STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676003	A. Building B. Wing	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azle Manor Health Care and Rehabilitation	721 Dunaway LN Azle, TX 76020

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 - Few	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** 48520 Based on interview and record review the facility failed to provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive for 1 of 8 residents (Resident #72) reviewed for advanced directives. The facility failed to ensure Resident #72 had a current copy of an advance directive in his medical record. This deficient practice could place residents at risk of not having their wishes known, which could delay emergency treatment . Findings include: Record review of Resident #72's face sheet, dated [DATE], reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included non-traumatic intracranial hemorrhage (this is stroke with brain bleed), stroke affecting left side, difficulty walking, and frontal lobe and executive deficit following other non-traumatic intracranial hemorrhage (this is when the frontal lobe of the brain is damaged due to bleeding and the skills it controls are impaired). His family was the party responsible and number one emergency contact. Record review of Resident #72's admission MDS, dated [DATE], reflected a BIMS of 10 out of 15, which indicated moderate cognitive impairment. Resident #72 required moderate assistance with ADLS , he was dependent on staff for mobility and wheelchair dependent. Resident #72 had other neurological conditions and was paralyzed on one side. Record review of Resident #72's hospital discharge, dated [DATE], reflected the following: Supportive/Palliative Care; Goals of Care: Rehabilitative focus Preference for life sustaining treatments; CPR/Code Status/Resuscitation Patient Wishes: DNR- I do not want any resuscitation, YES. Record review of the facility transfer orders, dated [DATE], reflected current and active procedures Do Not Resuscitate: DNR to be honored continuous. (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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #72's order, dated [DATE] , reflected Full Code order active [DATE]. Record review of Resident #72's care plan on, [DATE], care plan last reviewed on [DATE], reflected Resident #72 was a FULL CODE. The goal was Resident #72 would be kept as comfortable as possible and his wishes would be respected. He would have the right to full resuscitation within ethical/legal guidelines and according to his wishes. Target Date: [DATE]. His interventions were to ensure advanced directives were on his chart. In the event of a condition change, contact my family and/or refer to my advanced directives on file. -Keep my family updated on changes. -Mark chart to identify code status. Record review of admission progress note, by LVN E, dated [DATE] at 12:14 AM , reflected Resident #72 entered to [room number]; arriving via Stretcher. Transfer on arrival by [transport company name] Total dependence with Two person's physical assist. Reason for admission. Ordered therapies of: Physical Therapy Occupational Therapy Speech Therapy. Allergies: Bextra [Valdecoxib], Sulfa (Sulfonamide Antibiotics). Code status: FULL CODE; Code Status: Resuscitation In an interview with Resident #72's family on [DATE] at 01:43 PM, the family stated Resident #72 was a [AGE] year-old man and they had chosen quality of life for him over quantity. The family stated they elected a DNR for Resident #72 after he had a stroke. The family did not say if the facility was aware of the DNR . In an interview with Resident #72 on [DATE] at 09:10 AM, he stated he did not know his medical stuff to talk to his family who oversaw his medicals and medications. In an interview with the SW on [DATE] at 12:19 PM, he stated when Resident #72 admitted he asked him his wishes for code status which he replied was full code. The SW stated his BIMS was good and he just went by what Resident #72 was telling him. The SW stated he did not verify or reach out to Resident #72's RP because the resident was alert and oriented and he was his own responsible party. The SW stated he was not aware of Resident #72's transfer DNR wishes, and he had not spoken to the POA for Resident #72. The SW stated there was no risk to Resident #72 since the resident stated he wanted to be full code. In an interview with ADON A on [DATE] at 03:20 PM, she stated she was one of the acting DONs until the facility hired a new DON. She stated code status for Resident #72 had been changed from Full Code to DNR on [DATE]. She stated the SW just came to me and asked me to change it. The ADON stated if a resident admitted from the hospital, they did not honor the hospital DNR unless paperwork was brought with them but if a resident was transferred from another facility, then it was an out of hospital DNR and it was honored. She stated not verifying code status placed the resident at risk for getting CPR and not honoring their preference of DNR. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview with LVN E on [DATE] at 04:39 PM, she stated she admitted Resident #72 to the facility, and she could not remember what his code status was off the top of her head, and she could not remember seeing transfer orders with DNR on them. She stated if she had admitted him as Full Code it was because Resident #72 did not have DNR paperwork at the time of admission, there was no physician orders and no family at admission. LVN E stated all DNRs with transfer, or in hand DNR was handled by the social worker and code status was care planned at that time. She stated hospital admission was 100 percent Full Code. She stated not having the correct code could cause unnecessary CPR for a resident. In an interview with the Administrator on [DATE] at 04:46 PM, he stated he expected code status to be discussed with care plan, admission packet with family and resident. He stated the social worker was responsible for ensuring there was a current advanced directive on file. He stated the risk of not having the correct code was unnecessary damage to the patient, trying to revive, and crack ribs . Record review of Resident #72's Out of Hospital Do Not Resuscitate Order form, dated [DATE], reflected Resident #72's POA completed the form. The form was signed by a notary, and it was signed by Resident #72's physician. Record review of Resident #72's admission record, dated [DATE] at 02:50 PM, reflected advanced directive DO NOT RESUSCITATE. Record review of the facility's, undated, Advance directives Policy reflected . plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview and record review the facility failed to ensure, in accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys and provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility used single unit package drug distribution system in which the quantity stored is minimal and a missing dose could be readily detected for 3 of 8 residents (Residents #71, #304 and #305), 1 of 2 medication rooms (Med room A), and 1 of 1 treatment carts (Treatment cart A) reviewed for medication storage. 1.The facility failed to ensure the medication betadine (also known as povidone-iodine a topical antiseptic) was not disposed of and was left in Resident #304's trash can after wound care . 2.The facility failed to ensure treatment cart A was not left unlocked when out of view and unattended by LVN C . 3.The facility failed to ensure narcotic medications Morphine 10 mg and Diazepam 10 mg combination suppository was secured and under a double lock for narcotics in Med room A refrigerator. These failures could place residents at risk for accidental ingestion of medication, contamination, drug diversion and adverse effects. Findings include: 1. Record review of Resident #304's face sheet, dated [DATE], reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included displaced bicondylar fracture of right tibia (broken tibia), diabetic foot ulcers, cellulitis of right lower limb (a skin infection that causes inflammation, redness, and burning of skin), and depression (a mental health disorder characterized by persistently depressed mood and loss of interest in activities). Record review of Resident #304's admission MDS, dated [DATE], reflected Resident #304 had a BIMS of 14, which indicated the resident was cognitively intact. Resident #304 had symptoms and presence of depression, little interest, or pleasure in doing things and feeling down, depressed and or hopeless. Record review of Resident #304's orders, dated [DATE], reflected wound Care: Right great toe: Apply betadine to area daily, every day shift for wound care. Active [DATE] [DATE] Wound care: Right hand 2nd and 3rd fingers. Apply betadine daily every day shift for wound care. Order Active [DATE] (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Enhanced Barrier Precautions: PPE required for high contact resident care activities. Indication: wounds. Active [DATE]. Record review of Resident #304's care plan reflected the resident required Enhanced Barrier Precautions related to wounds. The goal was to minimize risk and exposure to infectious disease. Interventions was PPE required for high contact resident care activities. The Care plan further reflected Resident #304 had Cellulitis RLE o Interventions where he would have no complications resulting from the cellulitis through the review date. o Monitor /document healing of cellulitis. Any new or worsening symptoms should be reported to the MD.o Educate me about cellulitis. Include: what it is, how it is contracted, absence of contagion, risk to others, disease process, treatment options, when return to normal activities. During wound care observation and interview on [DATE] at 08:50 AM, LVN C completed Resident #304 wound care on his right foot big toe and his two fingers on the right hand with betadine. LVN C then threw the used betadine swabs that were used for wound care on the toes and finger into Resident #304's trash can and walked out of the room. LVN C stated he was done with wound care after completing hand hygiene. LVN C stated he was not aware he could not throw, and leave used wound care betadine swabs in the resident's room. LVN C stated usually he had a biohazard red bag that he would throw wound care band aides and items used. He stated he could see how someone may eat the swab and harm themselves or contaminate themselves. In an interview with RN G on [DATE] at 02:10 PM, she stated betadine could burn eyes if it got into the eyes. She stated she was the infection control nurse and throwing used wound care items at the bedside and leaving them was unacceptable practice. She stated it was to be disposed in the red biohazard bag as it was contaminated. She stated her expectation was for the nurse to have taken the trash out of the room after treatment. 2. Record review of Resident #71's face sheet, dated [DATE], reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included metabolic encephalopathy (this is a brain disease that alters brain function or structure), chronic kidney diseases stage 4, cellulitis of left lower lamb (a skin infection that causes inflammation, redness, and burning of skin), sepsis due to Escherichia coli (this is a life-threatening complication of an infection caused by Escherichia coli bacteria), urinal retention and urinary tract infection. Record review of Resident #71's wound care orders reflected wound care: left, lateral calf: clean with wound cleanser and pat dry. Apply Santyl ointment and calcium alginate and cover with silicone dressing daily, Everyday shift for wound care. Order active [DATE]. Enhanced barrier precautions: PPE required for high resident contact care activities. Indications: indwelling medical device (foley) and wounds. Order active [DATE] (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During wound care observation on [DATE] at 09:20 AM, revealed after preparing wound care items on Treatment Cart A, dry gauze, wet gauze with wound cleanser, Santyl ointment, calcium alginate, silicone dressing and a red biohazard bag. LVN C donned his PPE for EBP and went into Resident #71's room. Treatment Cart A was facing Resident #71's room away from the door with enough space for a person to pass in front of it. The treatment cart had three drawers. The treatment cart was left unlocked with the first drawer just slightly opened and the second drawer pulled out halfway opened. Treatment Cart A had wound care supplies, topical medications, betadine, scissors, would cleansers, gloves, biohazards bags and trash bags. LVN C could not see the treatment cart from where he was completing Resident #71's wound care. Three staff members and two residents were observed passing by Treatment Cart A on the back side of the cart. After removing the old dressing from Resident #71's wound, LVN C sanitized his hands and went to the treatment cart to get clean gloves. LVN C then closed the drawers to Treatment Cart A but he did not engage the push button lock in to lock Treatment Cart A. During an interview with LVN C on [DATE] at 09:25 AM, he stated he should have locked Treatment Cart A because he could not see where he was inside the room. He stated he was using the cart and did not think to lock it. He stated the treatment cart should have been locked because he had topical medications on the cart. LVN C stated the treatment cart should never be unlocked and left unattended because anyone could walk up and get into the medications on the cart . 3.Record review of Resident #305's face sheet, dated [DATE], reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included hydronephrosis and ureteral calculous obstruction (a condition characterized by excessive fluid in the kidneys due to back up of urine due to kidney stones blockages). Record review of Resident #305's discharge MDS, dated [DATE], reflected the resident was deceased in the facility on [DATE]. Record review of Resident #305's orders, dated [DATE], reflected Morphine 10mg/Diazepam 10mg combination Suppository Insert 1 suppository rectally every 12 hours as needed for pain/anxiety for 14 Days. Order active [DATE], discontinued on [DATE]. Record review of Resident #305's MAR on [DATE] reflected Morphine 10mg/Diazepam 10mg combination Suppository Insert 1 suppository rectally every 12 hours as needed for pain/anxiety for 14 Days. Order active [DATE], discontinued on [DATE] was last administered on [DATE] by LVN F. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During medication room observation with LVN H on [DATE] at 01:34 PM revealed Med Room A with a lock code on the door, LVN H entered the code to the door. Upon opening the refrigerator that did not have a lock on it, revealed narcotic medication morphine and diazepam medication inside a silver container lock box which was unlocked and the lid wide open . You could see the medication when you opened the refrigerator which did not have a lock on it. Two batches of morphine and diazepam totaling 19 in pink mold were left unsecure. LVN H stated the medication belonged to Resident #305 who had passed away last week. LVN H stated the box should not be open. She stated it was the responsibility of the nurse that gave the last dose to have locked up the narcotic medication or whoever got the narcotic report on the next shift should have locked it. She stated she as a nurse was responsible too had she seen it, she could have closed the silver box and locked it and reported it to ADON. She stated the risk was someone could take the narcotic medication. LVN H stated the ADONs were responsible for taking out the narcotic medications after a resident passed away or left. She stated the hospice nurses at times took the medications after the resident passed away . In an interview with LVN F on [DATE] at 01:38 PM, she stated she would have to look at the MAR for her initials to reflect if she administered the last dose of the narcotic medications. She stated she remembered administering one dose of the narcotic medication a day before Resident #305 passed away. LVN F stated she closed the silver lock box and confused the keys to lock the box keypad. LVN F stated the narcotic medications belonged to Resident #305 who had expired last week. LVN F stated the medication should be kept in the fridge because it was a suppository, and it could melt if left on a med cart. She stated the fridge was in the med room and there was a combination lock and only nursing staff were allowed in the med room. She stated she signed the narcotic log, cut off one pink mold package of the medication, and put it in a med cup and locked the lock box. LVN F stated narcotic medications should be kept in a locked storage because it was the law for controlled medication. She stated the risk was a resident or staff number could get into the fridge and take the narcotic medication that was not locked up in the fridge . She said unused medications were always supposed to be closed, pulled, and sent to designated person for med distraction if no longer in use. She stated hospice narcotic medications were destroyed by hospice or given to the ADON. LVN F stated all nursing staff were responsible for the medication room and to report anything that was out of order especially if they found the narcotic box unlocked to lock it then report it. In an interview with RN G on [DATE] at 02:10 PM, she stated the medication and treatment carts should always be locked to decrease the risk of residents, especially residents with dementia, getting into the cart and accessing medications or treatment items . She stated it was important to for the residents to not get into the medication and treatment carts so that they could not take something that could harm them. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with ADON B on[DATE] 02:33 PM, revealed she and ADON A were sharing DONs duties until the facility hired a new DON. She stated herself and ADON A were responsible for drug destruction, and they took all unused medications every Friday. She stated Resident #305 was admitted to the facility for short term hospice. She stated all nurses and med aides were responsible for reporting medication storages. She stated she was unaware of the open lock box with narcotic medications in it. ADON B stated all the nurses had the narcotic code to the silver lock box in the refrigerator in Med Room A. She stated she expected them to lock the box after taking medications that they needed. She stated there were three cameras in the medication room, she would look at the camera to review. ADON B stated the risk was missing medication. ADON B stated she did random fridge audits at the temps and made sure nothing was expired. She stated the pharmacy consultant also did random monthly audits of med rooms and watched med aides administer medications. The ADON stated the treatment cart should be locked if they walked away, whenever the nurse was away from the treatment cart. She said it should be kept at the nursing station. She stated the risk to not locking and securing the treatment cart was someone could grab something. She stated the expectation was to lock the med carts and treatment carts when not in use and out of view. The ADON stated betadine should be removed from the resident's trash can and out of the room. She stated the resident could grab it and contaminate themselves. The ADON stated the nurse should have taken the bag in for disposal or he should have taken the bag out of resident's room after he was done. In an interview with the Administrator on [DATE] at 04:46 PM, he stated he expected the staff to hold each other accountable and to follow the system in place following policy. He stated there was a risk of infection for not following proper protocols. The Administrator stated the medications should be secured according to policy. He stated the risk was theft and drug diversion. He stated the risk to the resident with the treatment cart left unlocked was they could get into the treatment creams, ointment etc . He stated he expected the DON and ADON to hold staff accountable and to monitor and make sure they were following protocols in place. Record review of the facility's policy titled Controlled Substance Administration & Accountability, revision date [DATE], reflected in part, .The charge nurse or other designee conducts a daily visual audit of the required documentation of controlled substances. Spot checks are performed to verify: Controlled substances that are destroyed are appropriately documented . Patient-specific controlled substances (e.g ., narcotic/epidural infusions, tablets, etc.) are stored under double lock until administered to the patient .The nurse must secure the medication cart during the medication pass to prevent unauthorized entry . Medication carts must be securely locked at all times when out of the nurse's view Record review of the facility's policy titled Storage of Medications, revision date [DATE], read in part The facility stores all drugs and biologicals in a safe, secure, and orderly manner . Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. Record review of the facility's, undated, policy titled Disposal of Medications, Syringes, and Needles reflected in part .medication awaiting disposal are stored in a locked secure area designated for that purpose until destroyed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43843 Based on observation, interview and record review the facility failed to store, prepare, and accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food and nutrition services. 1. The facility failed to ensure stored food was properly labeled (marked or identified with the contents in the bag), dated (date the item was received into the facility) . 2. The facility failed to ensure dented cans were not stored in the dry goods area. 3. The facility failed to ensure scoops were not stored in the Dry goods. These failures could place all residents at risk of cross contamination and food-borne illness. Findings include: Observation on 11/11/2024 at 8:54 AM, during initial kitchen rounds of the freezer, dry goods and kitchen area revealed: 1. An unopened bag of breaded chicken parts were not labeled (marked or identified with the contents in the bag) and not dated (date the item was received into the faciliy) and not in the original box. 2. A 10 oz can of Jalapeno Peppers was compressed or had a deformed shape near the opening. 3. A scoop was left inside the sugar bin. Interview on 11/13/2024 at 9:21 AM with Dietary Manager revealed whole foods should be labeled and dated to ensure they were being served prior to expiration date. All cans should be inspected for dents prior to storing on the shelf because there was a risk of metal from the can getting into the food. There should not be a scoop left in the sugar bin because the scoop could cause infection control or contamination. The scoop should have been removed and washed and not left inside the bin. The risk to the residence was the potential for foodborne illnesses. Record review of the Labeling and Dating Foods guideline & Procedure Manual, copyright 2020, reflected . Frozen Food packages removed from the case will be dated with the date items was received into the facility and will be stored using the first in- first out method of rotation. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the U.S. Public Health Service Food Code, dated 2022, reflected: 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. (C) A refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD ingredient or a portion of a refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is subsequently combined with additional ingredients or portions of FOOD shall retain the date marking of the earliest prepared or first-prepared ingredient. (D) A date marking system that meets the criteria stated in (A) and (B) of this section may include: (1) Using a method approved by the regulatory authority for refrigerated, ready-to-eat time/temperature control for safety food that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; (2) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (A) of this section; (3) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section; or (4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the REGULATORY AUTHORITY upon request.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676003	A. Building B. Wing	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azle Manor Health Care and Rehabilitation	721 Dunaway LN Azle, TX 76020

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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 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 2 of 8 (Residents #86 and #304) residents reviewed for infection control. 1.The facility failed to ensure medication were dispensed directly into a medication cup and not into LVN D's palm. 2.The facility failed to implement an infection control and prevention that included wound care procedures and cross contamination for Resident #304. These failures could place residents at risk of infectious diseases, cross contamination, staph infection and hospitalization . The finding include: 1. Record review of Resident #86's face sheet, dated 11/12/14, reflected an [AGE] year-old female who was initially admitted to the facility on [DATE] and a readmission on 06/07/24. Her diagnoses included orthostatic hypotension (low blood pressure upon standing), chronic bronchitis (this is a long-term condition that involves inflammation of the airways in the lungs), chronic obstructive pulmonary diseases (this a lung disease that blocks airflow and make it difficult to breath), sepsis (systemic infection), pneumonia (this is infection that inflames air sacs in one or both lungs which may fill with fluid), solitary pulmonary nodule (this is a small mass in the lung), shortness of breath and seasonal allergies, high blood pressure, and uncontrolled blood sugars. Record review of Resident #86's quarterly MDS, dated [DATE], reflected a BIMS score of 11 out of 15, which indicated moderate cognitive impairment. Resident #86 had breathing problems related to pulmonary diseases asthma, chronic obstructive pulmonary diseases , and other lung diseases (These are all lung disease that blocks airflow and make it difficult to breath). Record review of Resident #86's November MAR, dated 11/12/24 , reflected the following medication administered by LVN D: Acetaminophen-Codeine Oral Tablet 300-30 MG (Acetaminophen w/ Codeine). Give 1 tablet by mouth two times a day related to pain, unspecified. Do not exceed 3 Gm APAP in 24 hours from all sources. Gabapentin Oral Capsule 100 MG (Gabapentin). Give 1 capsule by mouth two times a day related to polyneuropathy, unspecified Hydrochlorothiazide Oral Tablet 25 MG (Hydrochlorothiazide). Give 1 tablet by mouth one time a day related to edema, unspecified Metformin HCl Oral Tablet 1000 MG (Metformin HCl). Give 1 tablet by mouth two times a day related to Type 2 diabetes mellitus without complications. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protonix Oral Tablet Delayed Release 40 MG (Pantoprazole Sodium). Give 1 tablet by mouth in the morning related to Gastro-Esophageal Reflux Disease Without Esophagitis. Sertraline HCl Oral Tablet 50 MG (Sertraline HCl) Give 1 tablet by mouth one time a day related to depression, unspecified. Zyrtec Allergy Oral Tablet 10 MG (Cetirizine HCl). Give 1 tablet by mouth one time a day related to other seasonal allergic rhinitis. Record review of Resident #86's care plan completed 10/10/24, reflected the Resident had emphysema (this is a diseases that is caused by destruction of air sacs)/COPD. The goal was to be free of signs and symptoms of respiratory infections through the review day, she would be displaying optimal breathing pattern daily through the review date 02/05/25. Her interventions were Give aerosol or bronchodilators as ordered. Monitor/document any side effects and effectiveness, monitor for difficulty breathing (Dyspnea) on exertion. Remind me not to push beyond endurance, monitor for s/sx of acute respiratory insufficiency: Anxiety, Confusion, Restlessness, SOB at rest, Cyanosis, Somnolence, Monitor/document/report to MD PRN any s/sx of respiratory infection: Fever, Chills, increase in sputum (document the amount, color and consistency), chest pain, increased difficulty breathing (Dyspnea), increased coughing and wheezing. Observation of medication administration on 11/12/24 at 07:09 AM, revealed LVN D put on gloves, and she touched the computer mouse to get to Resident #86's MAR. LVN D then opened the med cart drawer with Resident #86's narcotic and took out a bubble pack medication card with Acetaminophen-Codeine Oral Tablet which she popped into her gloved hand first then put it in the medicine cup. She then signed the book for control medication with the same gloves on after touching the computer mouse, the pen, the control book and the narcotics. LVN D opened the drawer with Gabapentin Oral Capsule 100 MG and popped the pill from the bubble pack into her unchanged gloved hand and put it in the medicine cup, she then went back to the computer mouse with the same gloves on and looked at the next medication. LVN D continued this process until all medications due were put in the medicine cup. Without changing her gloves, she went to Resident #86 and gave the medications to the resident in the medication cup. LVN D did not change her gloves and she did not complete hand hygiene. During an interview on 11/12/24 at 07:17 AM, LVN D stated she did not know why she popped the medicines into her soiled gloved hand. She stated she should have popped the medicine directly into the medicine cup without touching it. She stated she had contaminated the medicine by touching them before putting them into the cup. 2. Record review of Resident #304's face sheet, dated 11/12/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included displaced bicondylar fracture of right tibia (broken tibia), diabetic foot ulcers, cellulitis of right lower limb (a skin infection that causes inflammation, redness, and burning of skin), and depression (a mental health disorder characterized by persistently depressed mood and loss of interest in activities). Record review of Resident #304's admission MDS, dated [DATE], reflected Resident #304 had a BIMS of 14, which indicated cognitively intact cognition. Resident #304 had symptoms and presence of depression, little interest, or pleasure in doing things and feeling down, depressed and or hopeless. Record review of Resident #304's orders, dated 11/12/24, reflected (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wound Care: Right great toe: Apply betadine to area daily, everyday shift for wound care. Active 10/31/2024 11/01/24 Wound care: Right hand 2nd and 3rd fingers. Apply betadine daily everyday shift for wound care. Order Active 10/31/24. Enhanced Barrier Precautions: PPE required for high contact resident care activities. Indication: wounds. Active 10/31/24 Record review of Resident #304's care plan completed 11/10/24 reflected resident required Enhanced Barrier Precautions related to wounds. The goal was to minimize risk and exposure to infectious disease. Interventions were PPE required for high contact resident care activities. The Care plan further reflected Resident #304 had Cellulitis RLE o Interventions where he would have no complications resulting from the cellulitis through the review date. o Monitor /document healing of cellulitis. Any new or worsening symptoms should be reported to MD.o Educate me about cellulitis. Include: what it is, how it is contracted, absence of contagion, risk to others, disease process, treatment options, when return to normal activities. During wound care observation and interview on 11/12/24 at 08:50 AM, revealed LVN C completed Resident #304 wound care on his right foot big toe and his two fingers on the right hand with betadine. LVN C then threw the used betadine swabs into Resident #304's trash can and walked out the room. LVN C stated he was done with wound care after completing hand hygiene. LVN C stated he was not aware he could not throw, and leave used wound care betadine swabs in the resident's room. LVN C stated usually he had a biohazard red bag that he would throw wound care band aides and items used. He stated he could see how someone may eat the swab and harm themselves or contaminate themselves. In an interview with RN G on 11/13/24 at 02:10 PM, She stated she was the infection control nurse and throwing used wound care items at the bedside and leaving them was unacceptable practice. She stated betadine could burn eyes if it got into the eyes. RN G stated if medication was in a bubble pack, then you popped it directly into the medicine cup and if it was in a bottle then you put it on the lid for accuracy before putting in the cup. She stated at no point should a nurse or med aide touch the medications with their bare hands or gloved hands. She stated there was a risk of infection because you touch other surfaces that carried germs and their contamination of the pills. In an interview with ADON B on 11/13/24 at 02:33 PM, revealed she and ADON A were sharing DONs duties until the facility hired a new DON. ADON B stated betadine should be removed from the resident's trash can and out of the room. She stated the resident could grab it and contaminate themselves. ADON B stated the nurse should have taken the bag in for disposal or he should have taken the bag out of the resident's room after he was done. ADON B stated medications from a bubble should not be touched before putting it into a cup. She stated the expectation was that you picked up the bubble pack with the medicine and put the med cup close and popped the medicine directly into the cup. She stated the risk was infection by touching the pills. In an interview with the Administrator, on 11/13/24 at 04:46 PM, he stated he expected the staff to hold each other accountable and to follow the policy and procedure in place. He stated there was a risk of infection for not following proper protocols. He stated he expected the DON and the ADON to hold staff accountable and to monitor and make sure they were following protocols in place. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy, dated November 9, 2022, and titled Standard Precautions reflected . Standard precautions are used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status .hand hygiene is performed with soap (anti-microbial or non-antimicrobial) or alcohol-based hand rub before and after contact with the resident .Resident-Care Equipment: reusable equipment is not used for the care of more than one resident until it has been appropriately cleaned and reprocessed Record review of the facility's Enhanced Barrier Precautions policy, revised 03/21/24, reflected, .EBP are indicated for residents with any of the following: 1. Infection or colonization with a CDC-targeted MDRO . Wounds and/or indwelling medical devices even if a resident is not known to be infected or colonized with a MDRO .post signage .high-contact resident care activities requiring gown and glove use