine is unable to drain through the urinary tract). Review of Resident #64's Quarterly MDS dated [DATE] revealed a BIMS score of 6 indicating severe cognitive impairment, he had an indwelling catheter, and he had open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion). Review of Resident #64's care plan, revised on 01/14/25, revealed the following: (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Problem: I require enhanced barrier precautions due to the following: I am at increased risk of a MDRO acquisition due to having a wound and an indwelling catheter. Goal: I will have no signs/symptoms of a MDRO. Approach: A sign will be posted on my door that says 'contact nurse before entering'; Discard PPE inside my room in the appropriate receptacle prior to leaving my room; PPE will be available (including gowns/gloves/face shield or goggles) right outside my room, in the shower room; Staff will wear PPE during high-contact activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, incontinent care, wound care of any type requiring a dressing, device care or use (central line, urinary catheter, feeding tube, trach care, ostomy care, etc.)

Review of Resident #64's active physician orders on 02/06/25 revealed the following:

Enhanced barrier precautions due to increased risk of MDRO acquisition due to having a wound - Start Date: 01/16/25

Resident #331

In an observation on 02/06/2025 at 1:40 PM LVN C performed wound care on Resident #331's elbows. There was EBP signage outside Resident 331's door. LVN C did not wear a gown during the dressing changes. LVN C washed her hands, donned gloves, removed the dressing on the right elbow, and removed her gloves. LVN C donned clean gloves without hand washing or using hand sanitizer and proceeded to clean the wound. LVN C used the same surface area of a 4 X 4 gauze to wipe half of the wound 4 times. LVN C repeated the same process on the other half of the wound. After LVN C applied the dressing to the right elbow, she removed her gloves and donned another pair of gloves without hand washing or using hand sanitizer, removed the dressing on Resident #331's right elbow, and removed her gloves. LVN C donned clean gloves without hand washing or using hand sanitizer and proceeded to clean the wound. LVN C used the same surface area of a 4 X 4 gauze to wipe half of the wound 3 times. LVN C repeated the same process on the other half of the wound. After cleaning the second half of the wound, LVN C used the same 4 X 4 to wipe a different wound that is 2-3 inches away. LVN C stated this is a new wound. LVN C applied a dressing to this new wound.

Review of Resident #331's face sheet dated 02/06/2025 indicated he was admitted to the facility on [DATE] with diagnoses of Parkinson's disease (a disorder of the central nervous system, often including tremors), atherosclerotic heart disease (build-up of fats, cholesterol, and other substances in and on artery walls), chronic obstructive pulmonary disease (COPD-a group of lung diseases that causes persistent airflow limitation and breathing problems), and pulmonary fibrosis (a lung disease that causes scarring in the lungs, making it difficult to breathe). he was [AGE] years of age.

Review of Resident 331's Care Plan revealed the Care Plan was in the process of completion.

Review of Resident #331's Order Summary Report dated 02/06/2025 revealed the following orders:

- Wound Treatment Order-Clean left upper elbow with normal saline/wound cleanser, apply triple antibiotic ointment, cover with bordered dressing - every day until resolved (Order Date: 02/05/2025)

- Wound Treatment Order-Clean right elbow with normal saline/wound cleanser, apply triple antibiotic ointment, cover with bordered dressing - every day until resolved (Order Date: 02/05/2025)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #331's MDS assessments revealed the Admission MDS was in the process of completion. In an interview on 02/06/2025 at 4:13 PM, LVN C was asked to list the steps to follow when providing wound care and she stated wash hands, put gloves on, remove old dressing, take gloves off and wash or sanitize hands, put new gloves on, clean wound, take gloves off and wash or sanitize hands, put new gloves on then apply clean dressing. When asked how many times a wound should be wiped with the same surface area of a gauze pad, LVN C stated, once. When asked what happened when she wiped a wound repeatedly or wiped different wounds with the same gauze, LVN C stated, Cross-contamination. When asked if she considered cleaning a wound and placing the new dressing with the same gloves on, clean-clean, clean-dirty, dirty-clean, or dirty-dirty, LVN C stated, dirty-clean and I should have changed gloves. When asked about EBP, LVN C asked, What is EBP? When told EBP stood for Enhanced Barrier Precautions LVN C stated the facility did not use the abbreviation and she was aware of the facility policy. When asked if gowns should be worn during direct resident care if on EBP, LVN C said she thought it was only for chronic wounds. LVN C stated she had not had any training on EBP. In an interview on 02/06/2025 at 04:47 PM the DON/Infection Preventionist stated staff have been trained on EBP, the last in-service was conducted on 06/26/2024. The DON stated staff were expected to know which residents are on EBP and to follow the policy. Regarding the wound/dressing changes, DON stated all nurses should have been trained in school on preventing cross-contamination and follow the facility's policies. She staff had been trained on infection prevention and should follow their training. The DON said the staff are expected to change gloves when appropriate to prevent cross contamination and the spread of infection. In an interview on 02/06/2025 at 7:00 PM CNA G was asked to list the steps to follow when performing incontinent care and she stated wash hands, put gloves on, clean resident front first and back second, change gloves if poopy, wash hands if gloves were poopy, put new gloves on, remove soiled brief, place clean brief on resident, and then collect trash. When asked if her gloves were clean or dirty after using her left gloved hand to hold Resident #63's genitals and right gloved hand to wipe the genital area, CNA G stated the gloves would be dirty and she should have changed them. CNA G stated it would be cross contamination to perform tasks without changing soiled gloves. Review of facility policy titled Enhanced Barrier Precautions, revised 04/01/2024, reflected, in part: .PPE for enhanced barrier precautions is only necessary when performing high-contact care activities. High-contact resident care activities include: .Wound care: any skin opening requiring a dressing .Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes. Review of facility policy titled Dressings, Dry/Clean, revised 04/2020, reflected in part Preparation .Review the resident's care plan, current orders, and diagnoses to determine if there are special resident needs. Steps in the Procedure .Perform hand hygiene, put on clean gloves, loosen tape and remove soiled dressing, pull gloves over dressing and discard, perform hand hygiene, put on clean gloves, cleanse the wound with ordered cleanser (if using gauze, use clean gauze for each cleansing stroke), change gloves (perform hand hygiene), apply clean dressing, remove gloves, perform hand hygiene, reposition the bed covers, make the resident comfortable.