| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676031 | A. Building<br>B. Wing | 04/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Meadow Creek Nursing and Rehabilitation | 4343 Oak Grove Blvd<br>San Angelo, TX 76904 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221<br><br>Based on interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 2 of 2 residents (Resident #10 and #11), 2 of 2 residents who used a mechanical lift in the resident council meeting, and one unsampled resident reviewed for the mechanical lift.<br><br>The facility failed to have sufficient mechanical lift slings to accommodate all residents who required the use of a sling (Resident #10, Resident #11, two residents in the resident council meeting).<br><br>These failures could place residents at risk of a diminished quality of life due to an environment that is nonfunctional or uncomfortable.<br><br>The findings included:<br><br>Review of Resident #10's Admission Record dated 4/10/25 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis included Multiple Sclerosis (an autoimmune disease-causing numbness, weakness, and trouble walking), and osteoporosis (thinning of the bone) without fracture.<br><br>Review of Resident #10's Quarterly MDS assessment dated [DATE] revealed:<br><br>* a 15 of 15 on mental status exam. (indicating she was cognitively intact)<br><br>*Chair to bed transfer: dependent, the assistance of two or more helpers is required for the resident to complete the activity.<br><br>Review of Resident #10's Care Plan revised 10/19/22 revealed:<br><br>* an ADL self-care performance deficit related to weakness associated with MS.<br><br>*Interventions: Transfer: Resident #10 requires assist by (2) staff transfer. Requires mechanical lift.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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|---|---|
| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 4/8/25 at 3:35 p.m. Resident #10 stated she was left in bed because there were no slings occasionally. She said this made her angry because she liked to be involved in activities. Resident #10 said it was a once in a while thing and it did not happen all the time. Resident #10 said this happened once or twice a month.<br><br>Interview on 4/10/25 at 11:07 p.m. Resident #10 stated every once in a while they would not get her up and it would upset her. Resident #10 said it would also upset the aides because they (the aides) would want to get Resident #10 up. Resident #10 said it would mostly happen when there were new staff who did not know her. Resident #10 said it would hurt her feelings because it would make her feel like the residents who used the lift did not matter. Resident #10 said sometimes the staff would borrow her mechanical lift sling but it was ok because the staff would bring it right back.<br><br>Review of Resident #11's Admission Record revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, major depressive disorder, and generalized anxiety disorder.<br><br>Review of Resident #11's Quarterly MDS assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 15 indicating she was cognitively intact. She had impaired range of motion in her upper and lower extremities and required a wheelchair for mobility. She was dependent on staff or required maximum assistance for most ADLs (except eating and oral hygiene for which she required setup assistance).<br><br>Review of Resident #11's care plan revised 03/06/2025 revealed Problem: resident has an ADL self-care performance deficit related to osteoarthritis, pain, and weakness. Goal: resident will maintain current level of function through the review date. Interventions: may use mechanical lift with 2 staff assistance for transfers.<br><br>In an observation and interview on 04/08/2025 at 11:28 am Resident #11 was resting quietly in her bed. She stated she required a mechanical lift for transfers and the slings are always missing. She stated she had been left in bed for 3 days recently and the staff told her it was because the facility had run out of clean slings. She stated she had missed activities in the past due to staff not getting her out of bed.<br><br>Interview on 4/9/25 at 9:41 a.m. the two residents present in the Resident Council meeting who used the mechanical lift stated they lived on different wings of the facility. The Residents stated they both had been left in bed because there was no sling available. The Residents stated this did not happen often.<br><br>Interview on 4/8/25 at 2:28 p.m. Resident #39 stated her only issue with the facility was they would occasionally run out of slings for the mechanical lift, and she would have to spend the day in bed. Resident #39 said the last time this happened was 4/4/25. Resident # 39 said she did not like to be in bed all day. Resident # 39 said the facility did not have a sling for her about once a month.<br><br>Interview on 4/9/25 at 3:29 p.m. LVN B said the facility was getting more and more mechanical lift residents and sometimes laundry was unable to keep up with the demand for clean slings and the facility did run out occasionally. LVN B said the mechanical lift residents were very opinionated when it happened.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 4/9/25 at 3:35 p.m. CNA K stated slings getting backed up in laundry did not happen often and when he got here at 2 p.m. most of the mechanical lift residents were already in bed.<br><br>Interview on 4/9/25 at 3:42 p.m. LVN L said there were enough slings but occasionally the residents had to wait on laundry because the day shift started getting residents up at 6 a.m. and laundry did not start until 7 a.m. and they would have to wait.<br><br>Interview on 4/10/25 at 10:09 a.m. the Social Worker said the facility did have a complaint about not having enough slings, it was discussed in the morning meeting and the facility ordered more slings.<br><br>Interview on 4/10/25 at 10:16 a.m. the DON said there were 14 residents in the facility who used slings and 19 slings in the building. The DON stated the facility ordered 3 slings a month and believed it was enough to meet the needs of the residents. The DON said she did not remember hearing any complaints about there not being enough slings in the building and it had never been discussed in morning meeting.<br><br>Interview on 4/10/25 at 2:33 p.m. the Housekeeping Supervisor stated she had 3 sets of linen for each resident: one for use, one for back up, and one for washing. The DCO who was present stated the expectation was there be two slings for each resident.<br><br>Interview on 4/10/25 at 1:45 p.m. the Administrator stated the facility bought 3 new slings each month.<br><br>Review of the complaint book revealed a resident complained on 2/26/25 that there was not a sling for a transfer with a mechanical lift for an extended period of time. The complaint was forwarded to the DON for the investigation where it was: explained to the resident that she was a mechanical lift and required two people to assist her so it may take a minute, the resident was put on a prompt toileting schedule.<br><br>Review of the receipts revealed the facility ordered 3 slings on 4/2/25 and 4/10/25.<br><br>No policy or list of what was considered essential equipment was provided. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221<br><br>Based on interview and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 13 residents (Resident #20 and 41) reviewed for care plans.<br><br>There was no care plan addressing Resident #20's use of a gait belt across his wheelchair.<br><br>There was no care plan addressing Resident #41's isolation status.<br><br>This failure could affect the resident by placing them at risk for not receiving care and services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.<br><br>The findings included:<br><br>Review of Resident #20's Admission Record, dated 4/9/25, revealed he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including fracture of thoracic vertebra with routine healing (upper back).<br><br>Review of Resident #20's initial MDS Assessment, dated 3/9/25 revealed:<br><br>* a mental status of 11 of 15 (indicating moderate cognitive impairment).<br><br>* range of motion impairment of the upper and lower extremities on both sides and used a wheelchair.<br><br>* totally dependent on staff to transfer from the wheelchair to the bed.<br><br>Review of Resident #20's Care Plan, revised 3/17/25 revealed Resident #20 had an ADL self-care performance deficit related to Pneumonia (Fluid in the lungs), Congestive Heart Failure, and Chronic Obstructive Pulmonary Disorder (lung disease causing restricted air flow and breathing problems). Resident #20 requires maximum assist by staff to move between surfaces. There was no care plan addressing Resident #20's use of a gait belt across his wheelchair.<br><br>Observation and interview on 4/8/25 at 11:33 a.m. revealed Resident #20 in his wheelchair with a gait belt secured across the arms. Resident #20 stated he put the gait belt across the arms and the staff knew about it and were ok with it. Resident #20 said he had because it took too many people to help him transfer, so he had that around the wheelchair to keep him from falling out. Resident #20 stated he was aware if he fell out of the wheelchair with the gait belt secured across him that the wheelchair would fall on top of him. Resident #20 said he was at the facility for rehabilitation services.<br><br>(continued on next page) |

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|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 4/10/25 at 2:30 p.m. the DON stated Resident #20 was here for rehabilitation services and had been at the facility for about a month. The DON said she said if there was anything abnormal, she would expect staff to bring it to her attention. The DON stated she would consider Resident #20 tying a gait belt across his wheelchair abnormal and should have been brought to her attention. The DON said she did not think there was a risk to Resident #20 using a gait belt across his wheelchair since he could take it off himself. The DON said she could not say if there was a risk while he was asleep since she never had anything bad happen. The DON said she did not know what would happen if Resident #20 either slid out of his wheelchair with the gait belt in place or fell forward with the gait belt in place and could not speculate on what would happen.<br><br>Interview on 4/10/25 at 2:39 p.m. the DCO stated it was the resident's right to tie the gait belt across the wheelchair if it made him feel safe. The DCO said she did not see how it was a risk. The DCO said it was 50-50 chance that the wheelchair could go with him, if the resident was sliding out of the wheelchair. The DCO repeated she never saw Resident #20 put the gait belt across his wheelchair. When asked what would happen if the wheelchair landed on a resident the DON responded it never happened, she did not have a care plan for it, and if Resident #20 felt comfortable with it, it was his right to have it. The DCO stated she did not see how it was an issue.<br><br>Interview on 4/10/25 at 3:28 p.m. Physical Therapist(PT) M stated he knew Resident #20 put the gait belt across the wheelchair. PT M said he educated Resident #20 about taking it off.<br><br>Interview on 4/10/25 at 3:33 p.m. the Administrator stated she had previously seen Resident #20 wear the belt and was aware he wore it.<br><br>Review of Resident #41's Admission Record revealed she was an [AGE] year-old female originally admitted to the facility 03/14/2023 with a most recent admitted [DATE] with diagnoses including chronic respiratory failure with hypoxia (decreased levels of oxygen in the blood), Alzheimer's disease, and recurrent enterocolitis due to clostridium difficile (infection of the colon caused by the bacteria clostridium difficile resulting in inflammation of the lining of the colon and diarrhea).<br><br>Review of Resident #41's Annual MDS assessment dated [DATE] revealed she had a BIMS (Brief Interview for Mental Status) score of 15, indicating she was cognitively intact. She required moderate assistance with most ADLs. She was frequently incontinent of bowel and bladder. She was receiving an antibiotic.<br><br>Review of Resident #41's care plan most recently revised on 03/20/2025 revealed no care plan addressing her contact isolation due to recurrent C. difficile infections.<br><br>Review of the facility's policy and procedure on Comprehensive Person-Centered Care Plans, revised March 2022, revealed:<br><br>A comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.<br><br>The interdisciplinary team, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The comprehensive person-centered care plan: describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being include: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment.<br><br>Care plan interventions are chosen only after data gather, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.<br><br>When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221<br><br>Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible for 1 of 3 residents (Resident #20) reviewed for accidents and hazards:<br><br>The facility failed to ensure Resident #20 was thoroughly educated about the risks associated with strapping himself into his wheelchair with a gait belt (device typically used by aides as a transfer aide for more dependent resident to prevent falls).<br><br>This failure could place residents at risk of harm or injury and contribute to avoidable accidents and a decline in health.<br><br>The findings included:<br><br>Review of Resident #20's Admission Record, dated 4/9/25, revealed he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including fracture of thoracic vertebra with routine healing (upper back).<br><br>Review of Resident #20's initial MDS Assessment, dated 3/9/25 revealed:<br><br>He had a mental status of 11 of 15 (indicating moderate cognitive impairment).<br><br>He had range of motion impairment of the upper and lower extremities on both sides and used a wheelchair.<br><br>He was totally dependent on staff to transfer from the wheelchair to the bed.<br><br>Review of Resident #20's Care Plan, revised 3/17/25 revealed:<br><br>Resident #20 had an ADL self-care performance deficit related to Pneumonia (Fluid in the lungs), Congestive Heart Failure, and Chronic Obstructive Pulmonary Disorder (lung disease causing restricted air flow and breathing problems).<br><br>Resident #20 will improve current level of function in ADL's through the review date.<br><br>Transfer: Resident #20 requires maximum assist by staff to move between surfaces.<br><br>There was no care plan addressing Resident #20's use of a gait belt across his wheelchair.<br><br>(continued on next page) |

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|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation and interview on 4/8/25 at 11:33 a.m. revealed Resident #20 in his wheelchair with a gait belt secured across the arms. Resident #20 stated he put the gait belt across the arms and the staff knew about it and were ok with it. Resident #20 said he had because it took too many people to help him transfer, so he had that around the wheelchair to keep him from falling out. Resident #20 stated he was aware if he fell out of the wheelchair with the gait belt secured across him that the wheelchair would fall on top of him. Resident #20 said he was at the facility for rehab services.<br><br>Interview on 4/10/25 at 2:30 p.m. the DON stated Resident #20 was here for rehabilitation services and had been at the facility for about a month. The DON said she said if there was anything abnormal, she would expect staff to bring it to her attention. The DON stated she would consider Resident #20 tying a gait belt across his wheelchair abnormal and should have been brought to her attention. The DON said she did not think there was a risk to it since he could take it off himself. The DON said she could not say if there was a risk while he was asleep since she never had anything bad happen. The DON said she did not know what would happen if Resident #20 either slid out of his wheelchair with the gait belt in place or fell forward with the gait belt in place and could not speculate on what would happen. She stated again she did not see it as a hazard to the resident since he could take if off himself.<br><br>Interview on 4/10/25 at 2:39 p.m. the DCO stated it was the resident's right to tie the gait belt across the wheelchair if it made hm feel safe. The DCO said she did not see how it was a risk. Surveyor attached a gait belt across the arms of the chair the DCO was in and asked if she was asleep, if she slid out of the chair was it a risk. The DCO said it was 50-50 because the wheelchair could go with him. Surveyor pointed out that meant the wheelchair landed on top of the resident. The DON repeated she never saw Resident #20 put the gait belt across his wheelchair. When asked what would happen if the wheelchair landed on a resident the DON responded it never happened, and if Resident #20 felt comfortable with it, it was his right to have it. The DCO stated she did not see how it was an issue. Surveyor asked for a policy for accident hazards to residents.<br><br>Interview on 4/10/25 at 3:28 p.m. the Physical Therapist M stated he knew Resident #20 put the gait belt across the wheelchair. PT M said he educated Resident #20 about taking it off. PT M said Resident #20 told the therapy department it was too hard to get to the bathroom on time if he (Resident #20) was not already in his wheelchair due to chronic incontinence. PT M said if Resident #20 fell the potential risk was possible injury because Resident #20 restrained himself.<br><br>Interview on 4/10/25 at 3:33 p.m. the Administrator stated she had previously seen Resident #20 wear the belt and was aware he wore it.<br><br>No policy for hazards to residents was provided. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51011<br><br>Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for kitchen sanitation.<br><br>1. The facility failed to ensure stored foods were properly stored, labeled, and dated.<br><br>2. The facility failed to ensure prepared food was discarded after 72 hours (3 days) per facility policy.<br><br>3. The facility failed to check temperatures of food items prior to serving food.<br><br>4. The facility failed to ensure food was not handled with bare hands.<br><br>5. The facility failed to ensure food items remained covered on the steam table prior to food service between breakfast and lunch.<br><br>6. The facility failed to ensure personal food items were not stored in 1 of 2 of the kitchen refrigerators.<br><br>7. The facility failed to ensure dishes were washed and rinsed at the correct temperatures, per dishwasher manufacturer's instructions.<br><br>These failures could place residents who received prepared meals from the kitchen at risk for food borne illness and cross-contamination.<br><br>The findings included:<br><br>During the initial tour of the kitchen on 4/8/25 at 8:55 AM, the following was observed:<br><br>Dry storage<br><br>- a package labeled butterscotch pudding powder was opened and not sealed<br><br>- a package labeled cherry gelatin powder was opened and not sealed<br><br>- a package labeled citrus gelatin powder was opened and not sealed<br><br>- a package labeled dry potato pearls was opened and not sealed<br><br>Freezer<br><br>-a drinking glass with a whitish yellow frozen liquid, covered with plastic wrap, did not have a label, identification, or date.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Refrigerator #1<br><br>- a metal storage container with cooked sausage in the bottom and cooked eggs on top covered with plastic wrap - no date, For [name] was written in marker on the plastic wrap.<br><br>- meat sauce dated 3/18/25<br><br>- chicken noodle soup dated 3/26/25<br><br>- tomato soup dated 3/24/25<br><br>- vegetable soup dated 3/31/25<br><br>- pimento cheese dated 3/25/25<br><br>- sliced ham dated 3/29/25<br><br>- grated cheese dated 3/28/2<br><br>- a package of grated cheese was open to air and not dated.<br><br>Refrigerator #2<br><br>- crushed pineapple opened 3/24/25<br><br>- sour cream opened and not dated<br><br>- cranberry sauce opened 4/2/25<br><br>- apple sauce opened 3/29/25<br><br>During an observation of the kitchen on 4/9/25 at 11:25 AM, the following observations of the dishwasher were made:<br><br>- first load temperature for both washing and rinsing was 110 degrees F<br><br>- second load temperature for both washing and rinsing was 112 degrees F<br><br>- third load temperature for both washing and rinsing was 116 degrees F<br><br>- fourth load temperature for both washing and rinsing was 120 degrees F<br><br>- a sticker on the dishwasher stated manufacturer's recommended temperature for both washing and rinsing is 120 degrees F<br><br>Observation of lunch items on the steam table on 4/9/25 at 11:40 AM revealed the following:<br><br>(continued on next page) |

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| Meadow Creek Nursing and Rehabilitation | 4343 Oak Grove Blvd<br>San Angelo, TX 76904 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | - the fortified soup was not covered, temperature was not taken, the soup was dried out on top and was dried out on the sides of the container<br><br>- the white gravy was not covered, temperature was not taken, the gravy was dried out on top and was dried out on the sides of the container<br><br>- the chicken strips were not temped<br><br>- the fries were not temped<br><br>Observation of the lunch service on 4/9/25 at 1145 AM revealed the following:<br><br>- [NAME] N dropped a hot mitten on the floor, picked it up, and used it to transfer a pan of enchiladas to the steam table<br><br>- [NAME] N touched a baked potato with bare left hand while cutting it<br><br>In an interview on 4/9/25 at 11:35 AM with Dietary Aide O she said she was not sure what the dishwasher temperatures are supposed to be. Stated she was a cook covering the shift for the regular aide.<br><br>In an interview on 4/9/25 at 11:37 AM with the Dietary Manager (DM) he stated the staff should know to run the dishwasher a couple times until the water temperature reached 120.<br><br>In an interview on 4/9/25 at 11:40 AM with [NAME] N she said the fortified soup and white gravy was left from breakfast because they will be used again at lunch.<br><br>In an interview on 4/10/25 at 1:12 PM with the DM said his expectations for labeling opened/prepared food is - date opened/prepared, name of item if not on the package, and use by date. The DM said his expectations for the use by date was 72 hours for everything except canned soups can stay a few days longer. The DM said his expectations for open packages was to be placed in a resealable bag or container and to be sealed.<br><br>The DM stated the container with eggs and sausage, labeled for [name] was probably served the day before and saved for the cook, [name]. The DM stated it should have been in the employee's refrigerator. The DM states he went through both refrigerators 4/9/25 and removed everything that was past the use by date. The DM stated he tried to do that every morning or when he had time. The DM states the white gravy had been on the steam table since breakfast and stated the soup had just been placed on the steam table. The DM states all foods should be covered and temped before serving. The DM stated the hot mitten that fell on the floor should not have been re-used.<br><br>Review of facility policy Food Storage, revised 2018, revealed, in part:<br><br>- To ensure freshness, store opened and bulk items in tightly covered containers. All containers must be labeled and dated.<br><br>- Date, label and tightly seal all refrigerated foods using clean, nonabsorbent covered containers that are approved for food storage.<br><br>(continued on next page) |

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| | 676031 | A. Building<br>B. Wing | 04/10/2025 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | - Use all leftovers within 72 hours. Discard items that are over 72 hours old.<br><br>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 3-501.17 Ready-to-Eat/Time Temperature Control for Safety Food, Date Marking. (B) Except as specified in (E) - (G) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment 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. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45411<br><br>Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections for one (Resident #41) of two residents reviewed for transmission-based precautions care in that:<br><br>1. CNA G failed to wear required PPE when entering Resident #41's room on 04/08/2025.<br><br>2. HSK H failed to wear required PPE when entering Resident #41's room on 04/09/2025.<br><br>3. CNA I failed to wear required PPE when entering Resident #41's room on 04/10/2025.<br><br>This failure could place resident's risk for cross contamination and the spread of infection.<br><br>Findings included:<br><br>Review of Resident #41's Admission Record revealed she was an [AGE] year-old female originally admitted to the facility 03/14/2023 with a most recent admitted [DATE] with a diagnosis of recurrent enterocolitis due to clostridium difficile (infection of the colon caused by the bacteria clostridium difficile resulting in inflammation of the lining of the colon and diarrhea).<br><br>Review of Resident #41's Annual MDS assessment dated [DATE] revealed she had a BIMS (Brief Interview for Mental Status) score of 15, indicating she was cognitively intact. She required moderate assistance with most ADLs. She was frequently incontinent of bowel and bladder. She was receiving an antibiotic.<br><br>Review of Resident #41's care plan most recently revised on 03/20/2025 revealed no care plan addressing her contact isolation due to recurrent C. difficile infections.<br><br>Observation on 04/08/25 at 11:31 am revealed Resident #41 was on contact isolation. The resident had a PPE station outside her room and a STOP sign on door indicating the type of isolation and required PPE to be worn when in the resident's room. Resident #41's door was open at the time of the observation.<br><br>In an observation on 04/08/25 at 2:25 pm Resident #41's door remained open.<br><br>In an observation and interview on 04/08/25 at 5:19 pm Resident #41's door was open, and CNA G was observed entering the room wearing no PPE to deliver the resident's meal tray. The tray was a regular tray, not disposable. CNA G left the room and did not perform hand hygiene. CNA G stated she always worked on Resident #41's hall and that when the resident was on contact isolation, she (CNA G) was supposed to wear a gown, gloves, and a mask when providing care for any resident on contact isolation. She had no explanation for why she failed to wear PPE when delivering Resident #41's meal tray.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 04/09/25 at 8:54 am Resident #41 stated she was on an antibiotic for a UTI in March 2025 and she thought that was the cause of her current C. difficile flare up. She stated she had had C. difficile infections in the past. Resident #41 stated that she understood that she would remain in jail (on contact isolation) until the flare up was done.<br><br>In a telephone interview on 04/09/25 at 10:32 am with MD E, he stated that his expectation was that when a resident was placed on contact precautions/isolation, that the resident's room door remained closed at all times. He stated that any staff member entering the room of a resident on contact isolation should were a gown and gloves regardless of the activity to be performed. He stated that the PPE use was extremely important for a resident with an active C. difficile infection because of how easily it could spread. MD E stated that if the proper PPE was not worn by staff it could lead to an outbreak of C. difficile in the facility.<br><br>In a telephone interview on 04/09/25 at 10:59 am with MD F, she stated that her expectation was that all staff would wear masks, gloves, and gowns when entering the room of a resident on contact isolation. She stated she believed that disposable trays and utensils should be used for all meals when a resident was on contact isolation, but she was unsure of the facility's policy regarding meal service. MD F stated that a resident on contact isolation absolutely should not have their door left open and especially not if they had an active C. difficile infection.<br><br>In an interview on 04/09/25 at 12:32 pm with the DM, he stated he was notified by nursing staff when there was a contagious infection in the building. He stated that the serving process was the same for residents on contact isolation as other residents (regular dishes and plates), and currently there were not any infections in the facility that he was aware of.<br><br>In an observation and interview on 04/09/25 at 2:28 pm HSK H was observed in Resident #41's room wearing no PPE. She stated that when cleaning a Resident #41's room, she only wore gloves because her sickness doesn't spread but she made sure to leave the isolation rooms to the end of her rounds to be cleaned.<br><br>In an observation and interview on 4/10/25 at 9:33 am CNA I walked in and out of Resident #41's room three times without wearing PPE. She was observed leaning on the resident's bed during this time. CNA I stated she had been trained to wear a gown, gloves, and depending on what care was being provided to the resident, a mask. She stated that she was required to wash her hands before and after providing care because C. difficile was spread by spores.<br><br>In an interview on 04/10/25 at 11:05 am LVN B stated that Resident #41 had recurrent C. difficile flare ups because she was colonized with the bacteria, and she was placed on contact isolation each time. She stated that staff was required to wear a gown, gloves and a mask when doing direct care and at least gloves when entering the room. She stated that staff had been in-serviced on the different types of isolation precautions. She stated that the most recent in-service was done at the end of March 2025. She stated there was no reason that staff should be going into contact isolation rooms without PPE on. She stated the management staff did refresher in-services when any resident was diagnosed with an infection requiring isolation.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 04/10/25 at 11:15 am the Housekeeping Supervisor stated that she and all of her staff (housekeeping and laundry) were contract employees, but they received and were required to participate in trainings and in-services through the facility. She stated that for a resident on contact isolation her staff wore only gloves when cleaning the resident's room. She stated that the CNAs were responsible for picking up trash and laundry from contact isolation rooms.<br><br>In an interview on 04/10/25 at 12:30 pm the ADON stated her expectations for staff going in and out of a contact isolation room for any reason was to put on a gown and gloves. She stated that she expected staff to wear full PPE (gown and gloves, mask if they chose) when in the room of a resident with C. difficile for any reason not just when providing direct care. She stated that meals were taken into the room for a resident on contact isolation on regular trays, but she had always been taught/told that facilities were supposed to use disposable trays, plates, cups, and utensils, and that current facility policies did not address the issue. She stated that infection control in-services were done every month. She stated that the in-services the last three months had been focused on transmission-based precautions and C. difficile. She stated the last C. difficile in-service was done at the end of March 2025 when Resident #41 tested positive. She stated that the staff might not understand the severity of C. difficile and how contagious it was and that was why they were not wearing the appropriate PPE when entering Resident #41's room. The ADON stated that if the staff were not following contact isolation guidelines and wearing the proper PPE that the outcome could be disastrous. The ADON then clarified that by disastrous she meant that if the staff were not following proper PPE protocol for contact isolation C. difficile could spread like wildfire throughout the facility because it was so contagious and for some of the more medically fragile residents that could contracting C. difficile could be life or death.<br><br>In an interview on 04/10/25 at 1:01 pm The DON stated that her expectations were that staff would refer to signs on individual resident doors that indicated the type of isolation the resident was on (contact, droplet, enhanced barrier precaution) and what PPE was required when entering the room. The DON stated they (herself and the ADON) had done in-services the past three months regarding C. difficile and the different types of isolation. She stated that she did not understand why some staff were not wearing the proper PPE in any of the resident rooms. The DON stated that a C. difficile outbreak could occur if staff were not adhering to contact isolation guidelines and wearing the proper PPE.<br><br>Review of the facility infection tracking log on 04/10/2025 at 2:23 pm revealed one case of C. difficile in January 2025 and two cases in March 2025, one of which had resolved and the other being Resident #41.<br><br>Review of facility in-services revealed: an all-staff in-service on 01/28/2025 titled Covid Precautions/PPE/C. diff signed by CNA G, HSK H, and CNA I. A nursing department in-service titled EBP Guidelines/PPE dated 01/28/2025 which contained the CMS guidance for placing a resident on enhanced barrier precautions versus contact isolation, and was signed by CNA G and CNA I. An in-service for nurses titled C. diff Prevention was given on 03/31/2025.<br><br>Review of facility policy titled Clostridium Difficile revised October 2018 revealed, in part: Residents with diarrhea associated with C. difficile (i.e., residents who are colonized and symptomatic) are placed on Contact Precautions. Residents with diarrhea and suspected CDI (C. difficile infection) are placed on Contact Precautions while awaiting laboratory results.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A facility policy for contact isolation/precautions was requested by the survey team on 04/09/2025. The Corporate Compliance RN stated on 04/09/2025 at 4:30 pm that no policy was available that related to contact isolation.<br><br>Review of CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings last updated in September 2024 revealed when Contact Precautions are used (i.e., to prevent transmission of an infectious agent that is not interrupted by Standard Precautions alone and that is associated with environmental contamination), donning of both gown and gloves upon room entry is indicated to address unintentional contact with contaminated environmental surfaces. |