STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675938	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shiner Nursing and Rehabilitation Center Inc	1213 N Ave B Shiner, TX 77984

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observation, interviews, and record review, the facility failed to ensure the residents had the right to formulate an advanced directive and determine the choice to recieve or not recieve CPR (cardiopulmonary resuscitation) for 3 (Resident #5, Resident #25, Resident #40) of 8 residents reviewed for accuracy and completeness of clinical records. 1 The facility failed ensure Resident #5's OOH DNR was not missing the physicians printed name. 2 The facility failed to ensure Resident #25's OOH DNR was signed a 2nd time by the resident representative. 3. The facility failed to ensure Resident #40's OOH DNR was signed a 2nd time by the resident. This failure could affect any residents who have medical records and could result in misinformation about professional care provided. Findings included: 1. Record review of Resident #5's Admission Record, dated [DATE], revealed a [AGE] year-old female admitted on [DATE], and readmitted on [DATE] with diagnoses of non-ST elevation myocardial infarction (type of heart attack that occurs when a coronary artery is partially blocked, reducing blood flow to the heart muscle), hypertensive heart disease without heart failure (group of heart conditions that are caused by long-term high blood pressure), peripheral vascular disease (a progressive disorder that occurs when blood vessels outside of the heart and brain narrow, block, or spasm), need for assistance with personal care, unsteadiness on feet, reduced mobility, and chronic atrial fibrillation (a type of heart arrhythmia that occurs when the heart's upper chambers beat irregularly and quickly). The admission record showed she was a DNR. Record review of Resident #5's quarterly change MDS assessment, dated [DATE], revealed the resident had mild cognitive impairment for daily decision making. Record review of Resident #5's care plan, dated [DATE], revealed the resident had peripheral vascular disease with a goal for extremities to be free from pain, pallor, rubor, coldness, and edema. With interventions of apply compression stockings as ordered. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's care plan, dated [DATE], revealed the resident had an order for do not resuscitate (DNR) with interventions that that all aspects of the DNR will be explained to resident or RP, in absence of b/p, pulse, respirations, will not be initiated. Record review of Resident #5's order summary, dated [DATE], revealed an order for DNR with a start date of [DATE] and no end date. Record review of Resident #5's OOH DNR was signed by the physician on [DATE] and was blank for the printed name of the physician. 2. Record review of Resident #25's Admission Record, dated [DATE], revealed a [AGE] year-old female admitted on [DATE], and readmitted on [DATE] with diagnoses of Alzheimer's disease, chronic kidney disease stage 3, and seizures. The admission record showed she was a DNR. Record review of Resident #25's significant change MDS assessment, dated [DATE], revealed the resident's cognition was severely impaired. Record review of Resident #25's care plan, dated [DATE], revealed the resident had an order for DNR with an intervention that all aspects of the DNR will be explained to resident or RP. Record review of Resident #25's order summary, dated [DATE], revealed an order for DNR with a start date of [DATE], and no end date. Record review of Resident #25's OOH DNR was signed by the RP on [DATE] in section C. The RP signature was missing at the bottom of the document where all persons who have signed above must sign below. 3. Record review of Resident #40's Admission Record, dated [DATE], revealed a [AGE] year-old male admitted on [DATE], with peripheral vascular disease (a progressive disorder that occurs when blood vessels outside of the heart and brain narrow, block, or spasm), major depressive disorder, repeated falls, anxiety disorder, and chronic kidney disease stage 4. The admission record showed he had a DNR. Record review of Resident #40's quarterly change MDS assessment, dated [DATE], revealed the resident was intact cognitively for daily decision making. Record review of Resident #40's care plan, dated [DATE], revealed the resident had a DNR with interventions that that all aspects of the DNR will be explained to resident or RP, in absence of b/p, pulse, respirations, will not be initiated. Record review of Resident #40's order summary, dated [DATE], revealed an order for DNR with a start date of [DATE], and no end date. Record review of Resident #40's DNR was signed by the resident on [DATE] in section A. The resident signature was missing at the bottom of the document where all persons who have signed above must sign below. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a joint interview on [DATE] at 9:47 a.m. The DON, ADON, and Medical Records personnel stated medical records was helping residents with the DNRs. Medical Records stated she had helped complete Resident #25's DNR but the others were done by the previous Medical Records personnel. The ADON stated the facility's policy would ensure once a resident stated they wanted a DNR they would honor it even before the paperwork was completed. Medical Records stated she was not aware everyone needed to sign twice on the DNR paperwork. The ADON and DON stated they could see how it would be an issue with outside agencies not honoring the DNR if it was not filled out correctly. Record review of the facility's policy titled DNR, no date, stated There are 2 ways we can obtain a DNR order: 1. The Out of Hospital DNR used on the Texas form. This version is universally accepted for all medical personnel in all settings 2. Physician's order for DNR. This can only be honored by your facility . Below is a summary of requirements of a standalone physician order for DNR: (this does not apply to Out of Hospital DNR. That process remains unchanged) It can no longer just be a standalone physician order. There are certain components that must be met. We need to have it documented in the clinical record: That the resident or resident representative is requesting the DNR. Where we contacted the physician with that request. The physician's response to the request. Use the [EMR] Request for DNR in order to have all the components. This is active in [EMR] now Scan completed Request for DNR forms into the residents document tab of [EMR]. The order: The DNR order takes effect at the time the order is issued. It does not need to be signed in order to be valid Input into [EMR] as verbal or telephone order so the physician can sign as soon as possible. After the order is entered, update the resident's care plan. If a resident or their representative request a DNR, we should start the process immediately for the OOH DNR. While we are awaiting all the signature requirements for the OOH DNR, we need to follow the process for the stand alone order. Again the stand alone physicians is only recognized by our staff, but we can respect the resident or representative wishes .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observations, interviews, and record reviews the facility failed to develop and implement a comprehensive person-centered care plan that included measurable objectives and time frames to meet a resident's medical and nursing needs and described the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 8 residents (Resident #25) reviewed for comprehensive care plans: The facility failed to ensure Resident #25's care plan reflected that she had a chronic wound and was on enhanced barrier precautions. This deficient practice could place residents at risk of not being provided with the necessary care or services and having personalized plans developed to address their specific needs. The findings included: Record review of Resident #25's Admission Record, dated 12/13/24, revealed an [AGE] year-old female admitted on [DATE], and readmitted on [DATE] with diagnoses of Alzheimer's disease, chronic kidney disease stage 3, and seizures. Record review of Resident #25's significant change MDS assessment, dated 12/4/24, revealed the resident's cognition was severely impaired. Section M showed the resident had a skin tear and used a pressure reducing device for bed, application of nonsurgical dressings, application of ointments/medications for treatments. Record review of Resident #25's care plan, dated 12/11/24, revealed Enhanced barrier precautions were not mentioned in the care plan. Record review of Resident #25's nursing progress notes, dated 11/13/24, revealed: -11/29/24 Initial skin assessment written by LVN C .Skin Tear Present: Yes. Location, measurements of skin tear: Left ankle, 3cm in length . -12/03/24 Nursing note written by LVN A Res had order for Monitor skin tear to left ankle with steri strips in place; res has open area to left lower leg. Hospice wrote new order for Left Lower Leg- Cleanse with wound cleanser- apply TAO and cover with non-adherent dressing daily and prn. Family notified. -12/12/24 Nursing note written by LVN A RECEIVED CLARIFICATION TX ORDER FROM HOSPICE NURSE. CLARIFICATION TX ORDER: FULL THICKNESS WOUND TO LEFT LOWER LEG-- CLEANSE WITH WOUND CLEANSER, APPLY CALCIUM ALGINATE AND COVER WITH SECONDARY DRESSING OF CHOICE 3X WEEKLY AND PRN. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #25's order summary, dated 12/11/24, revealed an order for cleanse left lower leg with wound cleanser, apply medihoney and calcium alginate and cover with dry dressing three times a week, everyday shift Tuesday, Thursday, and Saturday for wound healing, with a start date of 12/6/24, and no end date. No order for EBP was found. During an observation on 12/10/24 at 10:10 a.m. no Enhanced Barrier Precaution signs or PPE bins were observed outside any resident rooms for Resident #25. Unidentified staff were observed pushing Resident #25 into her room to transfer her to bed. The staff did not have on gowns or gloves when touching the resident. During an observation on 12/12/24 at 1:32 p.m. Resident #25 had a sign added that showed she was on EBP and a PPE cart was located outside the resident's room. Resident #25 had drainage on her left sock. The resident had an approximately dime size wound that was 2-3 cm deep on her lateral lower left leg above her ankle. At 12:44 p.m. A nurse provided wound care while wearing a gown and gloves to the wound. During an interview on 12/12/24 at 12:53 p.m. the DON stated she was unaware Resident #25 had an open draining wound until 12/12/24. The DON stated Resident #25 should have been on EBP. The DON stated EBP should be used for any residents with an open area to prevent infections and should be care planned. The DON stated when EBP is added to the care plan it would generate a task for staff to know they are on EBP. The DON stated if they are not care planned staff would not know to follow protocol for EBP and there is a potential for infection.

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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** 45857 Based on observations, interviews and record reviews, the facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 (Resident #5) of 8 residents reviewed for quality of care. The facility failed to follow provider orders and care plan interventions by not placing knee high compression socks on Resident #5 for edema (swelling caused by too much fluid trapped in the body's tissues). This failure could prevent the resident from receiving treatments and worsening of edema. Findings included: Record review of Resident #5's Admission Record, dated 12/13/24, revealed a [AGE] year-old female admitted on [DATE], and readmitted on [DATE] with diagnoses of non-ST elevation myocardial infarction (type of heart attack that occurs when a coronary artery is partially blocked, reducing blood flow to the heart muscle), hypertensive heart disease without heart failure (group of heart conditions that are caused by long-term high blood pressure), peripheral vascular disease (a progressive disorder that occurs when blood vessels outside of the heart and brain narrow, block, or spasm), need for assistance with personal care, unsteadiness on feet, reduced mobility, and chronic atrial fibrillation (a type of heart arrhythmia that occurs when the heart's upper chambers beat irregularly and quickly). Record review of Resident #5's quarterly change MDS assessment, dated 11/20/24, revealed the resident had a moderate cognitive impairment for daily decision making. The MDS showed for putting on or taking off footwear the resident used setup or clean up assistance where the helper sets up or cleans up, resident completes activity. Helper assists only prior to or following the activity. The MDS showed she used a wheelchair and did not walk due to medical conditions or safety concerns. Record review of Resident #5's care plan, dated 12/10/24, revealed the resident had peripheral vascular disease with a goal for extremities to be free from pain, pallor (skin paleness), rubor (redness of the skin), coldness, and edema. With interventions of apply compression stockings as ordered. Record review of Resident #5's order summary, dated 12/10/24, revealed an order for: -apply knee high compression stockings bilateral every day shift every Mon, Wed, Fri with a start date of 11/03/23 and no end date. -apply knee high compression stockings bilateral one time a day every Tue, Thu, Sat, Sun with a start date of 11/04/23 and no end date. Record review of Resident #5's MAR, dated 12/11/24, revealed the resident had her compression socks applied on 12/10/24 and 12/11/24 during the day shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #5's medication administration audit report, dated 12/12/24, revealed on 12/11/24 LVN A documented she applied the knee-high compression stockings at 6:36 a.m. During observation and interview on 12/10/24 at 1:24 p.m. Resident #5 stated her legs and feet were swollen and it was bothering her. She stated she asked staff to put her compression socks on but they had not. Resident #5 lifted her blanket up and her lower legs and feet were edematous (abnormally swollen with fluid or relating to or affected with edema). Resident #5 had on non-skid socks, not the ordered compression stockings or socks. During an observation and interview on 12/11/24 at 11:40 a.m. Resident #5 was in the dining room. She had on regular ankle socks and her feet were swollen. Resident #5 stated they had given her shower that morning and put regular ankle socks on her after. During an observation and interview on 12/11/24 at 4:30 p.m. Resident #5 had on regular ankle socks. LVN A stated they monitor the resident's edema to her legs, and they apply compressions socks every Monday, Wednesday, and Friday. LVN A stated the resident was supposed to get a shower that morning, so they removed the socks, and put them back on the resident. LVN A stated she removed the socks around 1 p.m. on 12/11/24. LVN A stated Resident #5 had compression socks in her room. LVN A then walked to Resident #5's room and opened 1 drawer and stated she did not have any in her room. LVN A then checked the linen storage room and found 1 compression sock with no pair. LVN A then stated she was unsure if they had more and needed to ask. LVN A then checked a treatment cart and did not find any. LVN A then asked a staff member who oversaw ordering supplies, and the staff member unlocked a cart in the medication storage room where there were multiple boxes of new compression socks. LVN A stated she would document that she put the compression sock on before she put them on the resident. LVN A stated Resident #5 had +2 pitting edema (a moderate level of swelling where pressing on the affected area leaves a visible indentation (pit) that disappears within 15 seconds) to both lower extremities on 12/11/24. LVN A stated they used the compression socks for her swelling and the resident should have had the socks on at that time. LVN A was then observed putting compression socks on Resident #5. During an interview on 12/11/24 at 5:48 p.m. the ADON stated she was unsure why Resident #5 did not have her compression socks put back on after her shower. ADON stated when it was not the resident's shower day the night shift nurse would place the socks on the resident around 6 a.m. before the end of their shift. ADON stated Resident #5's order was for them to be worn during the day and removed at bedtime. ADON stated the resident would have swelling if she did not wear the compression socks. Record review of the facility's policy titled Physician's Orders, dated 2015, stated Purpose: to monitor and ensure the accuracy and completeness of the medication orders, treatment orders, and ADL order for each resident.

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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** 45857 Based on observation, interview, and record review, the facility failed to ensure the resident environment remains as free of accident hazards as is possible for 2 (Resident #5 and Resident #40) of 8 residents reviewed for environment, in that: 1. The facility failed to ensure Resident #5 did not have medicated chest rub and a bottle of hair spray on a dresser in her room. 2. The facility failed to ensure Resident #40 did not have a beer in his room without staff's knowledge of it. This deficient practice could result in residents encountering potentially hazardous materials. The findings were: Record review of Resident #5's Admission Record, dated 12/13/24, revealed a [AGE] year-old female admitted on [DATE], and readmitted on [DATE] with diagnoses of non-ST elevation myocardial infarction (type of heart attack that occurs when a coronary artery is partially blocked, reducing blood flow to the heart muscle), hypertensive heart disease without heart failure (group of heart conditions that are caused by long-term high blood pressure), peripheral vascular disease (a progressive disorder that occurs when blood vessels outside of the heart and brain narrow, block, or spasm), need for assistance with personal care, and chronic atrial fibrillation (a type of heart arrhythmia that occurs when the heart's upper chambers beat irregularly and quickly). Record review of Resident #5's quarterly change MDS assessment, dated 11/20/24, revealed the resident had a moderate cognitive impairment for daily decision making. Record review of Resident #5's care plan, dated 12/10/24, revealed the resident remained in the facility long term because she required 24-hour licensed nursing care related to short term memory loss and increased confusion and the resident had impaired cognitive function/dementia or impaired though processes, difficulty making decisions, impaired decision making, resident and family aware of forgetfulness and confusion. Record review of Resident #5's order summary, dated 12/10/24, revealed no orders for medicated chest rub or self-administration of medications. During an observation on 12/10/24 at 3:00 p.m. Resident #5 had a over the counter jar of medicated chest rub and a bottle of hairspray on her night stand in her room. During an interview on 12/10/24 at 3:03 p.m. Resident #5 said she used the medicated chest rub because it helped her breathe better, but she was not sick or congested. During an interview on 12/11/24 at 5:21 p.m. the ADON stated any residents who self-administered medications needed an order to do so. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/13/24 at 1:19 p.m. the DON stated Resident #5 did not have an order for the medicated chest rub or to self-administer medications. The DON stated she should not have had the bottle of hair spray in her room either because it was a combustible. The DON stated family may have brought the items for her. The DON stated there was a possibility the resident could use the items incorrectly and become sick. 2. Record review of Resident #40's Admission Record, dated 12/13/24, revealed a [AGE] year-old male admitted on [DATE], with peripheral vascular disease (a progressive disorder that occurs when blood vessels outside of the heart and brain narrow, block, or spasm), major depressive disorder, repeated falls, anxiety disorder, and chronic kidney disease stage 4. Record review of Resident #40's quarterly change MDS assessment, dated 9/17/24, revealed the resident's intact cognition for daily decision making. Record review of Resident #40's care plan, dated 12/10/24, revealed the resident often went across the street and smoked with his family member and drank alcohol initiated on 11/21/24 with intervention to education will be provided as tolerated by the resident. Record review of Resident #40's order summary, dated 12/10/24, revealed an order for may have alcoholic beverages at social functions, dated 6/24/24, and no end date. Record review of Resident #40's psychological services progress note, dated 11/19/24, revealed the resident had no substance abuse history. During an observation and interview on 12/10/24 at 1:47 p.m. Resident #40 was laying in bed. The resident had 1 open beer can at his bedside. The resident stated a friend brought him the beer and staff knew he had it. The resident did not appear drunk, spoke clearly, and did not smell of alcohol. During an observation on 12/11/24 at 4:35 p.m. Resident #40 was visiting with a friend in his room. The friend had brought him a package of sodas. The friend stated she was leaving and left through the B hallway door. The friend entered in a code to exit the door on her own and got into a vehicle that was parked by the door. During an observation on 12/13/24 at 4:31 p.m. Two visitors walked up to the outside door B hallway door and stopped outside the B wing door. They stood there, read a sign, and walked around to the front door. A sign on the inside of the door read leaving with a resident SNRC? please sign them out at the nurse's station. Outside sign said, Visitors must enter through the front door for resident safety, we are no longer allowing entry through the side doors. During an interview on 12/11/24 at 5:30 p.m. LVN A stated she was the charge nurse on B hallway where Resident #40 resided. LVN A stated she had never seen the resident with alcohol or appearing to be drunk. During an interview on 12/13/24 at 4:40 p.m. CNA D stated she worked on the B hallway and had never seen Resident #40 with a beer or appearing drunk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/12/24 at 10:24 a.m. the Administrator stated residents could have visitors at any hours. The Administrator stated visitors should come in the front doors only. The Administrator stated visitors should not have codes to the door and they were working to remove those codes. During an interview on 12/12/24 at 1:29 p.m. the DON stated they had what they called champions who would round on assigned residents to see if they needed anything and look for prohibited items. The DON stated the previous BOM was supposed to be Resident #40's champion but no longer worked at the facility and they overlooked this. The DON stated the Resident would be reassigned to a new department head. The DON stated Resident #40 had received psychiatric services, but they had never stated he had a substance use issue. The DON stated she only saw him drinking in the parking lot next to the facility on e time and it was his birthday. The DON stated that was when she added it to the care plan. The DON stated they would monitor him going forward. The DON stated the beer could have interactions with the resident's medications and could lead to all kind of other issues. The DON stated they had ordered new keypads for the door since they could not remove the older codes but for the time they had locked the doors from the outside. Record review of the facility's document Nursing Home List of Items Not Allowed in Resident Room, dated 5/6/2005, stated Medications: (includes all prescription and over-the-counter drugs, expect emergency items like nitro-glycerin, which must be ordered by the doctor through the Nursing Home) and in certain situations where the resident is allowed to self administer as per care plan . Mentholatum, Vicks, deep heat .Safety Hazards .AEROSOL CANS of any product are combustible .

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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** 45857 Based on observation, interviews, and record review, the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice for 2 of 6 (Resident #25 and Resident #34) residents reviewed for respiratory care. The facility failed to ensure Resident #25 and Resident #34 had an oxygen sign posted on their door to alert they had an oxygen tank and concentrator in their room. This deficient practice could place residents at risk for an increase in respiratory complications and make other unaware oxygen is in use. The findings included: Record review of Resident #25's Admission Record, dated 12/13/24, revealed an [AGE] year-old female admitted on [DATE], and readmitted on [DATE] with diagnoses of Alzheimer's disease, chronic kidney disease stage 3, and seizures. Record review of Resident #25's significant change MDS assessment, dated 12/4/24, revealed the resident's cognition was severely impaired. Section O showed the resident received oxygen therapy. Record review of Resident #25's care plan, dated 12/11/24, revealed the resident had risk for altered respiratory status/difficulty breathing related to allergies with an intervention to provide oxygen as ordered. Record review of Resident #25's order summary, dated 12/11/24, revealed an order for may apply oxygen at 2-3 liters per minute as needed for dyspnea or low oxygen saturation with a start date of 11/26/24, and no end date. During an observation on 12/10/24 at 10:15 a.m. an oxygen concentrator and portable oxygen tank were observed in Resident #25's room. There were no signs on or around the resident's room alerting there was oxygen. Record review of Resident #34's Admission Record, dated 12/13/24, revealed a [AGE] year-old male admitted on [DATE], and readmitted on [DATE] with diagnoses of atrial fibrillation (fast irregular heart rhythm), sleep apnea, and influenza due to unidentified influenza virus with other respiratory manifestations. Record review of Resident #34's quarterly change MDS assessment, dated 11/12/24, revealed the resident's cognition was intact for daily decision making. Section O did not show the resident received oxygen therapy. Record review of Resident #34's care plan, dated 12/11/24, revealed the resident had altered cardiovascular status related to hyperlipidemia (high cholesterol) with interventions to give oxygen as ordered by the physician. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #25's order summary, dated 12/11/24, revealed an order for oxygen per nasal cannula 1-2 liters per minute as needed for shortness of breath, with a start date of 3/22/24, and no end date. During an observation on 12/10/24 at 11:28 a.m. Resident #34 was in his room with oxygen tubing on. No sign was noted on or around the resident's door to indicate he had oxygen in the room. During an interview on 12/11/24 at 5:29 p.m. LVN A stated they are supposed to use oxygen signs for all residents who have oxygen. LVN A stated Resident #25, #34 and #11 all had oxygen in their rooms on B hall way and should have signs but did not. LVN A stated the signs needed to be up because no one should be smoking in the rooms. During an interview on 12/11/24 at 5:47 p.m. the ADON stated residents with oxygen should have signs posted so people know they are on oxygen and not to use anything with flames or sparks nearby. During an interview on 12/13/24 at 1:31 p.m. the DON stated residents with oxygen should have signs on the door because it is combustible. The DON stated they added the signs as soon as it was brought to their attention. Record review of the facility's policy titled Oxygen Administration, dated 2/13/2007, stated .The administration, monitoring of responses, and safety precautions associated with it are performed by the nurse .11. Place NO SMOKING signs in area when oxygen is administered and stored. Store oxygen cannister in an area free of flammable substances. Avoid the use of electrical appliances in the area of oxygen use as well

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 41095 Based on interview and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 42 days (5/11/24, 6/4/24, 6/5/24, 6/6/24, 6/7/24, 6/8/24, 6/10/24/, 6/12/24, 6/13/24, 6/14/24, 6/17/24, 6/18/24, 6/21/24. 6/22/24. 6/25/24, 6/27/24, 6/28/24, 6/29/24,7/1/24, 7/3/24, 7/5/24, 7/8/24, 7/9/24, 7/10/24, 7/11/24, 7/12/24, 7/13/24, 7/15/24, 7/16/24, 7/17/24, 7/18/24, 7/19/24, 7/20/24, 7/21/24, 7/22/24, 7/23,24, 7/24/24, 7/27/24, 7/28/24, 8/1/24, 8/2/24 and 8/12/24) of 184 days reviewed for nursing services. The facility had no RN coverage for 5/11/24, 6/4/24, 6/5/24, 6/6/24, 6/7/24, 6/8/24, 6/10/24/, 6/12/24, 6/13/24, 6/14/24, 6/17/24, 6/18/24, 6/21/24. 6/22/24. 6/25/24, 6/27/24, 6/28/24, 6/29/24,7/1/24, 7/3/24, 7/5/24, 7/8/24, 7/9/24, 7/10/24, 7/11/24, 7/12/24, 7/13/24, 7/15/24, 7/16/24, 7/17/24, 7/18/24, 7/19/24, 7/20/24, 7/21/24, 7/22/24, 7/23,24, 7/24/24, 7/27/24, 7/28/24, 8/1/24, 8/2/24 and 8/12/24 for a total of 42 days from May 11, 2024 through August 12, 2024. This failure could result in residents not receiving the required services to meet their needs. The findings were: Record review of the CMS PBJ staffing data report run date 11/27/24 for quarter 3 (April 1 - June 20) revealed the facility triggered for no RN hours on 5/11/24, 6/4/24, 6/5/24, 6/6/24, 6/7/24, 6/8/24, 6/10/24/, 6/12/24, 6/13/24, 6/14/24, 6/17/24, 6/18/24, 6/21/24. 6/22/24. 6/25/24, 6/27/24, 6/28/24, 6/29/24. Record review of the facility timesheets revealed no RN coverage for 7/1/24, 7/3/24, 7/5/24, 7/8/24, 7/9/24, 7/10/24, 7/11/24, 7/12/24, 7/13/24, 7/15/24, 7/16/24, 7/17/24, 7/18/24, 7/19/24, 7/20/24, 7/21/24, 7/22/24, 7/23,24, 7/24/24, 7/27/24, 7/28/24, 8/1/24, 8/2/24 and 8/12/24. During an interview on 12/12/24 at 10:01 a.m. the DON stated she worked at a minimum of 40 hours a week Monday through Friday but often worked outside her normally scheduled hours but is salaried and does not clock in or out so her hours were not recorded on a time sheet. The DON stated she just started working at the facility on 07/17/24 as the full time DON. During an interview on 12/13/24 at 3:00 pm with the previous Administrator B (who now works at a sister facility), she stated they did not have a DON during June and July but were trying to fill shifts. She stated we had an interim and our regional nurse who is an RN was coming in to help and also did things remotely. She also stated they put in an interim DON in August and she stayed until the current DON was hired. The Administrator stated they were actively trying to find a DON or get an RN to fill in to meet RN requirements but it was difficult to find an RN due to the competition for nursing staffing.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observation, interview, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 3 of 3 medication carts (medication A hall cart, medication B hall cart, and medication C hall cart) and 1 of 1 medication storage room reviewed for medications and pharmacy services, in that 1. The facility failed to maintain glucometer logs. 2. The facility failed to ensure expired supplies were discarded. 3. The facility failed to ensure loose pills were not stored in the medication cart. 4.) The facility failed to ensure staff administered Resident #39's omeprazole (antacid) and the ordered dose of polyethylene glycol (laxative). This failure could place residents at risk for not receiving therapeutic effects of treatments. The findings included: 1. During an observation and interview on [DATE] at 2:29 p.m. Nursing medication cart for the B hallway contained a glucometer and log for [DATE]. The log was blank for the 4th and 5th of December. The log did not specify the glucometer that was being tested . LVN A stated night shift would check the glucometers nightly to ensure they were working properly. LVN A stated she never checked to see if the nightly controls were being done. LVN A stated if the meter was ever not working, she would just use the one from the other nursing cart. During an observation on [DATE] at 2:37 p.m. Nursing medication cart for the C hallway contained a glucometer and log for [DATE]. The log was blank for the 4th, 5th, and 6th of December. The log did not specify the glucometer that was being tested . LVN C stated night shift would check the glucometers nightly to ensure they were working properly. LVN C stated she never checked to see if the nightly controls were being done. LVN C stated there was no way to know which glucometer went to which log because the log did not specify. 2. During an observation on [DATE] at 2:25 p.m. the medication storage room contained a box of IV alcohol caps with an expiration date of [DATE]. 3. During an observation on [DATE] at 2:10 p.m. medication cart for the A hallway had a medication cup with 2 pills in it. LVN B stated she had put them there to give to a resident who was due to take them at 1 p.m. LVN B stated she should not keep the pills like that and would discard them. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 1:20 p.m. the DON stated staff cannot store pills ahead of time because of infection control, they could lose track of what they gave, and give the medication again, or miss a dose. The DON stated staff should go through the MAR at the time of medication administration, dispense the pill, and then document what you administered. The DON stated the IV caps should be discarded. The DON stated they started new logs for the glucometers that contain an area for which meter was being checked and the meters were also labeled. The DON stated night shift was expected to check the glucometers each night to ensure they were working properly. The DON stated they are tested to ensure they are in the appropriate range so when you test a resident's blood glucose you know you are getting an accurate reading for treatment. Record review of the facility's policy titled Medication Administration Procedures, dated [DATE], stated .3. Open the unit dose package only when you are administering medication directly to the resident. Removing the medication from its unit dose packaging in advance lessens the ability to positively identify the medication and increases the chance of drug administration errors and contamination . 4. Record review of Resident #39's Admission Record, dated [DATE], revealed an [AGE] year-old female admitted on [DATE], and readmitted on [DATE] with diagnoses of fractured sacrum, hypertension, Alzheimer's Disease, and depression. Record review of Resident #39's quarterly MDS assessment, dated [DATE], revealed the resident's cognition was severely impaired. Record review of Resident #39's care plan, dated [DATE], revealed the resident had bladder incontinence, Parkinson's, took an antidepressant, and potential for uncontrolled pain related to fracture of sacrum and to monitor for constipation. Another area stated she had an alteration in gastrointestinal status related to vascular disorder of intestine and to avoid snacks that aggravate the condition. Record review of Resident #39's order summary, dated [DATE], revealed orders for: - polyethylene glycol 3350 give 17 grams orally one time a day for constipation mix in ,d+[DATE] oz fluid, with a start date of [DATE], and no end date. -20 mg of omeprazole give 1 capsule orally one time a day for indigestion do not crush or chew in the morning with meals. Record review of Resident #39's nursing progress notes, dated [DATE], revealed no nursing notes about any deviations in medication administration from physician orders on [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on [DATE] at 7:36 a.m. LVN B prepared to administer medications to Resident #39. LVN B had 4 blister packs of medication outside of her cart to administer. LVN B had 3 pills in the medication cup. LVN B put all the medication back in the cart and locked it. LVN B did not dispense the 20 mg capsule of omeprazole. This surveyor asked LVN B how many pills she was supposed to be giving. LVN B went back to her computer to look at the MAR. LVN B then removed the medication blister packs and stated she forgot the omeprazole. LVN B then went to give Resident #39 her medications. The resident was eating in the dining room. LVN B stated she needed to take her medications. Resident #39 stated she did not want to take all the polyethylene glycol mixture. LVN B stated okay and discarded the remaining amount. About , d+[DATE] of the medication was discarded. LVN B documented all the polyethylene glycol mixture was administered. During an interview on [DATE] at 1:14 p.m. the DON stated there are different options to choose from when a resident refuses a medication. The DON stated staff should go back and document what the resident took. The DON stated staff should be looking at the MAR at the time they are dispensing medications to ensure they are giving the right medications. The DON stated the resident took omeprazole for a chronic gastrointestinal problem and it could cause the resident to have an upset stomach if she missed a dose. Record review of the facility's policy titled Medication Administration Procedures, dated [DATE], stated .5. After the resident has been identified, administer the medication and immediately chart doses administered on the medication administration record. It is recommended that medication be charted immediately after administration, but if facility policy permits, medication may be charted immediately before administration. Initials are to be used. Check marks are not acceptable. During the medication administration process, the unlocked side of the cart must always be in full view of the nurse. All nurses administering medication must sign and initial the designated area of each resident's medication/treatment administration record or resident specific master signature log for identification of all initials used in charting. If a dose of regularly scheduled medication is withheld or refused, the nurse is to initial and circle the front of the medication administration record in the space provided for that dosage administration and an explanatory note is to be entered in the nursing notes or in the PRN nurses notes section of the medication administration record .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41095 Based on interview and record review, the facility failed to ensure residents' pharmacist medication regimen review recommendations were reviewed by the resident's attending physician and what, if any, action has been taken to address them, for 2 of 4 residents (Residents #4 and #16) reviewed for pharmacy services. The facility failed to ensure the pharmacist's recommendations to Residents' #4's and #16's physician were reviewed by the physician for medication regimen review. This failure could place residents at risk for significant health status declines and could place residents on psychoactive medications at risk for possible adverse side effects, adverse consequences, and decreased quality of life. Findings include: Resident #4 Record review of Resident #4's Admission Record, dated 12/13/24, revealed a [AGE] year-old female admitted on [DATE] with diagnoses of dementia, chronic atrial fibrillation, and psychotic disorder with delusions due to know physiological condition, and major depressive disorder. Record review of Resident #4's quarterly MDS assessment, dated 9/20/24, revealed the resident's cognition was moderately impaired for daily decision making. Section N revealed she took an antipsychotic and antidepressant. Record review of Resident #4's care plan, dated 12/13/24, revealed the resident required anti-psychotic medications with interventions to consult with pharmacy, MD to consider dosage reduction when clinically appropriate. Record review of Resident #4's order summary, dated 12/13/24, revealed an order for quetiapine fumarate 100 mg, give 1 tablet by mouth, one time a day, related to psychotic disorder with delusions due to know physiological condition, with a start date of 10/10/23, and no end date. Record review of Resident #4's medication regimen review, dated 10/29/24, reflected it was not completed by the MD. The pharmacist recommended a gradual dose reduction attempt for quetiapine fumarate 100 mg. During an interview on 12/13/24 at 11:45 a.m. the DON stated they would need to check in medical records to see if they had a form that the provider reviewed. The DON stated they would need to check to see if the provider had any notes from visits since 8/20/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/13/24 at 2:30 p.m. the former Administrator brought in a medication review form that was filled out by the provider but was not dated. She stated that was how the provider's office sent it on 12/13/24. At 2:50 p. m. they brought in a form that was faxed on 12/13/24 and dated 11/1/24 where the provider stated the resident needed to continue with the same dose to prevent injury to patient, other residents, and staff. Resident #16 Record review of Resident #16's Admission Record dated 12/13/24 documented a [AGE] year old female originally admitted to facility 05/14/25 with the most current admission on 01/08/19. Resident #16's diagnoses included bipolar disorder, personal history of traumatic brain injury, mild cognitive impairment of uncertain or unknown etiology, major depressive disorder, anxiety disorder and glaucoma. Record review of Resident #16's Physicians Orders as of 12/13/24 revealed an order for Zoloft dated 03/05/23 for 50 mg Zoloft (Sertraline) one time a day related to Major Depressive Disorder, Recurrent, Unspecified - Give with the 100 mg to = 150 mg. Additionally, Resident #16 had an order as of 10/30/23 for Zoloft 100 mg to give orally two times per day. Record review of Resident #16's Pharmacy Regimen Review dated 08/26/24 recommended a GDR (Gradual Dose Reduction) for the Zoloft 150 mg daily. Record review of Resident #16's medical chart did not indicate that the physician had addressed the recommendation as of 12/12/24. Interview with the DON on 12/12/24 at 10:01 am revealed that the facility's Medical Records clerk hand delivered the Pharmacy Recommendations to the physicians' office on the day after the recommendations were received. The DON stated The doctors, including the Medical Director, want to ignore the pharmacy recommendations since they don't like to be told what to do. The DON stated it often takes a couple of months before they receive the recommendations back. The DON acknowledged that the recommendation to do a GDR for Resident #16's Zoloft had not been addressed. The DON stated they had to abide by the physician's recommendation. On 12/13/24, the DON gave the surveyor a faxed copy of the Medication Regimen Review form for Resident #16 dated and signed by the physician on 12/13/24 which stated the risk of clinical deterioration outweighs benefit of recommended change. 45857

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observation, interviews, and record review, the facility failed to maintain clinical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident # 5) of 8 residents reviewed for accuracy and completeness of clinical records. 1. The facility failed to ensure nursing staff did not document they put on compression stocking on Resident #5 when they did not put them on. This failure could affect any residents who have medical records and could result in misinformation about professional care provided. Findings included: 1. Record review of Resident #5's Admission Record, dated 12/13/24, revealed a [AGE] year-old female admitted on [DATE], and readmitted on [DATE] with diagnoses of non-ST elevation myocardial infarction (type of heart attack that occurs when a coronary artery is partially blocked, reducing blood flow to the heart muscle), hypertensive heart disease without heart failure (group of heart conditions that are caused by long-term high blood pressure), peripheral vascular disease (a progressive disorder that occurs when blood vessels outside of the heart and brain narrow, block, or spasm), need for assistance with personal care, unsteadiness on feet, reduced mobility, and chronic atrial fibrillation (a type of heart arrhythmia that occurs when the heart's upper chambers beat irregularly and quickly). The admission record showed she was a DNR. Record review of Resident #5's quarterly change MDS assessment, dated 11/20/24, revealed the resident had mild cognitive impairment for daily decision making. Record review of Resident #5's care plan, dated 12/10/24, revealed the resident had peripheral vascular disease with a goal for extremities to be free from pain, pallor, rubor, coldness, and edema. With interventions of apply compression stockings as ordered. Record review of Resident #5's order summary, dated 12/10/24, revealed an order for: -apply knee high compression stockings bilateral every day shift every Mon, Wed, Fri with a start date of 11/03/23 and no end date. -apply knee high compression stockings bilateral one time a day every Tue, Thu, Sat, Sun with a start date of 11/04/23 and no end date. Record review of Resident #5's MAR, dated 12/11/24, revealed the resident had her compression socks applied on 12/10/24 and 12/11/24 during the day shift. Record review of Resident #5's medication admin audit report, dated 12/12/24, revealed on 12/11/24 LVN A documented she applied the knee-high compression stockings at 6:36 a.m. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 12/10/24 at 1:24 p.m. Resident #5 stated her legs and feet were swollen. She stated she asked staff to put her compression socks on but they had not. Resident #5 lifted her blanket up and her lower legs and feet edematous (abnormally swollen with fluid or relating to or affected with edema). Resident #5 had on non-skid socks. During an observation and interview on 12/11/24 at 11:40 a.m. Resident #5 was in the dining room. She had on regular ankle socks and her feet were swollen. Resident #5 stated they had given her a shower that morning and put regular ankle socks on her after. During an observation and interview on 12/11/24 at 4:30 p.m. Resident #5 had on regular ankle socks. LVN A stated they monitor the resident's edema to her legs, they apply compressions socks every Monday Wednesday and Friday. LVN A stated the resident was supposed to get a shower that morning, so they removed the socks, put them back on the resident, and removed the socks again around 1 p.m. that day. Resident #5 stated again that she never had on compression socks at all that day. During an interview on 12/11/24 at 5:48 p.m. the ADON stated she was unsure why Resident #5 did not have her compression socks put back on after her shower. The ADON stated when it was not the resident's shower day the night shift nurse would place the socks on the resident around 6 a.m. before the end of their shift. The ADON stated Resident #5's order was for them to be worn during the day and removed at bedtime. Record review of the facility's policy titled Documentation, dated 2003, stated Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident. It includes observations, investigations, and communications of the residents involving care and treatments. It has legal requirements regarding accuracy and completeness, legibility, and timing . 1. The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets. 2. The facility will ensure that information is comprehensive and timely and properly signed. Procedure . 3. Place all required and appropriately signed forms in the clinical record. Items such as copies of advance directives, consent for treatment, consents for specific procedures, consult results, laboratory, diagnostic procedures, history and physical reports, nursing documentation .

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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 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** 41095 Based 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 3 (Resident #25, Resident #26, Resident #43) of 16 residents and 1 (Hall A Medication cart) of 3 medication carts observed for infection control. 1. The facility failed to initiate enhanced barrier precautions for Resident #25, #26 and #43 who all required enhanced barrier precautions. 2. The facility failed to ensure an employee's name tag was not stored in a box of clean disposable wooden spoons used to mix crushed medications with food. These failures could place residents at risk for spread of infection and cross contamination. Findings include: Resident #25 Record review of Resident #25's Admission Record, dated 12/13/24, revealed an [AGE] year-old female admitted on [DATE], and readmitted on [DATE] with diagnoses of Alzheimer's disease, chronic kidney disease stage 3, and seizures. Record review of Resident #25's significant change MDS assessment, dated 12/4/24, revealed the resident's cognition was severely impaired. Section M showed the resident had a skin tear and used a pressure reducing device for bed, application of nonsurgical dressings, application of ointments/medications for treatments. Record review of Resident #25's care plan, dated 12/11/24, revealed the resident had potential for pressure ulcer development due to decreased mobility, impaired cognition, and frequently incontinent with interventions to assess skin condition weekly and as needed, record all findings. Enhanced barrier precautions were not mentioned in the care plan. Record review of Resident #25's nursing progress notes, dated 11/13/24, revealed: -11/29/24 Initial skin assessment written by ADON .Skin Tear Present: Yes. Location, measurements of skin tear: Left ankle, 3cm in length . -12/03/24 Nursing note written by LVN A Res had order for Monitor skin tear to left ankle with steri strips in place; res has open area to left lower leg. Hospice wrote new order for Left Lower Leg- Cleanse with wound cleanser- apply TAO and cover with non-adherent dressing daily and prn. Family notified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675938	A. Building B. Wing	12/13/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-12/12/24 Nursing note written by LVN A RECEIVED CLARIFICATION TX ORDER FROM HOSPICE NURSE. CLARIFICATION TX ORDER: FULL THICKNESS WOUND TO LEFT LOWER LEG-- CLEANSE WITH WOUND CLEANSER, APPLY CALCIUM ALGINATE AND COVER WITH SECONDARY DRESSING OF CHOICE 3X WEEKLY AND PRN. Record review of Resident #25's order summary, dated 12/11/24, revealed an order for cleanse left lower leg with wound cleanser, apply medihoney and calcium alginate and cover with dry dressing three times a week, every day shift Tuesday, Thursday, and Saturday for wound healing, with a start date of 12/6/24, and no end date. No order for EBP was found. During an observation on 12/10/24 at 10:10 a.m. no Enhanced Barrier Precaution signs or PPE bins were observed outside any resident rooms for Resident #25, #26 or #43. Unidentified staff were observed pushing Resident #25 into her room to transfer her to bed. The staff did not have on gowns or gloves when touching the resident. During an observation on 12/12/24 at 1:32 p.m. Resident #25 had a sign added that showed she was on EBP and a PPE cart was located outside the resident's room. Resident #25 had drainage on her left sock. The resident had an approximately dime size wound that was 2-3 cm deep on her lateral lower left leg above her ankle. At 12:44 p.m. A nurse provided wound care while wearing a gown and gloves to the wound. Resident #26 Record review of Resident #26's Admission Record dated 12/13/24 documented a [AGE] year-old female admitted on [DATE] with diagnoses that included end stage renal disease, emphysema (chronic lung disease), chronic systolic (congestive) heart failure (a condition where the left ventricle of the heart is weakened and can't pump blood effectively), renal osteodystrophy (a complication of chronic kidney disease that weakens the bones) and dependence on renal dialysis. Record review of Resident #26's 5-day Medicare Part A MDS assessment dated [DATE] showed a BIMS score of 14 indicating resident was cognitively intact. During an interview with Resident #26 on 12/11/24 at 10:51 am, resident stated she goes to dialysis 3 times per week. She has a dialysis port in her arm but also has a temporary central port in her chest. Resident #26 stated staff have never worn gowns during her care. Record review of Resident #26's Care Plan revealed a Focus of Resident is on enhanced barrier precautions with an initiated date of 12/12/24. Record review of Resident #26's current Physicians Orders active as of 12/12/24 did not reveal an order for Enhanced Barrier Precautions. Resident #43 Record review of Resident #43's Admission Record dated 12/13/24 documented an [AGE] year-old male admitted to facility 11/19/24 with diagnoses that included muscle weakness; localized swelling, mass and lump, lower limb, bilateral; and other spondylosis with myelopathy, lumbar region (a neurological condition that occurs when spinal cord is compressed due to age-related changes). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #43's Physician Orders with active orders as of 12/13/24, included Provide catheter care every shift and to change foley catheter using 16 Fr or coude (a type of catheter with a curved tip used to navigate the urethra) 10 cc bulb as needed. There was no order for Enhanced Barrier Precautions. Record review of Resident # 43's Baseline Care Plan dated 12/11/24 had a Focus of The resident has indwelling catheter. New catheter placed 11/30/24. There were no interventions or focus areas for ensuring enhanced barrier precautions were implemented. Record review of Resident #43's Revised Care Plan dated 12/11/24 had a Focus of Resident is on enhanced barrier precautions with Date Initiated: 12/10/24. Observation of Resident #43's room on 12/10/24 at 2:32 pm did not reveal any signs or a PPE bin for Enhanced Barrier Precautions. Observation of Resident #43's room on 12/11/24 revealed a sign regarding Enhanced Barrier Precautions and a PPE bin had been placed in front of resident's door. Record review of Resident #43's physicians order summary report with active orders as of 12/13/24 did not reveal an order for Enhanced Barrier Precautions. During an interview on 12/12/24 at 12:53 p.m. the DON stated she was unaware Resident #25 had an open draining wound until 12/12/24. The DON stated Resident #25 should have been on EBP. The DON stated she was unaware that Resident #26 had a central port because they had not accessed it. The DON stated Resident #43 had a catheter and should have been on enhanced barrier precautions but was not until 12/10/24. The DON stated EBP should be used for any residents with an open area to prevent infections. 2. During on observation on 12/11/24 at 2:20 p.m. a box of disposable wooden spoons used to mix residents medication with food was on the bottom of the A hall nursing cart. In the box was a name tag from a CNA. The name tag was sitting on top of the spoons and touching them. During an interview on 12/11/24 at 2:21 p.m. LVN B and the DON stated the name tag should not be in the box and they would throw away the whole box because it was contaminated. The DON took the box out of the medication cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility document titled Enhanced Barrier Precautions, dated 4/1/24, stated Multidrug-resistant organism ([NAME]) transmission is common in long term care (LTC) facilities. Many residents in nursing homes are at increased risk of becoming colonized and developing infections with MDROs. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. A single set of PPE cannot be used for more than 1 patient. EBP are indicated for residents with any of the following: Colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply (see MDRO list on page 3); or Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (e.g., Band-Aid(R)) or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. A peripheral intravenous line (not a peripherally inserted central catheter) is not considered an indwelling medical device for the purpose of EBP . Record review of the facility's policy titled Fundamentals of Infection Control Precautions, dated 03/24, stated A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control precautions . 45857