STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676034	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brady West Rehab & Nursing	2201 Menard Hwy Brady, TX 76825

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Based on interviews and record reviews the facility failed to ensure the resident's had the right to be informed of the risks, and participate in, his or her treatment which included the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she preferred, for 2 of 5 residents (Residents #14, Resident # 17) reviewed for resident rights. The facility failed to obtain informed consent based on information of the benefits, risks, and options available from Resident #14's or their Responsible Party for Mirtazapine, an antidepressant used to treat depression (a mood disorder that causes a persistent feeling of sadness or loss of interest) prior to administering the medication. The facility failed to obtain informed consent based on information of the benefits, risks, and options available from Resident #17 or their Responsible Party for Divalproex- a medication used to treat agitation in people with dementia (a cognitive disorder causing memory loss and personality changes) prior to administering medication. The facility failed to obtain consent based on information of the benefits, risks, and options available from Resident #17 or their Responsible Party for Melatonin - a supplement used to treat insomnia (difficulty sleeping) prior to administering the medication. These failures could place residents at risk of receiving medications without their prior knowledge or consent, or that of their responsible party. Findings included: Review of Resident #14's Admission Record, dated 8/21/24, revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including depression and dementia. She was on hospice. Review of Resident #14's Quarterly MDS Assessment, dated 7/1/24 revealed: She had long and short-term memory impairment with severely impaired decision-making skills. She took an anti-depressant. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #14's Care Plan revealed: Revised 3/13/24 Resident #14 has altered sleep pattern related to insomnia. The Goal was the Resident will obtain optimal amounts of sleep as evidenced by rested appearance, verbalization of feeling rested, and improvement of sleep pattern by next review date. Identified interventions included: Administer medications as ordered. Review of Resident #14's Order Summary Report, dated 8/21/24, revealed orders: Acceptable to Evaluate and Treat by Hospice dated 8/9/24. Lorazepam 1mg 1 capsule by mouth every 4 hours as needed for anxiety. Dated 8/11/24. Mirtazapine Tablet 7.5 mg Give 3 table by mouth at bedtime for Appetite Supplement. Take 3 tablets to equal 22.5 mg beginning 8/15/24. Review of the Misc. section of Resident #14's electronic chart found a consent for Mirtazapine signed by the doctor on 8/13/24. There was no signature of the Resident's Representative. In an interview on 8/22/24 at 3:29 p.m. the DON stated the doctor or Nurse Practitioner would sign any anti-psychotic or neuroleptic consent. The DON said the doctor signed Resident #14's Mirtazapine consent but did say no one else had signed it. The DON said it was not a valid consent because it needed the resident's or resident's Responsible Party to be valid. The DON said the consent needed to be valid because the consent was part of the resident's treatment plan and part of the resident's right to accept or not accept. Review of Resident #17's Admission Record, dated 8/22/24, revealed he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, depression with psychotic features, and anxiety. Resident #17 was on hospice. Review of Resident #17's Significant Change MDS, dated [DATE], revealed: He scored a 2 of 15 on his mental status exam (indicating severe cognitive impairment) with signs of delirium including inattention, disorganized thinking, and altered level of consciousness. He used an antipsychotic and an anti-anxiety medication. Review of Resident #17's Care Plan revealed: Initiated 3/30/24 Resident #17 used psychotropic medications (antidepressants, antipsychotics, anxiolytics, or hypnotics) related to depression and, generalized anxiety disorder. The identified goal was the Resident will maintain the highest level of function possible and not experience a decrease in functional abilities related to psychotropic drug use during the next 90 days. Identified interventions included: administer medications as ordered. Evaluate effectiveness and side effects of medications routinely for possible decrease/elimination of psychotropic medications. Review of Resident #17's Order Summary, dated 8/22/24, revealed orders: (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Divalproex Extended Release 250 mg 1 tablet two times a day related to Alzheimer's Disease and Major Depressive Disorder with Psychotic Symptoms for two weeks beginning 8/16/24 and ending 8/30/24. Divalproex Delayed Release 500 mg at bedtime relate to Alzheimer's Disease and Major Depressive Disorder with Psychotic Symptoms for two weeks beginning 8/16/24 and ending 8/30/24. Melatonin Extended Release Give 2 tablets by mouth at bedtime for sleep beginning 8/15/24. Review of the Misc. Section of Resident #17's electronic chart found no consent for the Divalproex or Melatonin . In an interview on 8/22/24 at 3:47 p.m. the DON said she did not find a consent for Resident #17's Divalproex. The DON said the facility should not need a consent for Resident #17's Melatonin. The Corporate RN joined the conversation and explained to the DON the facility did need a consent because the facility was using the supplement to help Resident #17 sleep . Review of the facility's policy and procedure on Clinical Practice Guidelines Use of Psychotropic Medication, revised 10/18/23 revealed: Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). Policy Explanation and Compliance Guidelines. 1. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include, but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics. 3., The attending physician or psychiatric physician will assume leadership in medication management by developing, monitoring, and modifying the medication regimen in collaboration with residents, their families and/or representatives, other professionals, and the interdisciplinary team. 4. Informed consent for Psychotropic Medication prior to administration. 6. Resident and/or representatives shall be educated on the risks and benefits of psychotropic drug use, as well as alternative treatments/ non-pharmacological interventions.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Based on interviews and record review the facility failed to electronically transmit within 14 days after the facility completed a resident's assessment, encoded MDS data including a subset of items upon a resident's quarterly MDS assessment for 1 (Residents #27) of 6 residents reviewed for electronic transmission of MDS data to the CMS system. The facility failed to transmit quarterly MDS data to the CMS system within 14 days of the completion of Resident #27's quarterly MDS Assessment. This failure could place residents at risk of not having specific information transmitted in a timely manner. Findings included: Review of Resident #27's Admission MDS Assessment, dated 3/26/24 revealed he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including stroke, high blood pressure, high cholesterol, and dementia. He scored a 4 of 15 on his mental status exam (indicating severe cognitive impairment) and showed signs of delirium including inattention. Review of Resident #27's e-chart MDS section revealed there was a Quarterly MDS completed on 6/26/24., In an interview and computer review on 8/21/24 at 4:21 p.m. the MDS Coordinator stated Resident #27 was admitted to the facility on [DATE] and his 5-day MDS Assessment was completed but not submitted because he was managed care. The MDS Coordinator stated Resident #27's 14-day Admission MDS Assessment was completed and accepted on 3/26/24. The MDS Coordinator stated Resident #27's next MDS was a quarterly and it was completed on 6/26/24 and her program showed it was completed and accepted. Upon confirmation in the CMS program, the MDS Coordinator stated the 6/26/24 Quarterly MDS didn't go through and was not pulled from the MDS section to the transmission's sections for the CMS program to accept. The MDS Coordinator stated this was the first time this had happened to her. The MDS Coordinator called her supervisor on the speaker phone. The MDS Supervisor explained the MDS transmission was a two-step validation process.: The MDS was first completed in the facility's computer program then it was pulled out and submitted into the CMS approved program. The MDS Supervisor stated they would have to do a correction and re-submit Resident #27's quarterly MDS. The MDS Coordinator stated it was important because without the information the facility did not get paid and the residents did not get services. The MDS Coordinator said CMS got the numbers for the Quality Measures the facility used for their Quality Assessment and Performance Improvement meetings from the MDS Assessments. The MDS Coordinator said if the Quality Measures were off it could be difficult for the facility to come up with accurate plans and that with a census of 34 residents one person could skew the measures . (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the CMS RAI Version 3.0 Manual, last revised October 2023, reflected: For a Quarterly, Significant Correction to Prior Quarterly, Discharge or PPS assessment, encoding must occur within 7 days after the MDS completion Date . Providers must transmit all sections of the MDS 3.0 required for their State-specific instrument, including the Care Area Assessment (CAA) Summary (Section V) and all tracking or correction information. Transmission requirements apply to all MDS 3.0 records used to meet both federal and state requirements. Care plans are not required to be transmitted. Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date. All other MDS assessments must be submitted within 14 days of the MDS Completion Date.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45411 Based on interviews 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 3 of 4 residents reviewed for care plans (Residents #18, #28, #32). 1. Residents #18, #28, and #32 did not have care plans in place to address their need for Enhanced Barrier Precautions (EBP). 2. Resident #32 did not have a care plan in place to address her pressure ulcer. These failures could affect residents by placing them at risk of not receiving individualized care and services to meet their needs. The findings included: Resident #18 Review of Resident #18's Admission Record revealed she was a [AGE] year-old female originally admitted to the facility on [DATE], with a most recent admitted [DATE]. She had diagnoses which included myelodysplastic syndrome (condition, considered a type of cancer, in which the blood-forming cells in the bone marrow become abnormal), B-cell lymphoma (cancer of a type of immune system cell) of the spleen, chronic kidney disease stage 3 (progressive damage and loss of function to the kidneys), anemia, and a stage 3 pressure ulcer of the left heel. Review of Resident #18's care plan revealed the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Focus - Pressure Ulcer: Resident #18 has a pressure ulcer and was at risk for infection, pain, and a decline in functional abilities. She refused to wear any other shoes besides her slip-ons and refused to stay out of wheelchair with feet elevated and heels offloaded to promote wound healing. (12/21/23 right heel resolved, left heel reclassified to an unstageable. Wound with slow but progressive healing. 5/17/24 left heel reclassified to a stage 3 and treatment order changed. 6/20/24 pressure ulcer to left heel was improving well, resident has been taking her sock and dressing off the past few days and digging/scratching at the wound with her dirty hands and has caused the wound to increase in size and depth.) (Initiated: 7/24/23, Revision: 8/19/24) Goal - Resident's pressure ulcer will show signs of healing through next review date (Revision: 11/28/23). Interventions - Encourage resident to leave dressing and sock in place (Initiated: 6/20/24). Encourage resident to stop touching the stray cats and instruct her to wash her hands when she was observed messing with the cats (Initiated: 6/20/24). Notify physician and responsible party of changes in status (Initiated: 7/24/23). Administer analgesics for discomfort or pain. If necessary, provide pain management prior to dressing changes and repositioning (Initiated: 7/24/23). Provide wound care per physician's order. Keep dressing clean, dry, and intact. Replace the dressing as needed for soiling (Initiated: 7/24/23). Weekly skin checks to monitor for redness, circulatory problems, pressure sores, open areas, and other changes in skin integrity. Report new conditions to the physician (Initiated: 7/24/23). Low air loss mattress (Initiated: 7/24/23). There was no care plan focus area in place to address EBP (Enhanced Barrier Precautions) related to Resident #18's pressure ulcers. Review of Resident #18's Significant Change MDS Assessment, dated 8/14/24, revealed: She scored a 9 on her mental status exam indicating moderate cognitive impairment, she required moderate assistance for all ADLs except for eating and oral hygiene which required only supervision or set-up, she used a wheelchair for mobility, she had an active diagnosis of a pressure ulcer of the left heel stage 3, she was at risk for developing pressure ulcers/injuries, she had one stage 3 pressure ulcer present at the time of the assessment that was not present at the time of admission/entry or reentry to the facility, she had moisture associated skin damage (MASD), she had a pressure reducing device for her chair and bed, nutrition or hydration interventions to manage skin problems, pressure ulcer/injury care, applications of ointments/medications (other than to feet), and applications of dressings to feet (with or without topical medications). Review of Resident #18's Order Summary Report, dated 8/22/24, revealed the following orders : - Med Plus 2.0 (fortified nutrition shake) - 60ml by mouth three times a day for supplemental needs regarding wound healing (Order Date: 8/20/24) - Weekly Skin Assessment - day shift every Thursday (Order Date: 8/27/23) - Monitor reddened areas to the left and right gluteal areas, apply barrier cream for each incontinent episode - every shift for skin integrity (Order Date: 8/8/24) - Red area on buttocks: clean with wound cleanser apply mupirocin 2% ointment - two times a day for redness (Order Date: 6/6/24) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Stage 2 decubitus (pressure) ulcer to heel: cleanse wound to left heel with wound cleanser, pat dry, apply collagen powder to wound bed only, cover with padded dressing, apply barrier cream to surrounding skin, and cover with Kerlex (clingy gauze wrap) - one time a day, every day shift related to pressure ulcer of left heel stage 3 (Order Date: 8/21/24) - Stage 2 decubitus ulcer to heel: cleanse wound to left heel with wound cleanser, pat dry, apply collagen powder to wound bed only, cover with padded dressing, apply barrier cream to surrounding skin, and cover with Kerlex (clingy gauze wrap) - as needed when dressing soiled related to pressure ulcer of left heel stage 3 (Order Date: 8/21/24) Resident #28 Review of Resident #28's Admission Record revealed she was a [AGE] year-old female originally admitted to the facility on [DATE] with a most recent admitted [DATE]. She had diagnoses which included malignant neoplasm of the pancreas (cancer), diabetes, protein-calorie malnutrition, anemia, and stage 2 pressure ulcer to coccyx (tailbone). Review of Resident #28's Admission MDS Assessment, dated 8/2/24, revealed the following: She scored a 14 on her mental status exam indicating she was cognitively intact, she required maximum assistance for showering/bathing but only required set-up assistance for all other ADLs, she required a wheelchair for mobility, she was at risk of developing pressure ulcers/injuries, she had one stage 2 pressure ulcer that was not present at the time of admission/entry or reentry to the facility, she had a pressure reducing device for her bed and pressure ulcer/injury care, and she received hospice care. Review of Resident #28's care plan, revised 8/13/24, revealed the following: Focus - Pressure Ulcer [NAME]: Resident has a pressure ulcer to coccyx (Initiated 7/29/24, Revision: 8/13/24). Goal - The resident will be free of further breakdown through next review date (Revision: 8/13/24). Interventions - Resident requesting personal mattress topper in addition to low air loss mattress. Educated on increased risk for pressure ulcers. Verbalizes understanding, as well as continued use of topper (Initiated: 8/13/24). Reposition frequently or more often as needed or requested (Initiated: 7/29/24). Weekly skin checks to monitor for redness, circulatory problems, pressure sores, open areas, and other changes in skin integrity. Report new conditions to the physicians (Initiated: 7/929/24). Low air loss mattress to bed with pressure relieving overlay, mattress has been changed 3 times since admission due to resident complaints of discomfort (Revision: 8/7/24). Maintain the bed as flat as possible to reduce shear (Initiated: 7/29/24). There was no care plan focus area in place to address EBP (Enhanced Barrier Precautions) related to Resident #28's pressure ulcer. Review of Resident #28's Order Summary Report, dated 8/22/24, revealed the following orders: - Low air loss mattress to aid in the healing/prevention of actual/prevention skin breakdown - every shift, check every shift and document settings (Order Date: 7/27/24) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Perform head to toe skin assessment. Document any changes in skin integrity in the medical record - every Monday day shift for wound prevention/early identification; notify the physician of any changes in skin integrity (Order Date: 7/27/24) - Stage 2 Coccyx: clean with wound cleaner, apply skin prep and cover with dry foam padded dressing every other day (Monday, Wednesday, Friday) - day shift every Monday, Wednesday, Friday for wound healing (Order Date: 8/4/24) Resident #32 Review of Resident #32's Admission Record revealed she was a [AGE] year-old female admitted to the facility on [DATE]. She had diagnoses which included dementia, protein-calorie malnutrition, urinary tract infection, and stage 2 pressure ulcer to the left foot. Review of Resident #32's care plan, revised 5/13/24, revealed the following: Focus - Pressure Ulcer Risk: Resident #32 has the potential for the development of a pressure ulcer due to history of pressure ulcer, incontinence, and malnutrition (Initiated: 2/8/24, Revision: 5/13/24). Goal - Resident's current skin concerns will show signs of healing with a decrease in size through the next review date (Initiated: 2/8/24). Interventions - Reposition frequently or more often as needed or requested (Initiated: 2/8/24). Check frequently for wetness and soiling, every two hours and provide incontinence care as needed (Initiated: 2/8/24). Briefs or adult incontinence products as needed for protection (Initiated: 2/8/24). Provide wound care per physician's order. Keep dressing clean, dry, and intact. Replace the dressing as needed for soiling (Initiated: 2/8/24). Bathe per schedule (Initiated: 2/8/24). Diet as ordered. Offer substitutes if resident does not eat. Record intake and report a decline in intake to the physician (Initiated: 2/8/24). There were no care plan focus areas in place to address Resident #32's active pressure ulcer or EBP (Enhanced Barrier Precautions) related to her pressure ulcer. Review of Resident #32's Quarterly MDS Assessment, dated 7/27/24, revealed the following: She scored an 11 on her mental status exam indicating mild cognitive impairment, she had functional limitation in range of motion in both upper extremities and required a wheelchair for mobility, she required moderate to maximum assistance for most ADLs, required supervision for eating and personal/oral hygiene, she was at risk of developing pressure ulcers/injuries, she had no reported pressure ulcers at the time of the assessment (the stage 2 pressure ulcer to her left foot was identified on 8/6/24), and she had a pressure reducing device for her chair and her bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 8/22/24 at 5:41 p.m. the MDS Coordinator stated she would do a care plan on pressure ulcers if she was asked to or if she was the nurse that found it. The MDS Coordinator stated if it did not happen in her 7-day look-back period for the MDS Assessment she did not know about it. The MDS Coordinator stated Resident #32 was admitted with a Stage III pressure ulcer that was healed and the care plan was discontinued. The MDS Coordinator said there was now a pressure ulcer on her medial foot that developed 8/6/24. The MDS Coordinator said this occurred after her MDS was completed but a care plan should have been done. The MDS Coordinator said nursing should have developed an acute care plan. The MDS Coordinator said she was not part of nursing, so she did not know if nursing had someone designated to do acute care plans. The MDS Coordinator stated Resident #32's pressure ulcer care plans consisted of the one that was resolved and her risk factors. The MDS Coordinator explained the facility did not have a stable DON for the last few months so there was miscommunication. The MDS Coordinator said the nursing department did not understand she was there for reimbursement and had this assumption that the MDS Coordinator was responsible for acute care plans. The MDS Coordinator said between MDS Assessments the residents obviously did not get their care plan in. The MDS Coordinator stated pressure ulcer interventions included wound care orders that were already established, nutrition, positioning, incontinence, and hydration. The MDS Coordinator stated it was probably slipping through the cracks without the care plan. The MDS Coordinator said she paid attention to weight loss, falls with major injuries, and stage II pressure sores that did not resolve in 2 weeks. The MDS Coordinator said EBP would require a care plan and it would depend on if the resident was admitted with it or not if she was responsible for doing it or the nurses were responsible for doing the acute care plan . In an interview on 8/22/24 at 6:22 p.m. the Administrator and the Regional Nurse Consultant stated care plans were supposed to be done in morning meetings as an interdisciplinary approach. The Regional Nurse Consultant said anyone in the morning meetings could do the care plan, including the Administrator. The Regional Nurse Consultant said there was another Corporate Nurse who was responsible for overseeing MDS and she had the conversation about nursing and the MDS department working better together before. The Regional Nurse Consultant said it was ongoing . Review of facility policy Care Plans and CAAs (Care Area Assessments), revised 10/12/22, revealed, in part: The purpose of this guide is to ensure that an Interdisciplinary Team (IDT) approach is utilized in addressing the Care Area Triggers (CATs) that were generated by the completion of the Minimum Data Set (MDS) in in order to effectively address the Care Area Assessments (CAAs) and ultimately achieve the completion of an effective comprehensive plan of care for each resident. Procedure: All Admission and Significant Change care plans that are generated by the MDS - CAAs will be coordinated by a Registered Nurse (RN). The facility IDT team is responsible for addressing their assigned CAT/CAA triggered by the MDS and deemed necessary at the time of the MDS Assessment. Case Mix Manager (CMM) or designee will be responsible for: Pressure Ulcer. Care Plan Updates: CMS updates care plans after Assessment before review by IDT at care plan meeting. The IDT will review the care plans on Admission/readmission, Quarterly, Annually, and as needed by the IDT. Acute Care Plans: As acute problems or changes to interventions or goals are identified, an appropriate care plan will be developed or modified by a Nursing staff member.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 Based on observations, interviews, and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate dispensing and administering of all drugs and biologicals to meet the needs of each resident for 1 (Residents #2) of 15 residents reviewed for pharmaceutical services. LVN A did not administer Resident #2's scheduled multivitamin with minerals as indicated by the physician orders. These failures could place residents at risk of not receiving the therapeutic benefit of medications and under dosed. The findings were: Record review of Resident #2's Admission Record, dated 08/21/2024, indicated she was admitted to the facility on [DATE] with diagnoses of anxiety and vitamin deficiency. She was [AGE] years of age. Record review of Resident #2's order summary report dated 08/21/2024 indicated in part: Multiple Vitamins with Minerals. Give 1 tablet by mouth one time a day for dietary supplement. Order status = active. Order date 08/30/20. Start date 06/07/22. During an observation on 08/21/24 at 11:04 AM LVN A administered Resident #2 her medications. LVN A poured one multi-vitamin with iron into a pill cup then gave it to Resident #2 to take by mouth. During an interview on 08/21/24 at 11:45 AM LVN A said she had accidentally administered the wrong vitamin to Resident #2 during the medication pass. LVN A said she meant to administer the vitamin with minerals but had gotten nervous and poured the vitamin with iron instead of the one with minerals. LVN A said if she did not administer the correct vitamin then the resident would not receive the minerals as ordered. During an interview on 08/21/24 at 12:10 PM the DON was made aware of the observation of LVN A administering Resident #2 a vitamin without minerals while on her orders it indicated to give a vitamin with minerals. The DON said the nurse should have administered the vitamin with minerals as they did have them in stock in the medication room. The DON said she monitored the nurses by conducting rounds at times, but she could not see everything that was going on. The DON said LVN A simply administered the wrong vitamin . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/22/24 at 02:07 PM the Administrator was made aware of the observation of LVN A administering Resident #2 a vitamin without minerals while on her orders it indicated to give a vitamin with minerals. The Administrator said that LVN A should have administered the vitamin as ordered. The Administrator said that the DON and the ADON would monitor the nurses to make sure they were following the physician orders. The Administrator said that by looking through their computer system the DON and the ADON could see if the nurses were documenting that the medications were being administered. The Administrator said if a nurse did not administer the correct vitamin, then the resident could not receive the desired outcome intended by the doctor's order. Record review of the facility document titled Medication-Treatment administration and documentation and dated 4/6/2023 indicated in part: Anticipated outcome: To provide a process for accurate timely administration and documentation of medication and treatments. Fundamental information: Medication are administered according to manufacturer's guidelines unless otherwise indicated by physician order. Process: Administer the medication according to the physician order.

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F 0790 Level of Harm - Actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45411 Based on observations, interviews, and record review, the facility failed to assist residents in obtaining routine and 24-hour emergency dental care for 2 of 2 residents (Residents #2 and #20) reviewed for dental services. 1. The facility failed to assist in providing routine dental services for Resident #2 and Resident #20. This failure could place residents at risk of oral complications, dental pain, and diminished quality of life. Findings included: Resident #20 Review of Resident #20's Admission Record revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included congestive heart failure (condition in which the heart does not pump blood well enough to give the body a normal supply), anxiety disorder, dental carries (cavities), bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and recurrent major depressive disorder. Review of Resident #20's Care Plan, revision date 5/23/24, revealed: Focus - Resident #20 has had multiple teeth extracted in the past and still has some more teeth he would like extracted. He would like all his teeth pulled and dental implants. Goals - Resident #20 will be free of infection, pain, or bleeding in the oral cavity through the next review date. Resident #20 will tolerate his diet through the next review date. Interventions - Provide mouth care as per ADL personal hygiene. Monitor and report as needed any signs and symptoms of oral/dental problems needing attention: pain, abscess, debris in mouth, lips cracked or bleeding, teeth missing, loose, broken, eroded, decayed, tongue black, coated, inflamed, white, smooth, ulcers in mouth, and lesions. Coordinate arrangements for dental care, transportation as needed/as ordered. Resident #20 has been to the dentist and was unable to pay for teeth extractions and dental implants out of pocket. Review of Resident #20's Quarterly MDS assessment dated [DATE] revealed: He scored a 14 on his BIMS indicating he was cognitively intact, he sometimes felt lonely or isolated from those around him, he required set-up assistance for all ADLs except for bathing for which he required partial assistance, he used a wheelchair for mobility, he received a mechanically altered diet, he had no reported weight gain or loss, and he denied mouth/dental pain at the time of the assessment. (continued on next page)

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F 0790 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #20's Comprehensive Dental Evaluation by PQR Dental dated 6/17/24 revealed: Treatment Plan Summary: Patient has generalized severe bone loss, and as a result has many teeth that are mobile and would advise removing these teeth. Patient also has several areas of new decay that can be restored with routine fillings. On the maxillary arch (upper jaw), advise removing all remaining teeth and fabricating a complete upper denture, as these teeth all show severe bone loss with mobility. On the lower arch, patient does have two teeth that are not mobile that can be restored with simple fillings and used as abutment teeth (support for a dental bridge or attachment for a dental implant) for a lower partial denture. Patient expressed that he would very much like to have dentures made. No follow-up visits by PQR Dental were found in the resident's chart. In an interview and observation on 8/20/24 at 3:31 pm, Resident #20 was sitting in his wheelchair in his room watching tv. Resident #20 stated he had been living at the facility for a little over a year and things were so far so good but there were things he did not understand. When asked to explain, he stated that he needed new teeth, and the facility was supposed to help him get them, but they have not. He stated he had seen a dentist one time since he had been a resident. Resident #20 opened his mouth and pointed to his top teeth to show that he was missing his four top, front teeth. He stated that he had been self-isolating in his room because he was embarrassed of his teeth and did not want to be seen in public looking the way he did. He stated he played guitar and sang/wrote songs, but he did not do it anymore because his missing front teeth affected the way he spoke and sang. He stated his missing teeth had changed the way he had to eat because of how he had to chew, and he did not like people watching him eat because it embarrassed him (he mentioned he had gained weight since living in the facility because he did enjoy the food). He stated he refused to go to therapy because of his teeth because he did not see the point of getting better when he was not going to leave the room. He stated that he went outside 2 or 3 times a day to smoke a cigar and fed the cats on the back patio and did go to the store with the other residents when that was offered as an activity. Resident #20 stated that he did not care that it made him sound [NAME] but the fact that he was missing his front teeth, and nothing was being done about it was ruining his life. Resident #2 Review of Resident #2's Admission Record, dated 8/21/24, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including stroke. Review of Resident #2's Quarterly MDS Assessment, dated 7/10/24, revealed: She scored a 15 of 15 on her mental status exam. She had mouth or facial pain, discomfort, or difficulty with chewing. Review of Resident #2's Care Plan revealed: (continued on next page)

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F 0790 Level of Harm - Actual harm Residents Affected - Few	Revised 12/29/20 ADLs: Resident #2 has an ADL Self Care Performance Deficit and is at risk for not having their needs met in a timely manner. Performance deficit related to: Hemiplegia/Hemiparesis (paralysis) secondary to stroke. The identified goal was: Resident #2 will maintain a sense of dignity by being clean, dry, odor free, and well-groomed through the next review date. Identified interventions included: Resident #2 is able to complete personal hygiene tasks with limited assist of staff x1. Revised 5/23/24: Resident #2 has oral/ dental problem: missing bottom teeth and dental company stopping in the middle of fixing her bottom partial plate. 5/23/24 UPDATE Resident #2 states that she has the bottom partial (dental plate), but it causes her pain to her back tooth, and she is wanting that fixed. Facility continues to have issues with obtaining a XYZ Dental contract and family has not been able to find a dentist that accepts Resident #2's insurance. Resident #2 reports that she is not having any pain this time associated with the broken teeth and she is able to eat her meals fine. The identified goal was Resident #2 will be free of infection, pain, or bleeding in the oral cavity through the next review date. Interventions included: coordinate arrangements for dental care, transportation as needed/as ordered. Refer to dentist for evaluation and recommendation when new dental company comes to work here. Review of Resident #2's Order Summary Report, dated 8/21/24 revealed: May have Dental care as needed (Order Date 2/19/19) In an interview on 8/20/24 at 11:56 a.m. Resident #2 stated her only issue with her care was that she would like to be seen by a dentist and the facility had yet to get her seen due to an issue with the local dentists requiring Medicaid for dental coverage. During a confidential resident council meeting on 8/21/24 at 3:30 p.m., 2 of the 6 residents who attended the meeting stated if they could change one thing at the facility it would be to have access to routine dental services. In an interview on 8/21/24 at 4:56 p.m. the MDS Coordinator stated the facility used XYZ Dental and TUV Dental for dental providers and had issues with both. The MDS Coordinator stated she was not sure which provider the DON got to come to the facility, and she was not sure the last time a dental provider came to the facility. In an interview on 8/21/24 at 4:57 p.m. the DON stated she had a referral out to PQR Dental to come see a handful of residents. The DON said she could reach out to PQR Dental to find out when they planned on coming to the facility. The DON stated she had several residents express interest in dental services since the second [she] got here, actually. (continued on next page)

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F 0790 Level of Harm - Actual harm Residents Affected - Few	In an interview on 8/22/24 at 9:33 a.m. the DON stated she reached out the PQR Dental and they had already been contracted with the facility one time. The DON stated Resident #2 was already being seen by PQR Dental. The DON stated she sent out about nine referrals yesterday and PQR Dental said they would call before noon that day (8/22/24) with an update on when they would be able to do a facility visit. The DON said she had been working with PQR Dental for about a week before something went awry and PQR Dental quit showing up. The DON said she knew dental services were an issue, that was why she had contracted with them. The DON stated after that she tried working with PQR Dental, they started doing some snaky practices like pulling information (such as financial information) without the resident's permission. The DON said PQR Dental was politely aggressive about the situation. The DON stated she knew residents needed to be seen through Quality-of-Life rounds, weight reviews, if the resident had reduced intake, and complained of mouth pain which was based on CNA documentation. The DON said, I go out and talk to my residents, that's how I got my list (referring to residents that needed or wanted to be seen for dental services). The DON stated possible impact to the residents included broken or chipped teeth, not eating as much, difficulty chewing meat, cavities, and discomfort. The DON said one resident (Resident #20) said he was embarrassed about his teeth but did not know if the dental provider took that resident's insurance. The DON said the dental company gave the facility a week's notice about when they came to the facility. She said it was her first interaction with the company, so she was not sure about payment. The DON described Resident #20 as a nice guy who was not getting out of his room as much anymore. The DON said Resident #20 liked to play the guitar, was an occasional smoker, and did therapy. The DON said Resident #20 and Resident #2 were the only patients PQR Dental had an account with. In an interview on 8/22/24 at 1:30 p.m. the DON stated the facility had a contract with PQR Dental and TUV Dental, but the person she talked to at TUV Dental was out and said the DON would have to talk to the scheduler. The DON stated the PQR Dental company had not called her back, they sent an email about Resident #2 pending insurance to see a dentist. The DON stated she felt it was taking too long to get a response. In an interview on 8/22/24 at 6:02 pm the ADON stated that Resident #20 had been self-isolating since she started working at the facility in September 2023. She stated that he used to play his guitar and sing, but he has stopped doing both because he can no longer sing due to his missing teeth. She stated she was not aware that his isolating was because of his missing teeth. She stated that he would come out of his room to smoke, to feed the cats, and go to the store but then he would go straight back to his room. She stated that he had never verbalized that he was embarrassed by his lack of teeth to her. The ADON stated that she had never spoken to him about why he did not participate in activities or why he was staying in his room so much. She stated that the DON had been working to get a dentist to come to the facility to see the residents. She stated that the lack of routine dental care could be detrimental to residents nutritionally because they could have weight loss. More importantly, especially regarding Resident #20, it could cause psychological damage because he in particular was withdrawing socially and making comments that his quality of life was suffering. Requested facility policy regarding dental services on 8/22/24 at 9:45 am. At time of survey exit on 8/22/24 at 8:00pm, no policy had been provided to the survey team for review.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45411 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. 1. The facility failed to ensure stored foods were properly stored, labeled, and dated. 2. The facility failed to ensure food items remained covered prior to food service. 3. The facility failed to ensure the refrigerator's thermometers reflected similar temperatures. 4. The facility failed to ensure expired food items were discarded by the expiration date. 5. The facility failed to maintain cleanliness in the kitchen. The dry storage had food particles on the shelves and the ice machine had a brown substance on the ice making mechanism. These failures could place residents who received prepared meals from the kitchen at risk for food borne illness and cross-contamination. The findings included: During the initial tour of the kitchen on [DATE] from 11:20 am to 12:00 pm the following observations were made: - A coffee filter was noted sitting on top of a clear plastic bin next to the coffee machine with approximately 1 (one) cup of coffee scooped in it. The filter and coffee were not covered. - 7 (seven) metal bins of various sizes containing food were noted on the steam table at the time of entrance to the kitchen, none of which had covers. The food on the steam table remained uncovered for no less than thirty minutes until the kitchen staff began plating and serving the residents lunch at approximately 11:55 am. - Refrigerator temperature reading on built-in thermometer located on outside of the unit read 40.7 degrees Fahrenheit while internal, removable thermometers (2 noted inside on different shelves) read 45 degrees Fahrenheit and 44 degrees Fahrenheit. - 1 (one) resealable, clear plastic bag labeled lettuce, [DATE], Use By [DATE] found with bag of lettuce in original package with open end rolled up and shoved into open resealable plastic bag with open side down. Original lettuce package label stated weight of 5-pounds. Resealable plastic bag noted to be too small to contain the original packaging, therefore it was not sealed, and the original packaging bag for the [pp; lettuce was sticking out approximately 4-inches from the opening of the resealable bag. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- 1 (one) 2-gallon resealable plastic bag labeled shredded cheese, [DATE], Use By [DATE] noted in refrigerator, resealable plastic bag not properly sealed and original packaging inside not sealed. - Clear plastic tub with blue lid noted on shelf in dry storage with facility label stated Product: rice crispy; Date: [DATE]; Use By: [DATE]. - [NAME] plastic 5-gallon storage bucket with lid and facility label stated Product: elbow noodles; Date: [DATE]; Use By: [DATE]; Received: [DATE] noted on bottom shelf in dry storage with large crack on the side of the bucket preventing the lid from sealing. - Loose noodles noted on bottom shelf where pastas stored in dry storage. - [NAME] powder and gritty white substance noted on bottom shelf where flour, sugar, and salt stored in dry storage. - Floor in dry storage room and surrounding refrigerator sticky when walking. - Vent above dishwasher sink appears furry with collection of debris - unable to inspect closely due to height . In an interview on [DATE] at 12:05 pm, the Dietary Manager stated that the lettuce should not have been shoved into a resealable bag that was too small to hold it. She stated she did not know why anyone would have thought that was acceptable. The lettuce was immediately disposed of. She stated that the shredded cheese was not properly sealed and removed it from the refrigerator. She stated that the cheese looked like someone was in a hurry when putting it away and it did not get sealed completely. She stated she would throw it away just to be safe. The Dietary Manager stated that the dietary staff was supposed to use the built-in thermometer reading when logging refrigerator temperatures and she had not been told anything about the internal thermometers reading too high. The Dietary Manager and the State Surveyor returned to the refrigerator to check the internal and built-in thermometers and the built-in temperature read 39.9 degrees Fahrenheit while the internal thermometers read 44 degrees Fahrenheit and 44 degrees Fahrenheit respectively. The Dietary Manager stated that the two internal thermometers were old, and she had purchased replacements that she would place in the refrigerator immediately to see if it changed the readings. She stated that the plastic bin containing expired cereal was not a food the facility used anymore and immediately disposed of the bin. She stated she understood that having outdated food was still an issue even if it was not being used. The Dietary manager stated that she was aware of the broken storage bin containing the elbow noodles and that she had ordered new bins that were to be delivered hopefully today or tomorrow. She stated the staff had continued using the noodles from the broken bin. She stated she did not recall how long the storage bin had been broken. She stated that the loose pasta and the collection of flour and salt or sugar on the bottom shelves in the dry storage room could become a pest control issue because having food on the floor would bring in rodents and bugs. She stated that the floor in the dry storage room was always sticky and was hard to keep clean, but she had not noticed the floor in the kitchen being sticky. When the Dietary Manager was shown the coffee filter with coffee in it sitting next to the coffee machine she asked, is that not ok? The Dietary Manager was made aware that upon the State Surveyor's entry to the kitchen for observation, 7 containers of food were noted to be on the steam table with no covers for at least thirty minutes until lunch service began and the Dietary Manager asked, should they be covered? (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on [DATE] at 12:30 pm revealed brown liquid build-up noted on the lip of the ice dispenser on the inside of the ice machine in the dining room. The brown liquid was noted to be the entire length of the white plastic piece of the machine where the ice dropped down into the holding bin. When the build-up was touched, the State Surveyor's fingers came away with a watery, brown, gritty substance on them. The build-up did not appear to drip into the holding bin and the ice in the bin appeared clean. In a follow-up observation on [DATE] at 12:02 pm, the built-in thermometer on the refrigerator read 40.2 degrees Fahrenheit and the internal thermometers read 44 degrees and 45 degrees Fahrenheit respectively. The Dietary Manager stated that the thermometers inside the refrigerator had been replaced with the newly purchased thermometers on [DATE] and that when the temperatures had been logged that morning, both internal thermometers had read 40 degrees. The Dietary Manager stated she did not understand why the new thermometers were reading higher during the observation. In an interview on [DATE] at 12:15 pm, the Food Service Bench Manager stated that she had been made aware of the issues identified on [DATE] by the Dietary Manager but wanted to go over everything anyway. She stated that she had already started in-serving the dietary staff on food storage protocols. She stated that she did not know why the staff would think it was ok to try to shove a 5-pound bag of anything into a 1-gallon resealable bag because it would never fit or properly seal. She stated that she was not aware that the dietary staff had continued to use the elbow noodles from the broken storage bin instead of throwing them out and using resealable bags to store the noodles until the new bin arrived. She stated that as soon as the broken bin was discovered, it and the noodles should have been thrown away due to the risk of cross contamination. The Food Service Bench Manager stated that the food on the bottom shelves in the dry storage room was a risk for rodents and insects coming into the building and having the broken bin in the room contributed to that too. She stated that all food items should have been properly covered at all times whether they were in the refrigerator, on the steam table, or on the counter. She had no explanation for why there was a coffee filter full of coffee sitting on the counter. She stated that the corporate policy was that food was not to be held on the steam table. - She stated that the food should be coming straight from the oven or stove to the steam table and being served. There should not have been a reason for the steam table to have food sitting uncovered for thirty or more minutes. She stated she would have to investigate what happened during the lunch service on [DATE] to cause the food to sit out that long at all, but especially uncovered. She stated that the steam table being uncovered was a risk for cross contamination because anything could have been blown into the food with it open to air. The Food Service Bench Manager stated that the Dietary Manager was incorrect about the logs for the refrigerator temperatures, and that the staff should be recording the internal temperatures. She stated that she had checked them herself that morning and the temperatures were within range. She stated that cleaning the vent above the dishwasher sink was the responsibility of maintenance. She stated that she had noticed how dirty it was and felt like it was a risk for contamination if some of the debris fell off or got blown into the food while the staff were cooking or serving food. She stated that the kitchen was old and could look dirtier than it was but that was no excuse for it to not be kept clean. She stated that there was a lot of education that needed to be done with the kitchen staff. In a follow-up observation on [DATE] at 11:05 am, the built-in thermometer on the refrigerator read 40.6 degrees Fahrenheit and the internal thermometers read 40 degrees Fahrenheit and 41 degrees Fahrenheit respectively. Review of facility policy Equipment Cleaning Procedures, revised ,d+[DATE], revealed, in part: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Routine cleaning will be practiced on a regular basis in order to keep all dietary equipment and the environment safe, sanitary, and in compliance with state and federal regulations. Cleaning Frequency: Daily - Kitchen and storeroom floors should be swept and mopped daily. Weekly - Clean refrigerator and freezer weekly. Appropriate chemical should be used to mop freezer floor. Monthly - Wash walls, ceilings, doors, and vents monthly or as needed. Review of facility policy Food Safety and Sanitation Plan, revised ,d+[DATE], revealed, in part: Cross Contamination: the transfer of harmful substances or disease-causing microorganisms to food by hands, food contact surfaces, sponges, towels, or utensils which are not cleaned after touching raw food and then touching ready-to-eat foods. It can also occur when raw food drips onto cooked or ready-to-eat foods. Food Contamination: the unintended presence of potentially harmful substances, including but not limited to microorganisms, chemicals, or physical objects in food. Potentially Hazardous Food (PHF) or Time/Temperature Control for Safety (TCS) Food: food that requires time/temperature control for safety to limit the growth of pathogens. Proper Refrigeration Storage: foods will be stored at 41 degrees Fahrenheit or below. All cooked or prepared foods shall be protected at all times from cross contamination. Ice - Appropriate ice and water handling practices prevent contamination and the potential for waterborne illness. Keeping the ice machine clean and sanitary will help prevent contamination of the ice. Contamination risks associated with ice and water handling practices may include, but are not limited to unclean equipment, including the internal components of ice machines that are not drained, cleaned, and sanitized as needed according to manufacturer's specifications. Review of facility policy Dry Food and Supplies Storage, revised [DATE], revealed, in part: All bulk food items that are removed from original containers into food grade containers must have tight fitting lids; Dry storage areas will be kept neat, clean, and orderly. Routine cleaning of walls, flooring and shelving will be maintained. Expiration or use by dates will be checked and product will be put in order of use by or expiration date. Any product that is found to be out of date will be discarded. Bulk food products that are removed from original containers must be placed in plastic or metal food grade containers with tight fitting lids. All opened products must be resealed effectively and properly labeled, dated, and rotated for use. 'Use by', 'Best by' and Sell by' dates should be routinely checked to ensure that items which have expired are discarded appropriately. Review of facility policy Frozen and Refrigerated Foods Storage, revised [DATE], revealed, in part: PHF/TCS (potentially hazardous foods/time temperature controlled for safety foods) must be kept in refrigerated units at or below 41 degrees Fahrenheit. All refrigerator and freezer units in the facility used to store facility-purchased food for residents must be equipped with an internal thermometer even if an external thermometer is present. Refrigerator and freezer temperatures should be checked and logged a minimum of twice daily, once in the morning and once in the evening. Packaged frozen items that are opened and not used in their entirety must be properly sealed, labeled, and dated for continued storage.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 45411 Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for one (Resident #4) of 2 residents reviewed for incontinent care and 3 (Resident #18, #28, and #32) of 4 residents reviewed for Enhanced Barrier Protections (EBP) for infection control practices. 1. CNA B washed her hands then closed the faucet with her bare hands before providing personal care for Resident #4. CNA B also did not sanitize her hands in between glove change during personal care provided to Resident #4. 2. The facility failed to ensure Residents #18, #28, and #32 were identified for and implemented Enhanced Barrier Precautions related to pressure ulcers. These failures could place resident's risk for cross contamination and the spread of infection. Finding included: Resident #4 Record review of Resident #4's admission record dated 08/21/2024 indicated she was admitted to the facility on [DATE] with diagnoses of generalized anxiety disorder, dementia, and muscle wasting and atrophy (waste away). She was [AGE] years of age. Record review of Resident #4's care plan revised 06/07/2023 indicated in part: Focus: Incontinence: Resident is incontinent of bowel/bladder related to cognitive impairment secondary to dementia and is at risk for the complications of incontinence, Physical limitations GOAL: The resident will remain free from skin breakdown due to incontinence and brief use through next review date. Interventions: INCONTINENT: Check frequently for wetness and soiling, every two hours, and change as needed. Record review of Resident #4's Quarterly MDS dated [DATE] indicated in part: BIMS of 15 (indicating she was cognitively intact), Bladder and bowel: Urinary continence and Bowel continence = Always incontinent. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 08/21/24 at 01:30 PM CNA B performed incontinent care for Resident #4. CNA B entered the residents' room and proceeded to wash her hands. CNA B turned the faucet on and washed her hands with soap, rinsed them then proceeded to close the faucet with her bare hands. CNA B then dried her hands put on a pair of gloves and proceeded to perform personal care to Resident #4. During the incontinent care, it was noted that the resident had a bowel movement. CNA B used several wet wipes to wipe off the bowel movement from Resident #4's rectal area. CNA B then removed her gloves and put on a new pair of gloves without first sanitizing her hands and then proceeded to perform care for the resident. In an interview on 08/22/24 at 10:12 AM the DON was made aware of the incontinent care performed by CNA B. The DON said it was expected for the CNA to use a paper towel to turn off the faucet to prevent re-contamination of her hands. The DON said the CNAs were expected to wash their hands in between glove change to prevent cross contamination and the use of gloves did not replace hand washing. The DON said if the staff did not close the faucet with a paper towel or washed their hands at the appropriate time that could lead to the spread of infections. The DON said the staff were trained every 2 months on infection control. The DON said that perhaps the failure occurred because the CNA got nervous and forgot her steps. In an interview on 08/22/24 at 11:00 AM CNA B said she should have closed the faucet with a paper towel but had gotten nervous and forgot. CNA B said if she touched the faucet with her bare hands her hands could get re-contaminated. CNA B said that she was supposed to wash her hands in between glove changes but she had forgotten to do that when she had provided care for Resident #4. CNA B said her closing the faucet with her bare hands and not washing her hands before changing gloves could lead to cross contamination. In an interview on 08/22/24 at 02:10 PM the Administrator was made aware of the incontinent care performed by CNA B. The Administrator said that staff was expected to close the faucet with a paper towel to prevent from contaminating their hands. The Administrator said staff were expected to sanitize or wash their hands in between glove changes to prevent contamination. The Administrator said the DON and ADON conducted quarterly training with staff regarding infection control. The Administrator said if staff did not wash their hands correctly or at the appropriate time then that could lead to cross contamination. The Administrator said the failure probably occurred because the staff member got nervous and forgot the steps. Resident #18 Review of Resident #18's Admission Record revealed she was a [AGE] year-old female originally admitted to the facility on [DATE], with a most recent admitted [DATE]. She had diagnoses which included myelodysplastic syndrome (condition, considered a type of cancer, in which the blood-forming cells in the bone marrow become abnormal), B-cell lymphoma (cancer of a type of immune system cell) of the spleen, chronic kidney disease stage 3 (progressive damage and loss of function to the kidneys), anemia, and a stage 3 pressure ulcer of the left heel. Review of Resident #18's care plan revealed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Focus - Pressure Ulcer: Resident #18 has a pressure ulcer and was at risk for infection, pain, and a decline in functional abilities. She refused to wear any other shoes besides her slip-ons and refused to stay out of wheelchair with feet elevated and heels offloaded to promote wound healing. (12/21/23 right heel resolved, left heel reclassified to an unstageable. Wound with slow but progressive healing. 5/17/24 left heel reclassified to a stage 3 and treatment order changed. 6/20/24 pressure ulcer to left heel was improving well, resident has been taking her sock and dressing off the past few days and digging/scratching at the wound with her dirty hands and has caused the wound to increase in size and depth.) (Initiated: 7/24/23, Revision: 8/19/24) Goal - Resident's pressure ulcer will show signs of healing through next review date (Revision: 11/28/23). Interventions - Encourage resident to leave dressing and sock in place (Initiated: 6/20/24). Encourage resident to stop touching the stray cats and instruct her to wash her hands when she was observed messing with the cats (Initiated: 6/20/24). Notify physician and responsible party of changes in status (Initiated: 7/24/23). Administer analgesics for discomfort or pain. If necessary, provide pain management prior to dressing changes and repositioning (Initiated: 7/24/23). Provide wound care per physician's order. Keep dressing clean, dry, and intact. Replace the dressing as needed for soiling (Initiated: 7/24/23). Weekly skin checks to monitor for redness, circulatory problems, pressure sores, open areas, and other changes in skin integrity. Report new conditions to the physician (Initiated: 7/24/23). Low air loss mattress (Initiated: 7/24/23). There was no care plan focus area in place to address EBP (Enhanced Barrier Precautions) related to Resident #18's pressure ulcers. Review of Resident #18's Significant Change MDS Assessment, dated 8/14/24, revealed: She scored a 9 on her mental status exam indicating moderate cognitive impairment, she required moderate assistance for all ADLs except for eating and oral hygiene which required only supervision or set-up, she used a wheelchair for mobility, she had an active diagnosis of a pressure ulcer of the left heel stage 3, she was at risk for developing pressure ulcers/injuries, she had one stage 3 pressure ulcer present at the time of the assessment that was not present at the time of admission/entry or reentry to the facility, she had moisture associated skin damage (MASD), she had a pressure reducing device for her chair and bed, nutrition or hydration interventions to manage skin problems, pressure ulcer/injury care, applications of ointments/medications (other than to feet), and applications of dressings to feet (with or without topical medications). Review of Resident #18's Order Summary Report, dated 8/22/24, revealed the following orders: - Med Plus 2.0 (fortified nutrition shake) - 60ml by mouth three times a day for supplemental needs regarding wound healing (Order Date: 8/20/24) - Weekly Skin Assessment - day shift every Thursday (Order Date: 8/27/23) - Monitor reddened areas to the left and right gluteal areas, apply barrier cream for each incontinent episode - every shift for skin integrity (Order Date: 8/8/24) - Red area on buttocks: clean with wound cleanser apply mupirocin 2% ointment - two times a day for redness (Order Date: 6/6/24) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Stage 2 decubitus (pressure) ulcer to heel: cleanse wound to left heel with wound cleanser, pat dry, apply collagen powder to wound bed only, cover with padded dressing, apply barrier cream to surrounding skin, and cover with Kerlex (clingy gauze wrap) - one time a day, every day shift related to pressure ulcer of left heel stage 3 (Order Date: 8/21/24) - Stage 2 decubitus ulcer to heel: cleanse wound to left heel with wound cleanser, pat dry, apply collagen powder to wound bed only, cover with padded dressing, apply barrier cream to surrounding skin, and cover with Kerlex (clingy gauze wrap) - as needed when dressing soiled related to pressure ulcer of left heel stage 3 (Order Date: 8/21/24) Resident #28 Review of Resident #28's Admission Record revealed she was a [AGE] year-old female originally admitted to the facility on [DATE] with a most recent admitted [DATE]. She had diagnoses which included malignant neoplasm of the pancreas (cancer), diabetes, protein-calorie malnutrition, anemia, and stage 2 pressure ulcer to coccyx (tailbone). Review of Resident #28's Admission MDS Assessment, dated 8/2/24, revealed the following: She scored a 14 on her mental status exam indicating she was cognitively intact, she required maximum assistance for showering/bathing but only required set-up assistance for all other ADLs, she required a wheelchair for mobility, she was at risk of developing pressure ulcers/injuries, she had one stage 2 pressure ulcer that was not present at the time of admission/entry or reentry to the facility, she had a pressure reducing device for her bed and pressure ulcer/injury care, and she received hospice care. Review of Resident #28's care plan, revised 8/13/24, revealed the following: Focus - Pressure Ulcer [NAME]: Resident has a pressure ulcer to coccyx (Initiated 7/29/24, Revision: 8/13/24). Goal - The resident will be free of further breakdown through next review date (Revision: 8/13/24). Interventions - Resident requesting personal mattress topper in addition to low air loss mattress. Educated on increased risk for pressure ulcers. Verbalizes understanding, as well as continued use of topper (Initiated: 8/13/24). Reposition frequently or more often as needed or requested (Initiated: 7/29/24). Weekly skin checks to monitor for redness, circulatory problems, pressure sores, open areas, and other changes in skin integrity. Report new conditions to the physicians (Initiated: 7/929/24). Low air loss mattress to bed with pressure relieving overlay, mattress has been changed 3 times since admission due to resident complaints of discomfort (Revision: 8/7/24). Maintain the bed as flat as possible to reduce shear (Initiated: 7/29/24). There was no care plan focus area in place to address EBP (Enhanced Barrier Precautions) related to Resident #28's pressure ulcer. Review of Resident #28's Order Summary Report, dated 8/22/24, revealed the following orders: - Low air loss mattress to aid in the healing/prevention of actual/prevention skin breakdown - every shift, check every shift and document settings (Order Date: 7/27/24) - Perform head to toe skin assessment. Document any changes in skin integrity in the medical record - every Monday day shift for wound prevention/early identification; notify the physician of any changes in skin integrity (Order Date: 7/27/24) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Stage 2 Coccyx: clean with wound cleaner, apply skin prep and cover with dry foam padded dressing every other day (Monday, Wednesday, Friday) - day shift every Monday, Wednesday, Friday for wound healing (Order Date: 8/4/24) Resident #32 Review of Resident #32's Admission Record revealed she was a [AGE] year-old female admitted to the facility on [DATE]. She had diagnoses which included dementia, protein-calorie malnutrition, urinary tract infection, and stage 2 pressure ulcer to the left foot. Review of Resident #32's care plan, revised 5/13/24, revealed the following: Focus - Pressure Ulcer Risk: Resident #32 has the potential for the development of a pressure ulcer due to history of pressure ulcer, incontinence, and malnutrition (Initiated: 2/8/24, Revision: 5/13/24). Goal - Resident's current skin concerns will show signs of healing with a decrease in size through the next review date (Initiated: 2/8/24). Interventions - Reposition frequently or more often as needed or requested (Initiated: 2/8/24). Check frequently for wetness and soiling, every two hours and provide incontinence care as needed (Initiated: 2/8/24). Briefs or adult incontinence products as needed for protection (Initiated: 2/8/24). Provide wound care per physician's order. Keep dressing clean, dry, and intact. Replace the dressing as needed for soiling (Initiated: 2/8/24). Bathe per schedule (Initiated: 2/8/24). Diet as ordered. Offer substitutes if resident does not eat. Record intake and report a decline in intake to the physician (Initiated: 2/8/24).There were no care plan focus areas in place to address Resident #32's active pressure ulcer or EBP (Enhanced Barrier Precautions) related to her pressure ulcer. Review of Resident #32's Quarterly MDS Assessment, dated 7/27/24, revealed the following: She scored an 11 on her mental status exam indicating mild cognitive impairment, she had functional limitation in range of motion in both upper extremities and required a wheelchair for mobility, she required moderate to maximum assistance for most ADLs, required supervision for eating and personal/oral hygiene, she was at risk of developing pressure ulcers/injuries, she had no reported pressure ulcers at the time of the assessment (the stage 2 pressure ulcer to her left foot was identified on 8/6/24), and she had a pressure reducing device for her chair and her bed. Observation on 8/22/24 from 1:20 pm through 1:40 pm revealed that Resident #18, Resident #28, and Resident #32's rooms did not have signs posted outside their doors stating the residents were on EBP or explaining the protocol for PPE use while providing resident care. No PPE was noted outside or inside of the resident's rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 8/22/24 at 3:29 pm with the ADON, she stated that she had been ADON for about one year and in the Infection Control Preventionist role off and on for that year. She stated that EBP was for when a resident has a catheter and they (facility staff) take extra precautions to prevent infections with PPE and hand hygiene while providing care. She stated EBP was not just for residents with catheters. She stated she did not have a lot of experience with EBP because she just received full training on it a few weeks ago. The ADON stated the training was basic and just went over the steps of how to implement EBP. She stated that there had been a lot of turnover in nursing management so the facility had not been implementing the EBP guidance but she was aware it had been around for a little while. She stated that a resident that was colonized with MRSA would be placed on EBP. She stated that a resident with a pressure ulcer would be placed on EBP dependent on the type of pressure ulcer. For example, an MDRO wound she would wear full PPE but a wound that had a clean culture she would not. She stated she was not aware if there was a specific EBP policy and she would ask the corporate RN if they had one. She stated she thought the staff had been in-serviced about EBP but could not be certain because she had been out on medical leave when the facility first began putting EBP in place. In an interview on 8/22/24 at 5:33 pm, the Regional Nurse Consultant stated that she was notified about the EBP guidelines in April. She stated that the information came from her corporate office, and she sent the information out to her facilities as soon as she received it (4/1/24 for the initial information and 4/23/24 for a refresher). She stated that training was given to facilities on EBP the same week the guidelines came out, and it was done as a step-by-step roll out. The roll out was done with the guidelines, a log form for residents that were placed on EBP, the laminated cards given to management with the basic information for EBP, a training video for staff, the CMS guidance, how to do care plans pertaining to EBP, resident/family education on EBP, and all of that was followed up with their weekly meetings with management staff. She stated that residents were given the option to have the PPE stored on the back of their door or out of sight, like in a drawer (Resident #16). She stated that the goal for the roll out was to keep the homelike feel for the residents as much as possible. She stated that the DON who was at the facility at the time of the roll out was no longer employed with the company and the ADON was out on medical leave. She stated that it was apparently hit or miss with the previous DON implementing the policy for residents. She stated the current DON began working in the facility in July 2024, but the ADON was the main ICP The Regional Nurse Consultant stated that the facility needed to go back over the roll out and review all current residents to make sure all residents had the appropriate precautions in place. In an interview on 8/22/24 at 5:41 p.m. CNA E stated she wore PPE when she did catheter care or was doing isolation precautions. CNA E stated she would not wear PPE when taking care of a resident with a pressure sore. CNA E stated the facility had one resident who just came out of isolation and Resident #16 had a catheter, no one else needed any type of isolation for any reason. CNA E stated she got training on when to wear PPE when she did her classroom training on being a CNA and the interim DON did an in-service on how and when to wear PPE. CNA E said with Resident #16 she put on gloves, a gown, and set up a barrier on the ground because she did not want to make a mess and getting anything on her (CNA E). CNA E stated she did not help with wound care and wound dressings typically did not get dirty unless the resident had a big bowel movement and then she would let the nurse know. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 8/22/24 at 5:41 p.m. the MDS Coordinator stated EBP was used with residents with cancer, catheters, respirators, tracheostomies, and feeding tubes. The MDS Coordinator said any kind of ostomy that would require care would also require EBP. The MDS Coordinator stated Resident #32 was admitted to the facility in January 2024 with a Stage III pressure ulcer that was healed sometime in May but there was now a pressure ulcer on her left medial foot that developed 8/6/24. She did not have any comment regarding Resident #18 or Resident #28's pressure ulcers or why the residents with pressure ulcers required EBP. In an interview on 8/22/24 at 6:22 p.m. the Regional Nurse Consultant said residents were reassessed and those who needed EBP had signs posted. She stated she had an EBP in-service set up for the staff for 8/23/24. In an interview on 08/22/24 at 06:30 pm, LVN C said she had been working at the facility for almost a year. LVN C said she had heard about EBP and that currently there were no residents in the facility that were on EBP. LVN C said she usually worked on halls B and C. LVN C said EBP meant for resident's that were in isolation such as COVID or C-Diff. LVN C said she had received training regarding EBP a few months ago. LVN C said Resident's like Resident #16 and Resident #23 could be on EBP, but she had not seen any PPE or signs posted outside the door. LVN C said she did not think they specified which residents were on EBP in the facility. In an interview on 08/22/24 at 06:44 pm, NA D said that EBP meant for staff to use infection control precautions for all residents. NA D said that he worked all the halls. NA D said that he knew of one resident that was on EBP and that was Resident #16 because the resident had urinary catheter. NA D said whenever he assisted Resident #16, he would wear PPE which was located in the resident's room. Review of facility policy Hand Hygiene, dated 11/12/2017, revealed, in part: Policy: Staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Policy explanation and compliance guidelines: Staff will perform hand hygiene when indicated using proper technique consistent with accepted standards of practice. Hand hygiene is indicated and will be performed under the conditions listed in but not limited to the attached hand hygiene table. The use of gloves does not replace hand washing. Wash hands after removing gloves. Hand hygiene table: Between resident contacts, after handling contaminated objects, before applying and after removing personal protective equipment including gloves, before performing resident care procedures, when during resident care moving from a contaminated body site to a clean body site. Review of facility policy Incontinence Care, dated 04/10/2017, revealed, in part: Purpose to outline a procedure for cleaning the perineum and buttocks after an incontinence episode. Procedure knock on door and request entrance. Introduce self and explain procedure and provide privacy. Wash hands. If feces present remove with toilet paper or disposable wipe by wiping from front or perineum toward rectum. Discard soiled materials and gloves. Wash hands. Put on non-sterile, latex free gloves. Review of facility policy Infection Prevention and Control Program, revised 3/26/24, revealed, in part: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and investigations of exposures of infectious diseases. Enhanced Barrier Precautions: EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP are indicated for residents with any of the following: Infection or colonization with an MDRO when Contact Precautions do not otherwise apply; Wounds and/or indwelling medical devices (e.g. central lines, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status. All staff shall receive training, relevant to their specific roles and responsibilities, regarding the facility's infection prevention and control program, including policies and procedures related to their job function. All staff are expected to provide care consistent with infection control practices. Direct care staff shall demonstrate competence in resident care procedures established by our facility. The Infection Control Preventionist implements/monitors/validates that staff are trained in infection control practices.