STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675972	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrollton Health and Rehabilitation Center	1618 Kirby Rd Carrollton, TX 75006

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 27070 Based on observation, interview and record review, the facility failed to ensure all assistive devices, wheelchairs were maintained and free of hazards for three (Residents #4, #40, and #55) of 6 residents reviewed for essential equipment. The facility failed to properly maintain wheelchairs for Residents #4, #40, and #55. The failure could place residents at risk for equipment that is in unsafe operating condition, that could cause injury. Findings included: Review of Resident #40's quarterly MDS assessment, dated 03/07/2025, reflected she was an [AGE] year-old male admitted to the facility on [DATE], with diagnoses of Dementia (confusion), cerebral vascular accident (stroke), and instability on feet. Review of the Resident #40's plan of care dated 04/17/2025 with updates reflected goals and approaches to include wheelchair mobility. Observation on 05/04/2025 at 12:00 p.m. revealed Resident #40 confused, was sitting in her wheelchair in the dining room and had no skin problems. The wheelchair's right armrest was cracked with exposed foam. Review of Resident #4's quarterly MDS assessment, dated 03/11/2025, reflected he was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Heart Failure (weak heart), hypertension (high blood pressure), weakness, and unsteady on feet. Review of the Resident #4's plan of care dated 03/18/2025 with updates reflected goals and approaches to include wheelchair mobility for locomotion. Observation on 05/04/2025 at 12:07 p.m. revealed Resident #4, confused, was sitting in her wheelchair, in the dining room and had no skin problems. The wheelchair's right armrest was cracked with exposed foam. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #55's quarterly MDS assessment, dated 03/11/2025, reflected she was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses of Hypertension (high blood pressure) heart failure (weak heart), dementia (confusion), unsteadiness, and muscle weakness. Review of the Resident #55's plan of care dated 03/13/2025 with updates reflected goals and approaches to include wheelchair mobility. Observation on 05/04/2025 at 12:10 p.m. revealed Resident #55 was in her wheelchair in the dining room, and the wheelchair's right armrest was cracked with the foam exposed. There were no skin tears on the residents arms. In an interview on 05/04/2025 at 12:11 p.m. with Resident #55, who spoke broken English, and the assistance of her table mates Resident #55 stated she was fine with her wheelchair, but if she could get it fixed that would be better. In an interview on 05/05/24 at 11:20 a.m. CNA E stated when a resident's wheelchair needed repair she would report it to the nurse in charge. CNA E stated she had never written anything in the computer though; she usually told the nurse in charge. In an interview on 05/04/2025 at 12:00 p.m. RN F stated when a resident's wheelchair needed repair the staff were to tell the maintenance man. The RN stated he would try to find a new wheelchair that was not being used. In an interview on 05/05/2025 at 11:46 a.m. the Maintenance Director stated he and his assistant repaired the wheelchairs when there were needed repairs. He stated staff were to place the needed repairs in the electronic system. The Maintenance Director was informed about the residents' wheelchairs condition, and he stated if the wheelchairs' issues had not been placed in the electronic system for repair he would not know. The Maintenance Director stated that all staff could place information about needed repairs in the electronic system. The Maintenance Director stated the staff told him or his assistant about repairs that were needed , including wheelchairs, but he told the staff if they did not place the information in the electronic system, and he could not remember and keep up with the needed repairs. The Maintenance Director stated sometimes he would enter the information himself, so the equipment could be repaired. A review of the electronic maintenance system with the ADON on 05/06/2025 reflected there were no entries that indicated residents' wheelchairs needed the armrest repaired for the March- May 2025 In an interview on 05/06/2025 at 8:39 a.m. with the Administrator revealed the wheelchairs that required repair should be placed in the electronic system. Then Administrator stated they had in-serviced the staff on how to use the system. The staff would just forget and then the staff would just tell the maintenance department and then they could not keep up. The Administration stated they had started a new in-service yesterday with the entire staff. In an interview on 05/06/2025 at 11:00 a.m. the Administrator stated that the facility had no policy and procedure related to equipment repair.

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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** 27070 Based on observation, interview and record review, the facility failed to ensure the accurate acquitting, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 of 4 (Resident #56) for medication pass 1. RN D failed to follow physician orders to administer Resident #56's ASA (aspirin) capsule 81 mg per G-tube (feeding tube), and instead administered chewable ASA 81 mg per G-tube. RN D failed to check the medication room and to inquire of the other nursing staff if the staff had the appropriate ASA on their medication carts. 2. RN D failed to follow physician order to administer Resident #56's Calcium D (vitamin supplement) oral tables 600-400 mg and administered Over the counter Calcium D. RN D did not mix the Calcium D completely prior to administering the medication per G-tube. 3. RN D failed to administer Resident #56's Maalox (anti-acid) (aluminum/magnesium) Suspension, Suspension 200-200-20 5 ml 30 cc per G-tube. RN D administered Geritol 5 ml instead. These failures could place residents at risk for not receiving therapeutic dosages of their medications as ordered by the physician and a decreased health status. Findings included: These failures could place residents at risk for not receiving therapeutic dosages of their medications as ordered by the physician and a decreased health status. Findings included: Record review of Resident #56's quarterly MDS assessment, dated 02/05/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #56 had diagnoses which included: Cerebrovascular Accident (stroke), hemiplegia (paralysis) and muscle weakness and atrophy with multiple sites (arms and legs weak). Resident #56 was cognitively confused at times and unable to make decisions and required assistance of two staff for activities of daily living. Review of Resident #56's Physician's Order dated 04/02/24 and updated 03/31/2025 reflected, ASA (used to prevent blood clots) capsules 81 mg via G-tube. Review of Resident #56's Medication Administration Record dated 04/01/2025 reflected there had been doses of the ASA 81 mg capsules via G-tube daily, prior to 05/04/2025. Observation on 05/04/2025 at 9:15 a.m., revealed RN D did not administered the following medication to Resident #56 correctly during morning medications. RN D did not provide the ASA 81 mg capsules to the resident, due to not having the medication available. RN D provided ASA 81 mg chewable instead, she had no available ASA 81 mg on her cart. RN D did not check the medication room and did not follow- up with the other staff to verify if any was available on the their medication carts. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #56's physician's order dated 12/06/2023 and updated 03/31/2025 reflected Calcium-D oral tablets 600-400 mg-unit give one table via G-Tube. Review of Resident #56's Medication Administration Record 04/01/2025 reflected there had been doses of the Calcium-D oral tablets 600 mg-400 mg-unit daily, prior to 05/04/2025. Observation on 05/04/2025 at 9:16 a.m., revealed RN D administered the following medication to Resident #56 per G-tube Calcium-D oral tablets 600 mg one tab. The RN had attempted to crush the medicine, inappropriately, and the medication would not mix well with the water to be administered down the G-tube. There was no direction on the bottle, but the RN stated that she knew something was wrong because the medication did not mix properly. RN D stated she would need to talk to her DON about that sometime. Review of Resident #56's physician's orders dated 04/18/2025 reflected Maalox (aluminum/magnesium Suspension 200-200-20 5 ml give 30 cc via G-tube. Review of Resident#56's Medication Administration Record 04/01/2025 reflected there had been doses of the Maalox 5 ml 300 per G-Tube prior to 05/04/2025. Observation on 05/04/2025 at 9:17 a.m., revealed Maalox (anti-acid) (aluminum/magnesium) Suspension, Suspension 200-200-20 5 ml 30 cc per G-tube, RN D administered Geritol 5 ml instead. In an interview on 5/04/2025 at 11:45 a.m. with RN D, she stated they were supposed to let the DON know if they did not have medication available to give, reorder the medication, and sometimes the medication room was checked to see if there were medications available. If the medicines were not available and they gave a substitute medicine, the medication should be an equal substitute for the medication they did not have. RN D stated they had to inform the doctor of what they have given. RN D stated the resident could suffer harm if they did not get the medications the doctor had ordered correctly. The RN stated that the medications should be given using the rules of dispensing, 1) look at the order on the Medication Administration Record, 2) pull the medications and compare, 3) place in the cup and check one last time that they were giving the correct medication. Then they enter the room, explain to the resident what you were giving and stay with the resident while they take the medications and make sure they have taken them. The RN D stated Resident #56 received his medications by the G-tube, the nurse must administer. RN D stated she did not know why she had given all the medicine substitutes that she did, incorrectly. RN D stated she gave the resident his medications all the time and she did not understand why she gave the wrong ones. She stated she was just very busy and running behind. In an interview on 05/04/2025 at 1:00 p.m. with Resident #56 revealed the resident could answer some yes and no questions by shaking his head. Resident #56 agreed he was taken care of at the facility and the staff was nice. Resident #56 agreed that he felt safe at the facility. Resident #56 refused to answer anymore questions, he wanted to sleep. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/06/2025 at 4:45 p.m., the DON revealed the staff who administered medications should always practice best practices. The DON stated the best practice would be to follow the three basic rules prior to administering the medications. The DON stated if the medication was not available, she needed to know. She could order the medications and the resident could receive the medications as ordered. The DON stated she would see that the staff administering medications had additional training, with follow-up for compliance. The DON stated that if the administering staff was considering giving a substitute for any medication, they should consult her or the physician first prior to giving the medication, not after giving. Review of the facility policy and procedure Administration of Medications dated July 2023 reflected, It is the policy of this Facility, medication shall be administered as prescribed by the resident's physician, nurse practitioner, or physician's assistance. Procedure: . 3. Medications must be administered in accordance with the written orders of the attending physician .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47855 Based on observation, interview and record review, the facility failed to ensure it was free of a medication error rate of five percent (5%) or greater for 3 of 30 opportunities during medication pass resulting in a 10 percent (10%) error rate for one (Residents #13) of 4 residents observed for medication pass. 1. RN D failed to administer Resident #56's ASA (aspirin) capsule 81 mg per G-tube (feeding tube), and instead administered chewable ASA 81 mg, as RN D had no ASA capsules 81 mg on her medication cart. 2. RN D failed to administer Resident #56's Calcium D (vitamin supplement) oral tables 600-400 mg correctly. RN D crushed the incorrect Calcium D (that was not supposed to be crushed) and delivered by G-tube. 3. RN D failed to administer Resident #56's Maalox (anti-acid) (aluminum/magnesium) Suspension, Suspension 200-200-20 5 ml 30 cc per G-tube. RN D administered Geritol 5 ml instead. These failures could place residents at risk for not receiving therapeutic dosages of their medications as ordered by the physician and a decreased health status. Findings included: Record review of Resident #56's quarterly MDS assessment, dated 02/05/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #56 had diagnoses which included: Cerebrovascular Accident (stroke), hemiplegia (paralysis) and muscle weakness and atrophy with multiple sites (arms and legs weak). Resident #56 was cognitively confused at times and unable to make decisions and required assistance of two staff for activities of daily living. Review of Resident #56's Physician's Order dated 04/02/24 and updated 03/31/2025 reflected, ASA (used to prevent blood clots) capsules 81 mg via G-tube. Review of Resident #56's Medication Administration Record dated 04/01/2025 reflected there had been doses of the ASA 81 mg capsules via G-tube daily, prior to 05/04/2025. Observation on 05/04/2025 at 9:15 a.m., revealed RN D did not administered the following medication to Resident #56 correctly during morning medications. RN D did not provide the ASA 81 mg capsules to the resident, due to not having the medication available. RN D provided ASA 81 mg chewable per G-tube instead, she had no available ASA 81 mg on her cart. Review of Resident #56's physician's order dated 12/06/2023 and updated 03/31/2025 reflected Calcium-D oral tablets 600-400 mg-unit give one table via G-Tube. Review of Resident #56's Medication Administration Record 04/01/2025 reflected there had been doses of the Calcium-D oral tablets 600 mg-400 mg-unit daily, prior to 05/04/2025. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/04/2025 at 9:16 a.m., revealed RN D administered the following medication to Resident #56 per G-tube Calcium-D oral tablets 600 mg one tab per G-tube. The RN had attempted to crush the medicine, inappropriately, and the medication would not mix well with the water. There was no direction on the bottle, but the RN stated that she knew something was wrong because the medication did not mix properly. RN D stated she would need to talk to her DON about that sometime. Review of Resident #56's physician's orders dated 04/18/2025 reflected Maalox (aluminum/magnesium Suspension 200-200-20 5 ml give 30 cc via G-tube. Review of Resident#56's Medication Administration Record 04/01/2025 reflected there had been doses of the Maalox 5 ml 300 per G-Tube prior to 05/04/2025. Observation on 05/04/2025 at 9:17 a.m., revealed Maalox (anti-acid) (aluminum/magnesium) Suspension, Suspension 200-200-20 5 ml 30 cc per G-tube, RN D administered Geritol 5 ml instead. In an interview on 5/04/2025 at 11:45 a.m. with RN D, she stated they were supposed to let the DON know if they did not have medication available to give, reorder the medication, and sometimes the medication room was checked to see if there were medications available. If the medicines were not available and they gave a substitute medicine, the medication should be an equal substitute for the medication they did not have. RN D stated they had to inform the doctor of what they have given. RN D stated the resident could suffer harm if they did not get the medications the doctor had ordered correctly. The RN stated that the medications should be given using the rules of dispensing, 1) look at the order on the Medication Administration Record, 2) pull the medications and compare, 3) place in the cup and check one last time that they were giving the correct medication. Then they enter the room, explain to the resident what you were giving and stay with the resident while they take the medications and make sure they have taken them. The RN D stated Resident #56 received his medications by the G-tube, the nurse must administer. RN D stated she did not know why she had given all the medicine substitutes that she did, incorrectly. RN D stated she gave the resident his medications all the time and she did not understand why she gave the wrong ones. She stated she was just very busy and running behind. In an interview on 05/04/2025 at 1:00 p.m. with Resident #56 revealed the resident could answer some yes and no questions by shaking his head. Resident #56 agreed he was taken care of at the facility and the staff was nice. Resident #56 agreed that he felt safe at the facility. Resident #56 refused to answer anymore questions, he wanted to sleep. In an interview on 05/06/2025 at 4:45 p.m., the DON revealed the staff who administered medications should always practice best practices. The DON stated the best practice would be to follow the three basic rules prior to administering the medications. The DON stated if the medication was not available, she needed to know. She could order the medications and the resident could receive the medications as ordered. The DON stated she would see that the staff administering medications had additional training, with follow-up for compliance. The DON stated that if the administering staff was considering giving a substitute for any medication, they should consult her or the physician first prior to giving the medication, not after giving. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy and procedure Administration of Medications dated July 2023 reflected, It is the policy of this Facility, medication shall be administered as prescribed by the resident's physician, nurse practitioner, or physician's assistance. Procedure: . 3. Medications must be administered in accordance with the written orders of the attending physician .

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070 Based on interview and record review, the facility failed to provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Promptly obtain the Chest X-ray per the ordering physician's orders for one (Resident #39) of five residents reviewed for radiology services. The facility failed to obtain the chest X-ray and the results for Resident #39's chest in a timely manner, resulting in a delay to diagnosis Resident #39. The routine X-ray should be completed on the same day as ordered. This failure could place residents at risk of injury, pain and a delay in treatment. Findings included: Record review of Resident #39's electronic admission record revealed a [AGE] year-old female who admitted on [DATE] with a diagnoses that included Coronary Artery Disease (blocked arteries), Hypertension (high blood pressure), and Pneumonia (infection of the lungs). Record review of Resident #39's Quarterly MDS assessment, dated 04/17/2025, reflected the resident was cognitively alert and oriented with short periods of confusion. Resident #39 required the assistance of one staff member to assist with activities of daily living. Record review of Resident #39's care plan, undated, reflected Resident #39 was at risk for decline in self-care related to unsteady balance and weakness. Further review of the care plan revealed Resident #39 required assistance to maintain cognitive function due to diagnosis of Dementia. Staff was to report on changes in cognition, alertness, increased confusion, or difficulty in expressing herself. Record review of Resident #39's nurse's note, dated 04/07/2025 at 10:58 p.m., written by RN A revealed the resident was seen by the Physician Assistant during clinical rounds and has new orders as follow: 1. Chest x-ray X two views DX: cough . Record review of Resident #39's physician orders dated 04/07/2025 reflected a chest X-ray ordered for Resident #39 due to a cough. Record review of Resident #39's nurse's note, dated 04/08/2025 at 12:30 p.m., written by RN A revealed no complications noted related to cough, still awaiting the chest x-ray. Record review of Resident #39's progress note, dated 04/09/2025 at 12:05 p.m., written by the Physician Assistance revealed . F/u visit. Called by nurse to review lab results. Pt remains anxious & upset about her overall health issues .reviewed lab results .pending CXR .monitor for sob con't with POC . (continued on next page)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #39's nurse's note, dated 04/10/2024 at 2:31 p.m., written by RN B revealed Resident's X-ray . results received (CXR: Patchy Opacity is seen in the right lower lobe). Notified to PA. Got new order of tab cefdinir (antibiotic) 300 mg bid for 7 days for PNA (Pneumonia) and DuoNeb (inhalation treatment) q 8 hrs for 7 days. Order carried out and notified to resident and responsible party . Record review of Resident #39's Medication Administration Record dated 04/01/2025 reflected the Cefdinir 300mg BID and DuoNeb q 8 hrs for 7 days had been initiated on 04/10/2025 and continued for seven days. Record review of Resident #39's nurse's note dated 04/10/2025 through 04/17/2025 reflected the charge nurses were monitoring and documenting for any related changes of condition reflecting any side effects related to the antibiotics or changes noted related to the pneumonia. Further review reflected the nursing staff continued to monitor for seventy-two hours following the completion of the antibiotics for any related symptoms of the Pneumonia. Resident #39 had no further respiratory complications noted. Interview on 05/04/2025 at 2:00 p.m. with LVN C revealed the doctor or the Physician Assistant would order the X-ray, then the nurses must fill out a form and fax it to the X-ray company. The X-ray company would come and perform the X-ray, after the doctor reads the X-ray then the facility receive the X-ray results on the fax machine at the nurse's station. LVN C stated Resident #39, in April 2025, did have a chest X-ray ordered by the Physician Assistant because she had a cough, was weak and felt tired. The X-ray was not ordered STAT. The chest X-ray was ordered routine, that allowed the X-ray company to take their time to come and do the X-ray. The company took their time, instead of coming the same day or the next sometimes they came days after it was ordered. LVN C stated she continued to follow-up on Resident #39's X-ray but sometimes the X-ray company would tell them they were too busy to come. LVN C stated that sometimes they would refuse to come on the weekends, and they would have to send the resident to the hospital for the X-ray, the doctor had ordered. LVN C stated that had only happened one time, because she just started ordering everything STAT. LVN C stated this had been reported to the DON. Interview on 05/04/2025 at 2:07 p.m. with the Physician Assistant revealed that she had ordered a chest x-ray on Resident #39 as the charge had informed me she had a cough. I later spoke with the DON about the Chest X-ray not being completed timely. The DON tried to change the Chest X-ray to STAT, but the lab had already processed it as routine and did not change the order. The Chest X-ray was completed and the Resident was treated with antibiotics. The Physician Assistant stated the charge nurses were monitoring Resident #39 for any related changes, while we were waiting on the Chest X-ray. Interview on 05/04/2025 at 2:11 pm with RN D revealed she did not have problems related to having her residents X-rays completed timely, when the doctor ordered X-rays. RN D stated she ordered all her X-rays STAT and the X-ray company came no later than 5 hours on the same day. RN D stated she knew there had been a problem one time with getting an X-ray completed timely, so she just started ordering all her X-rays STAT. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrollton Health and Rehabilitation Center	1618 Kirby Rd Carrollton, TX 75006

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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/06/2025 at 9:15 a.m., with the DON revealed she was aware there had been a failure with Resident #39. The DON stated the nursing staff had ordered the chest x-ray routine, due to a cough. Upon follow-up the chest X-ray was changed to a STAT order, but the X-ray company got that messed up, and the X-ray was completed later. The DON stated she had spoken to the Physician Assistant about the chest X-ray and they had suggested maybe looking into a different company that was more customer service oriented. The DON stated Resident #39 had no other noted changes in her condition, so they waited until the chest X-ray was completed. The DON stated she had all the charge nurses start ordering all their X-rays STAT, until the facility found another X-ray company. The DON stated she had a meeting with another company scheduled for tomorrow (05/07/2025) because she needed the residents taken care of and the test needed to be timely with timely results, so the residents could be treated. Interview on 05/06/2025 at 12:20 p.m. with the Administrator revealed he was not aware there was a problem with the X-ray company. The Administrator was informed by the Surveyor, that the DON had a meeting scheduled on tomorrow (05/07/2025). The Administrator stated that was good because the facility needed a reliable X-ray company to service the residents, so they could be treated timely. On 05/06/2025 at 1:28 p.m. the DON stated the facility did not have any policy and procedure specific to X-rays/test results.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675972	A. Building B. Wing	05/06/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070 Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 2 (RN D) staff members and 1 of 5 residents (Residents #56) reviewed for infection control procedures. RN D failed to disinfect the blood pressure cuff in between blood pressure checks for Residents #56 and was observed using blood pressure cuffs on two other unknown residents. RN D failed to cleanse her hands following stoma care and prior to administering G-tube medications for Resident #56. The failures could place residents at risk for cross contamination and infections. Findings included: Record review of Resident #56's quarterly MDS assessment, dated 02/05/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #56 had diagnoses which included: Cerebrovascular Accident (stroke), hemiplegia (paralysis) and muscle weakness and atrophy with multiple sites (arms and legs weak). Resident #56 was cognitively confused at times and unable to make decisions and required assistance of two staff for activities of daily living. Record review of Resident #56's physician's orders dated 03/31/2025 reflected, midodrine HCL (high blood pressure) tablet 5 mg give 2 tablets via G-tube 3.125mg give one tab by mouth two times a day and to obtain blood pressure one time a day on each shift. Observation on 05/04/2025 at 9:12 a.m., revealed RN D taking the blood pressure machine into Resident #56's room to check his blood pressure and his oxygen saturation. The oxygen saturation was low and the RN D assessed and determined the stoma (opening in the neck that the resident breaths through) required cleaning and the resident was having difficulty breathing. RN D obtained a pair of tweezers that were in the room, began to pull out the crusted areas at the edge of the stoma on both sides, as the resident would allow. RN D then placed the tweezers back into the cup on the bedside table after cleaning with normal saline. Without removing her gloves or washing her hands, RN D used the blood pressure machine again to check the oxygen saturation of Resident #56, which had returned to normal. RN D then removed her gloves and gown, placing them in the trash and walked out of the room without washing her hands or using hand sanitizer. RN D then prepared Resident #56's medications and returned to Resident #56's room. RN D placed on another gown and a pair of gloves. RN D proceeded to give Resident #56 his medications via G-tube (feeding tube into stomach), and after completion RN D washed her hands after removing gown and gloves. RN D removed the blood pressure machine out of the room, did not wipe the machine down with Sani wipes and went into another resident's room to take a blood pressure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 05/04/2025 at 2:30 p.m., RN D stated if they did not wash their hands or use a hand sanitizer it could spread germs to other residents. RN D stated the equipment, like the blood pressures machine should be cleaned between every two residents, with Sani Wipes. The tweezers in Resident #56's room should be cleaned after each usage with Sani-Wipes. RN D stated she knew that, she was just nervous. An interview with the DON, who was the infection control preventionist, on 05/06/2025 at 9:15 a.m., revealed the DON stated that all direct care staff must clean equipment, including blood pressure cuffs after having contact with each resident, and Sani-wipes were available. The DON stated the staff should be wearing gowns and gloves and practicing infection control precautions when cleaning Resident #56's stoma. The staff should be washing their hands or using hand sanitizer after direct care contact with any resident. The DON stated when giving medications they should be cleaning their hands before and after and in between each resident. The DON stated, the staff had available the disinfectant wipes that would kill all germs. The DON stated the staff would be in-serviced on infection control and she would perform teaching concerning infection control. If they did not clean the blood pressure cuffs appropriately, they could spread germs to themselves and the residents. Record review of an in-service dated 04/23/2025 revealed RN D had received cleaning and properly storing equipment after each use, standard infection control precautions, and hand hygiene. Record review of the Facility's Policy titled Infection Prevention and Control dated revised 2007, reflected: I. Goals The goals of the Infection Control Program to: A. Decrease the risk of infection to patients and personnel II. Scope of the infection Control Program The Infection Control Program is comprehensive int hat it addressed detection, prevention, and control of infections among patients and personnel. The Major Activities of the Program are: . C. Prevention of Infection Staff and patient education is one to focus on risk of infection and practices to decrease risk. Policies, procedures and aseptic practices are followed by personnel in performing procedure and in disinfection of equipment. Record review of the Facility's Policy titled Routine Procedures Handwashing revised dated July 2014 reflected: It is the policy of this facility to cleanse hands to prevent transmission of possible infectious material and to provide clean, healthy environment for residents and staff. Purpose: hand washing/hand hygiene is generally considered the most important singe procedure for preventing the transmission.