STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676051	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcliff Skilled Nursing Facility	4054 Northwest Loop Carthage, TX 75633

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958 Based on observation and interview, the facility failed to ensure the resident to be free from any physical restraints imposed for purposes of convenience and not required to treat medical symptoms for 1 of 2 residents reviewed for restraint use (Resident #5). The facility failed to ensure Resident #5 was free from physical restraints in the form of a lap harness on a broda chair (a broda chair is a chair or wheelchair that provides comfort, support and mobility throughout the day). The facility failed to ensure Resident #5's restraint was accurately assessed, monitored, documentation of ongoing re-evaluation of the need for the restraint and provided a physician order for the lap harness. This failure could place residents at risk for a decreased quality of life, a decline in physical functioning and injury. Findings included: Record review of Resident #5's face sheet dated 1/29/25 revealed she was [AGE] years old and admitted to the facility on [DATE]. Resident #5 had diagnoses including anxiety disorder, retts syndrome (a rare genetic mutation affecting brain development in girls), epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), weakness. Record review of Resident #5's quarterly MDS assessment dated [DATE] indicated she had no BIMS assessment performed, which indicated she was severely cognitively impaired. The MDS indicated Resident #5 had active diagnoses of anxiety disorder. The MDS did not indicate Resident #5 had a limb restraint in Section P0100. Physical Restraints. Record review of Resident #5 care plan dated 1/29/25 indicated Resident #5 required broda chair and lap harness for safe positioning and fall prevention, unsafe positioning without lap harness and uncontrolled lurching while in chair requires a lap harness for safety for resident. Interventions indicated assess skin under and around harness. Assist as needed with applying and removing harness. Resident #5's care plan also indicated Resident #5 had falls on 10/7/23, 3/29/24 and 11/15/24. Record review of Resident #5's fall risk report dated 6/19/23 indicated hap harness. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676051	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER Briarcliff Skilled Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 4054 Northwest Loop Carthage, TX 75633	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #5's Consolidated Orders dated 1/29/25 indicated: there was no order for the lap harness. Record review of Resident #5's chart dated 1/30/25 at 9:45 AM indicated there was no signed consent, no assessments and no monitoring for the broda chair with lap harness for safe positioning. During an observation on 1/29/25 at 8:25 AM, Resident #5 was sitting in a broda chair in the common area. There was a leg harness across each leg attached to the broad chair and clipped to the back of the broad chair. During an observation on 1/29/25 at 10:02 AM, Resident #5 was sitting in a broda chair in the common area. There was a leg harness across each leg attached to the broda chair and clipped to the back of the broda chair. During an observation on 1/29/25 at 11:11 AM, Resident #5 was sitting in a broda chair in the common area. There was a leg harness across each leg attached to the broda chair and clipped to the back of the broda chair. During an observation on 1/30/25 at 8:40 AM, Resident #5 was sitting in a broda chair in the common area. There was a leg harness across each leg attached to the broda chair and clipped to the back of the broda chair. During an observation on 1/30/25 at 9:04 AM, Resident #5 was sitting in a broda chair in the common area. There was a leg harness across each leg attached to the broda chair and clipped to the back of the broda chair . During an interview on 1/30/25 at 8:44 AM, LVN B said the legs straps on Resident #5 was just a safety device to keep her from sliding out of the chair. She has had those since she started working there and she had been here for 4 years. LVN B said Resident #5 could not take the leg straps off by herself . LVN B said Resident #5 was checked every 2 hours for incontinent care. She said staff laid Resident #5 down for a nap after lunch. LVN B said she did not feel like the straps were a restraint. LVN B said she did not see an order for the leg straps in the system and she did not know what they were called. During an interview on 01/30/25 at 9:07 AM, CNA A said the legs straps on Resident #5 were to hold her in the chair. She said Resident #5 has had that chair with the straps since she had been working there. She said she started working at the facility a year ago. CNA A said the leg straps was to keep Resident #5 in the chair, because she would jump out of the chair without it . She said staff laid Resident #5 down after lunch and checked the straps throughout the day to make sure they were not twisted or tight. She said she did not feel like the straps was a restraint. She said Resident #5 could not take the leg straps off by herself, because the leg straps clip around to the back of her chair. She said Resident #5 had seizures, so that may be another reason she has the straps. During an interview on 1/30/25 at 9:26 AM, LVN D said could not find an order for the leg straps and she did not work with Resident #5. LVN D said if Resident #5 did not have the leg straps, she would fall out of her chair. She said Resident #5 could not remove the leg straps herself. LVN D said the leg straps were technically a restraint, but they were to benefit Resident #5 from not falling out of her chair and she could still move. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Briarcliff Skilled Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 4054 Northwest Loop Carthage, TX 75633	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 01/30/25 at 9:35 AM, the ADON said Resident #5 had a history of throwing herself out of the wheelchair and she also had seizures. She said the leg straps were to prevent Resident #5 from falling out of the chair and was for her safety. She said she was not sure what the leg straps were called. She said when Resident #5 got up the staff put her in her chair, they adjusted the straps and checked the straps for redness throughout the day. She said after lunch the staff laid Resident #5 down in bed. She said she did not feel like the leg straps were a restraint. During an interview on 01/30/25 at 10:36 AM, the DON said the lap harness on Resident #5 was used for positioning, because she threw herself and leaps out of her chair, due to her mental condition. She said Resident #5 could not remove the lap harness by herself. She said Resident #5 could not functionally do anything by herself. She said the lap harness did not restrict Resident #5 from moving freely. She said before Resident #5 came to that facility and before she got that chair she fell out of a chair and broke all her teeth. She said Resident #5 could move her trunk. She said the facility did not have a signed consent form, but Resident #5's family member was fully aware of the leg harness. She said the leg harness was not a restraint it was a positioning device. She said she did not have orders for a wheelchair and lap harness , but it was care planned. During an interview on 1/30/25 at 10:49 AM, Regional Nurse J said Resident #5 would be restricted to the bed without the lap harness device. She would have a decrease in quality of life because she could not attend activities without the lap harness. During an interview on 1/30/25 at 11:06 AM, the ADM said to his understanding the lap harness was to keep Resident #5 safe from harming herself and ensure to keep her from throwing herself out of the wheelchair. He said Resident #5 could not remove the lap harness off herself. He said the lap harness did not restrict her from moving freely or from her normal activities. He said he thought she should have a signed consent for the lap harness. He said the lap harness could restrict her from falling from her chair. He said he did not agree that the lap harness restricts her normal activity. He said he agreed the lap harness should have the proper measures in place for the resident to use it. Requested a policy on Restraints on 1/30/25 at 11:25 AM from the DON. She said she did not have one. Record review of Resident #5's MD statement dated 1/31/25, received by email after exit on 2/03/25 at 11:31 AM, indicated Resident #5 had a diagnosis of Rett's Syndrome, Anxiety Disorder, Epilepsy, spastic hemiplegia , abnormal involuntary movement, and intellectual disabilities with the following medications related to these diagnoses: levetiracetam l00mg/mL oral solution twice a day; phenytoin 50mg three times a day; ropinirole 0.25mg every day; tizanidine 4mg PRN three times a day. The MD statement indicated due to these diagnoses, it was his professional opinion that the leg harnesses ordered for this resident were a safety device and do not constitute a restraint because they did not restrict her freedom of movement or normal access to her body. The MD statement indicated she did not have the cognitive ability to desire to attempt to ambulate or get out of her broda chair, nor the physical ability to do so. The MD statement indicated additionally these devices do not restrict her mobility, but rather were necessary for her mobility in that were they not provided to this resident she could not safely be in any chair due to the potential of seizures or involuntary motions that could and have resulted in significant injury in the past. She would therefore be restricted to her bed and bed bound. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #5's Safety Letter written by her PASRR Habilitation Coordinator dated 1/31/25, received by email after exit on 2/03/25 at 11:31 AM, indicated she provided assistance to access appropriate specialized services necessary to achieve a quality of life and level of community participation acceptable to Resident #5 and her family. The PASRR Habilitation Coordinator indicated Resident #5's unique safety needs stem from a combination of her diagnoses of Rett's Syndrome, Epilepsy, Muscle Spasms, Abnormal Involuntary Movements (lurching forward), and Convulsions. The PASRR Habilitation Coordinator indicated Resident #5 has difficulty remaining in a safe, upright position while in her wheelchair. This puts her at a higher risk for falls and injury. The PASRR Habilitation Coordinator indicated for this reason, when they requested Resident #5's Customized Manual Wheelchair (CMWC) through PASRR in 2019, a padded thigh belt and full footbox were included and were signed off on by the therapist, her primary care physician, and was approved by the state on 4/25/2019. These wheelchair accessories are not meant to restrain Resident #5, but to provide safety and allow her to be more active and independent while in her wheelchair. The PASRR Habilitation Coordinator indicated without the support of the safety belt and harness, she would be confined to her bed due to her history and high risks of falls. The PASRR Habilitation Coordinator indicated by having the safety accessories, Resident #5 is able to spend the majority of her day in her wheelchair where she is able to interact with her community to the best of her ability. The risk of falls and need for the safety supports are documented in her nursing facility care plan. In terms of daily care, it aligns seamlessly with the resident's care plan, supporting her participation in essential routines and complement other safety measures within the care plan. The PASRR Habilitation Coordinator said in her opinion that this comprehensive approach to safety allows for a more holistic care strategy, encouraging Resident #5's engagement in meaningful activities while minimizing risks. It becomes part of a larger framework designed to balance safety concerns with the pursuit of a fulfilling and active lifestyle. Record review of the Resident Rights Policy last revised August 14, 2022, revealed .staff will abide by resident rights as outlined within CMS State Operations Manual Appendix PP- Guidance to Surveyors for Long Term Care Facilities (Rev. 11-22-17).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062 Based on observation, interview, and record review the facility failed to ensure assessments accurately reflected the resident status for 2 of 22 residents (Resident #2 and Resident #5) reviewed for MDS assessment accuracy. 1. The facility failed to accurately reflect Resident #2's safety vest (trunk harness) or lap belt as a restraint on her quarterly MDS assessment dated [DATE]. 2. The facility failed to ensure Resident #5's restraint was accurately coded on her quarterly MDS assessment dated [DATE]. These failures could place residents at risk for not receiving care and services to meet their needs. Findings included: 1. Record review of Resident #2's face sheet dated 1/28/25 indicated she was [AGE] years old and admitted to the facility on [DATE]. Resident #2 had diagnoses which included profound intellectual disabilities, Cerebral Palsy (disorder of movement, muscle tone, or posture due to abnormal brain development, often before birth), dysphagia (difficulty swallowing), weakness, and diabetes (high blood sugar). Record review of Resident #2's quarterly MDS assessment dated [DATE] indicated Resident #2 was unable to perform a BIMS due to rarely/never understood. The MDS indicated Resident #2 was dependent on staff for most ADLs. The MDS indicated Resident #2 required partial/moderate staff assistance to roll left and right in bed and substantial/maximal assistance of staff to go from sit to lying or lying to sitting on the side of the bed. The MDS indicated Resident #2 used a wheelchair for mobility able to wheel self once seated. The MDS indicated Resident #2 did not use a trunk restraint. Record review of Resident #2's undated care plan with a print date of 1/28/25 indicated she had cognitive deficits related to decision-making and communicating needs. The care plan indicated Resident #2 was at high risk for falls and had an intervention to use a safety vest and a lap positioning aide for positioning and had a scoop mattress related to a history of rolling out of the bed. The care plan indicated Resident #2 had impaired physical mobility as evidenced by sitting balance impaired and required a safety harness to prevent front forward falling. The care plan indicated Resident #2 had self-care deficits. The care plan indicated Resident #2 had a positioning harness related to Cerebral Palsy as evidenced by wearing a positioning harness and seatbelt to enable resident to get out of the bed and be seated in a wheelchair, poor trunk control, history of falls, and leans to a side, forward, and backward. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #2's MD statement received by email after exit on 2/03/25 at 11:31 AM, indicated Resident #2 had a diagnosis of epilepsy (seizures), cerebral palsy with profound intellectual disabilities, and spastic quadriplegic cerebral palsy (form of cerebral palsy that affects both arms, legs, and often the torso and face). The MD statement indicated the safety devices including the lap belt and chest harness ordered for Resident #2 did not constitute a restraint because they did not restrict her freedom of movement or normal access to her body. The MD statement indicated Resident #2 did not have the cognitive ability to desire to attempt to ambulate or get out of her chair, nor the physical ability to do so. The MD statement indicated the devices did not restrict Resident #2's mobility but were necessary for her mobility and without the devices, Resident #2 could not safely be in her wheelchair and self-propel herself throughout the facility due to the potential of seizures or involuntary motions that could result in significant injury. The MD statement indicated Resident #2 would be restricted to her bed and bed bound without the devices. Record review of Resident #2's Safety Letter written by her PASRR Habilitation Coordinator and received by email after exit on 2/03/25 at 11:31 AM, indicated Resident #2 had unique safety needs stemming from a combination of her diagnoses of Profound Intellectual Disabilities, Cerebral Palsy, Epilepsy, and convulsions (type of seizure). The PASRR Habilitation Coordinator indicated Resident #2 had poor trunk control and had difficulty remaining in a safe, upright position while in her wheelchair and placed her at a higher risk for falls and injury. The PASRR Habilitation Coordinator indicated the Customized Manual Wheelchair was requested through PASRR in 2018 with a safety pelvic belt and shoulder harness were included and were signed off on by the therapist, her primary care physician, and was approved by the state on 9/14/2018. The PASRR Habilitation Coordinator indicated the wheelchair accessories were not meant to restrain Resident #2, but to provide safety and allow her to be more active and independent while in her wheelchair. The PASRR Habilitation Coordinator indicated without the support of the safety belt and harness, Resident #2 would be confined to her bed due to her high risks for falls. The PASRR Habilitation Coordinator indicated by having the safety accessories, Resident #2 was able to spend the majority of her day in her wheelchair, moving about the facility independently while interacting with her community. The PASRR Habilitation Coordinator indicated the risks for falls and the need for the safety supports were documented her nursing facility care plan and in her physician orders. The PASRR Habilitation Coordinator indicated in terms of daily care, it aligned seamlessly with Resident #2's care plan, supporting their participation in essential routines and complement other safety measures within the care plan. The PASRR Habilitation Coordinator indicated it was her opinion that the comprehensive approach to safety allowed for a more holistic care strategy, encouraging Resident #2's engagement in meaningful activities while minimizing risks and was part of a larger framework designed to balance safety concerns with the pursuit of a fulfilling and active lifestyle. During an observation of lunch meal service in the assisted dining room on 1/27/25 beginning at 11:47 AM, Resident #2 was sitting up in a high back wheelchair with a trunk harness and lap belt. The trunk harness formed a crisscross X across Resident #2's chest with straps that went over both shoulders and attached to the back upper frame of the wheelchair with plastic push together buckles (required the sides to be pushed together to unbuckle) and straps that went under both arms and attached to the back mid-lower frame of the wheelchair with plastic push together buckles. Resident #2 had a lap belt across her upper thighs. Resident #2 was non-verbal and only made noises. During an observation on 1/28/25 at 8:56 AM, Resident #2 was by the nurse's station sitting up in a high back wheelchair with a trunk harness and lap belt in place. Resident #2 was able to lean her upper body forward approximately six inches before the trunk harness restricted her forward motion. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 1/28/25 at 3:28 PM, Resident #2's RP said Resident #2 had been at the facility for years and they took excellent care of her. Resident #2's RP said the facility was probably using the trunk harness and lap belt, so she did not fall over in her chair or fall out of the chair. Resident #2's RP said he did not have a problem with the facility using the trunk harness or lap belt to keep her safe. During an observation on 1/29/25 at 9:12 AM, Resident #2 was by the nurse's station sitting up in a high back wheelchair with a trunk harness and lap belt in place. During an observation on 1/30/25 at 11:24 AM, Resident #2 was self-propelling herself in her wheelchair with a trunk harness and lap belt in place. During an interview on 1/30/25 at 8:48 AM, the MDS Coordinator said she had worked at the facility for approximately three years as the MDS nurse. The MDS Coordinator said a restraint was a device that prevented a resident's movement. The MDS Coordinator said Resident #2's vest was a positioning harness and without it Resident #2 could not hold up her trunk. The MDS Coordinator said Resident #2 could move and lean forward with the vest on. The MDS Coordinator said Resident #2's harness did not meet the definition of a restraint due to it was used for positioning. The MDS Coordinator said she was sure they had a policy related to accuracy of assessments, but it was also in the RAI manual for accuracy of assessment. During an interview on 1/30/25 at 10:03 AM, the ADON said Resident #2's safety vest was a safety harness, and it was to prevent her from falling from her chair. The ADON said the definition of a restraint was something that prevented movement or kept someone in one spot against their will. The ADON said Resident #2 could still move her arms and go where she wanted. The ADON said Resident #2 was not ambulatory and Resident #2 could lean forward to reach for something if she wanted to. The ADON said the safety vest was not a restraint. During an interview on 1/30/25 at 11:07 AM, the DON said Resident #2 would not be able to go around if she did not have the safety vest and would be confined to bed. The DON said Resident #2's safety vest and lap belt were not restraints and did not restrict her movement. During an interview on 1/30/25 at 11:29 AM, the ADM said MDS nurse was responsible for ensuring the MDS assessment was accurate. The ADM said the MDS assessment should accurately reflect the resident's care and needs. The ADM said if the MDS assessment was not accurate it could not reflect care needs of the resident or continuity of care, but he was not sure how it could affect the resident. 2. Record review of Resident #5's face sheet dated 1/29/25 revealed she was [AGE] years old and admitted to the facility on [DATE]. Resident #5 had diagnoses including anxiety disorder, retts syndrome (a rare genetic mutation affecting brain development in girls), epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), and weakness. Record review of Resident #5's quarterly MDS assessment dated [DATE] indicated she had no BIMS assessment performed, which indicated she was severely cognitively impaired. The MDS indicated Resident #5 had active diagnoses of anxiety disorder. The MDS did not indicate Resident #5 had a limb restraint in Section P0100. Physical Restraints. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #5 care plan dated 1/29/25 indicated Resident #5 requires broad chair and lap harness for safe positioning and fall prevention, unsafe positioning without lap harness and uncontrolled lurching while in chair requires a lap harness for safety for resident. Interventions indicated assess skin under and around harness. Assist as needed with applying and removing harness. Record review of Resident #5's Consolidated Orders dated 1/29/25 indicated: there was no order for the lap harness. Record review of Resident #5's chart dated 1/30/25 at 9:45 AM indicated there was no consent and no assessment for the broda chair with lap harness for safe positioning. Record review of Resident #5's MD statement received by email after exit on 2/03/25 at 11:31 AM, indicated Resident #5 had a diagnosis of Rett's Syndrome, Anxiety Disorder, Epilepsy, spastic hemiplegia, abnormal involuntary movement, and intellectual disabilities with the following medications related to these diagnoses: levetiracetam l00mg/mL oral solution twice a day; phenytoin 50mg three times a day; ropinirole 0.25mg every day; tizanidine 4mg PRN three times a day. The MD statement indicated due to these diagnoses, it was his professional opinion that the leg harnesses ordered for this resident were a safety device and do not constitute a restraint because they did not restrict her freedom of movement or normal access to her body. The MD statement indicated she did not have the cognitive ability to desire to attempt to ambulate or get out of her broda chair, nor the physical ability to do so. The MD statement indicated additionally these devices do not restrict her mobility, but rather were necessary for her mobility in that were they not provided to this resident she could not safely be in any chair due to the potential of seizures or involuntary motions that could and have resulted in significant injury in the past. She would therefore be restricted to her bed and bed bound. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #5's Safety Letter written by her PASRR Habilitation Coordinator and received by email after exit on 2/03/25 at 11:31 AM, indicated she provided assistance to access appropriate specialized services necessary to achieve a quality of life and level of community participation acceptable to Resident #5 and her family. The PASRR Habilitation Coordinator indicated Resident #5's unique safety needs stem from a combination of her diagnoses of Rett's Syndrome, Epilepsy, Muscle Spasms, Abnormal Involuntary Movements (lurching forward), and Convulsions. The PASRR Habilitation Coordinator indicated Resident #5 has difficulty remaining in a safe, upright position while in her wheelchair. This puts her at a higher risk for falls and injury. The PASRR Habilitation Coordinator indicated for this reason, when they requested Resident #5's Customized Manual Wheelchair (CMWC) through PASRR in 2019, a padded thigh belt and full footbox were included and were signed off on by the therapist, her primary care physician, and was approved by the state on 4/25/2019. These wheelchair accessories are not meant to restrain Resident #5, but to provide safety and allow her to be more active and independent while in her wheelchair. The PASRR Habilitation Coordinator indicated without the support of the safety belt and harness, she would be confined to her bed due to her history and high risks of falls. The PASRR Habilitation Coordinator indicated by having the safety accessories, Resident #5 is able to spend the majority of her day in her wheelchair where she is able to interact with her community to the best of her ability. The risk of falls and need for the safety supports are documented in her nursing facility care plan. In terms of daily care, it aligns seamlessly with the resident's care plan, supporting her participation in essential routines and complement other safety measures within the care plan. The PASRR Habilitation Coordinator said in her opinion that this comprehensive approach to safety allows for a more holistic care strategy, encouraging Resident #5's engagement in meaningful activities while minimizing risks. It becomes part of a larger framework designed to balance safety concerns with the pursuit of a fulfilling and active lifestyle. During an observation on 1/29/25 at 8:25 AM and 11:11 AM, Resident #5 was sitting in her broda chair with leg harness to both legs and secured to chair. During an observation on 1/30/25 at 8:40 AM, 9:04 AM and 10:02 AM, Resident #5 was sitting in her broda chair with leg harness to both legs and secured to chair. During an interview on 1/30/25 at 8:44 AM, LVN B said the legs straps on Resident #5 was just a safety device to keep her from sliding out of the chair. She has had those since she started working there and she had been here for 4 years. LVN B said Resident #5 could not take the leg straps off by herself. LVN B said Resident #5 was checked every 2 hours for incontinent care. She said staff laid Resident #5 down for a nap after lunch. LVN B said she did not feel like the straps were a restraint. LVN B said she did not see an order for the leg straps in the system and she did not know what they were called. During an interview on 01/30/25 at 9:07 AM, CNA A said the legs straps on Resident #5 were to hold her in the chair. She said Resident #5 has had that chair with the straps since she had been working there. CNA A said the leg straps was to keep Resident #5 in the chair, because she would jump out of the chair without it. She said staff laid Resident #5 down after lunch and checked the straps throughout the day to make sure they were not twisted or tight. She said she did not feel like the straps were a restraint. She said Resident #5 could not take the leg straps off by herself, because the leg straps clip around to the back of her chair. She said Resident #5 had seizures, so that may be another reason she has the straps. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Briarcliff Skilled Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 4054 Northwest Loop Carthage, TX 75633	

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 1/30/25 at 9:26 AM, LVN D said could not find an order for the leg straps and she did not work with Resident #5. LVN D said if Resident #5 did not have the leg straps, she would fall out of her chair. She said Resident #5 could not remove the leg straps herself. LVN D said the leg straps were technically a restraint, but they were to benefit Resident #5 from not falling out of her chair and she could still move. During an interview on 01/30/25 at 9:35 AM, ADON said Resident #5 had a history of throwing herself out of the wheelchair and she also had seizures. She said the leg straps were to prevent Resident #5 from falling out of the chair and was for her safety. She said she was not sure what the leg straps were called. She said when Resident #5 got up the staff put her in her chair, they adjusted the straps and checked the straps for redness throughout the day. She said after lunch the staff laid Resident #5 down in bed. She said she did not feel like the leg straps were a restraint. During an interview on 01/30/25 at 10:36 AM, the DON said the lap harness on Resident #5 was used for positioning, because she threw herself and leaps out of her chair, due to her mental condition. She said Resident #5 could not remove the lap harness by herself. She said Resident #5 could not functionally do anything by herself. She said the lap harness did not restrict Resident #5 from moving freely. She said before Resident #5 came to that facility and before she got that chair she fell out of a chair and broke all her teeth. She said Resident #5 could move her trunk. She said the facility did not have a signed consent form, but Resident #5's father was fully aware of the leg harness. She said the leg harness was not a restraint it was a positioning device. She said she did not have orders for a wheelchair and lap harness, but it was care planned. During an interview on 1/30/25 at 10:49 AM, Regional Nurse J said Resident #5 would be restricted to the bed without the lap harness device. She would have a decrease in quality of life because she could not attend activities without the lap harness. During an interview on 1/30/25 at 11:06 AM, the ADM said to his understanding the lap harness was to keep Resident #5 safe from harming herself and ensure to keep her from throwing herself out of the wheelchair. He said Resident #5 could not remove the lap harness off herself. He said the lap harness did not restrict her from moving freely or from her normal activities. He said he thought she should have a signed consent for the lap harness. He said the lap harness could restrict her from falling from her chair. He said he did not agree that the lap harness restricts her normal activity. He said he agree the lap harness should have the proper measures in place for the resident to use it. Record review of the Resident Assessment Instrument 3.0 User's Manual (RAI) last revised October 2024, revealed . the RAI process was the basis for the accurate assessment of each resident . trunk restraints included any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the resident cannot easily remove such as, but not limited to . vest . belts used in a wheelchair that either restricts freedom of movement or access to their body . limb restraints include any manual method or physical or mechanical device, material or equipment that the resident cannot easily remove, that restricts movement of any part of . lower extremity . that either restricts freedom of movement or access to their own body . (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of the facility's policy titled Resident Assessment with a revised date of January 12, 2020 indicated . purpose . to assess each resident's strengths, weaknesses, and care needs . to use the assessment date to develop a person-centered comprehensive plan of care for each resident that would assist a resident in achieving and maintaining the highest practical level of mental functioning, physical functioning, and wellbeing as possible . it is the Standard of Care at the facility to conduct, initially and periodically, a comprehensive, accurate assessment of each resident's functional capacity utilizing the MDS according to the guidelines set forth in the RAI manual . Completing the Care Area Assessments (CAAs) . Upon completion of comprehensive assessments (as defined by the RAI Manual), CAAs will be triggered to flag areas of concern that may need to be addressed in the POC for that resident. Each triggered CAA will be reviewed by designated staff to determine if a triggered condition affects the resident's function and quality of life or if the resident is at significant risk of developing the triggered condition. Additional assessments will be conducted, if needed to obtain and document additional information on a care area. CAA documentation will be done following guidelines in the RAI Manual and will state whether or not a care plan is needed to address the triggered area and the rationale for arriving at this decision. While CAAs identify common areas of concern in nursing home residents, the POC is not to be limited to the triggered areas. The comprehensive POC must address all care issues that are relevant to the individual, whether or not they are specifically covered in the MDS/CAA process .

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcliff Skilled Nursing Facility	4054 Northwest Loop Carthage, TX 75633

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062 Based on observation, interview, and record review, the facility failed to ensure an environment that was free of accident hazards for 1 of 22 residents reviewed for accident hazards. (Resident #3) 1. The facility failed to ensure coffee was served at a safe temperature for Resident #3 resulting in Resident #3 obtaining 2nd degree burns to her right and left upper thigh and groin areas. 2. The facility failed to implement measures to prevent other coffee spills with burns. 3. The facility failed to monitor the temperatures of hot liquids served to residents. 4. The facility failed to identify residents at risk for coffee burns. 5. The facility failed to ensure coffee temperatures were at an appropriate safe temperature prior to serving to residents. An Immediate Jeopardy (IJ) was identified on 1/28/25. The IJ Template was provided to the facility on [DATE] at 11:54 AM. While the IJ was removed on 1/29/25 at 11:00 AM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility's need to complete training in-services with all staff and evaluate the effectiveness of the corrective systems . These failures could place residents at risk for further burns, serious harm, serious injury, accidents, and a diminished quality of life. Findings included: Record review of Resident #3's face sheet dated 1/28/25 indicated she was [AGE] years old and admitted to the facility initially on 2/14/13 and readmitted on [DATE]. Resident #3 had diagnoses which included Chronic Obstructive Pulmonary disease (COPD-lung disease that causes difficulty breathing and shortness of breath), depression (persistent sadness), Parkinson's disease (disorder of central nervous system that affects movement, often including tremors) with dyskinesia (common complication of Parkinson's disease that causes involuntary, writhing, or jerky movements) with fluctuations, dysphagia (difficulty swallowing), and dyspnea (shortness of breath). Record review of Resident #3's quarterly MDS assessment dated [DATE] indicated Resident #3 a BIMS of 12 which indicated she had moderate cognitive impairment. The MDS indicated Resident #3 required setup or clean-up assistance with eating. The MDS indicated Resident #3 was dependent on staff for most ADLs. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #3's care plan with a print date of 1/27/25 indicated she had cognitive deficit of decision-making as evidenced by a BIMS of 12 and short-term memory loss. The care plan indicated Resident #3 had impaired physical mobility related to hemiplegia or hemiparesis (unable to move or weakness to one side of body), Parkinson's disease, history of a stroke (disruption of blood flow/oxygen to areas of the brain resulting in brain tissue death) and had an intervention to provide appropriate level of assistance to promote safety of resident. The care plan indicated Resident #3 had limited range of motion related to left upper extremity contracture and decreased range of motion to left lower extremity. The care plan indicated Resident #3 was at risk for/actual skin breakdown related to spilled coffee causing burn on 1/5/25 with interventions of resident supplied with another cup with a lid for coffee and encouraged to use; resident is oriented, alert, and able to make her own decisions and makes her needs known; left thigh, with wound cleanser, apply Silvadene cream, cover with non-stick dressing and wrap with kerlix (rolled gauze); right thigh, with wound cleanser, apply Silvadene cream, cover with non-stick dressing and wrap with kerlix. The care plan indicated Resident #3 had Parkinson's and had intervention to observe for tremors, rigidity, and limited range of motion. Record review of Resident #3's Consolidated Orders with print date of 1/28/25 reflected the following orders and diagnosis: *Cleanse site on day shift, left thigh, with wound cleanser, apply Silvadene cream, cover with non-stick dressing, and wrap with kerlix. Start date of 1/08/25. *Cleanse site on day shift, right thigh, with wound cleanser, apply Silvadene cream, cover with non-stick dressing, and wrap with kerlix. Start date of 1/08/25. *Burn of unspecified body region, unspecified degree *Burn of third degree of right thigh, initial encounter *Burn of third degree of left thigh, initial encounter *Dementia (serious mental decline) Record review of Resident #3's EHR revealed a hot liquid assessment had not been completed prior to the 1/05/25 coffee spill incident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #3's incident report dated 1/05/25 at 10:45 AM and completed by LVN M, indicated Resident #3 at approximately 10:40 AM was in her wheelchair in the dining room and asked for a cup of coffee. The incident report indicated RN K got Resident #3 a cup of fresh coffee and sat the coffee on the table and advised Resident #3 to wait a few minutes before attempting to drink the coffee due to it being hot and Resident #3 was acting normal. Resident then reached for the coffee and spilled coffee into her lap (bilateral groin areas/right and left medial, upper legs). and had redness to both of her inner and top thighs. The incident report indicated LVN M heard Resident #3 yell for help, and she immediately went to her and accessed the area, dabbed with a cool damp cloth, and did not see the blisters until several minutes after the accident. Blisters formed shortly after and while cleaning the area the blisters ruptured and a Vaseline coating was applied, then two large non-stick gauze dressings, wrapped with gauze, and secured with tape and measurements of 12 cm by 6.5 cm. The incident report indicated Resident #3 had 2nd degree burn to right and left upper medial legs/groin areas and the physician and DON was notified, and a voicemail was left for Resident #3's family member. Record review of Resident #3's nurse note dated 1/05/25 electronically signed at 1:09 PM by LVN M revealed Resident #3 was in the dining room at 10:40 AM and asked for a cup of coffee. RN K got Resident #3 a cup of fresh coffee and sat the coffee on the table and advised Resident #3 to wait a few minutes before attempting to drink the coffee due to it being hot and Resident #3 was acting normal. Resident #3 proceeded to grab the cup of coffee without waiting for it to cool spilling into her groin causing a burn to the right inner thigh/groin area. LVN M documented she immediately attended to Resident #3 and removed the coffee with a clean washcloth and then dampened the cloth with cold water and applied it to the area. LVN M documented once the area was cleaned, Resident #3 stated it felt better and was only hurting a little. LVN M documented blisters formed shortly after and while cleaning the area the blisters ruptured and she applied a Vaseline coating was applied, then two large non-stick gauze dressings, wrapped with gauze, and secured with tape and notified the MD, DON, and left a voicemail for Resident #3's family member. Record review of Resident #3's nurse note dated 1/05/25 electronically signed at 2:17 PM by LVN M indicated new order for Silvadene ointment to be applied topically twice daily for 7 days to burn on inner thigh/groin area. Record review of Resident #3's nurse note dated 1/05/25 electronically signed at 3:28 AM by LVN R revealed Resident #3's dressing to left upper, medial leg was soaked and she changed the dressing and noted that right, upper, medial leg also, had burns that appeared to be the same grade as burn on the left leg from earlier incident when Resident #3 spilled her coffee. LVN R documented Resident #3 stated she did not spill anymore coffee since the earlier reported incident and those burns occurred at the same time but were overlooked, possibly due to blistering that was not visible at time of the incident. Wound care was provided, and pain medication was administered due complaint of burning, sharp pain in bilateral upper legs in burn areas. Record review of Resident #3's NP visit note dated 1/06/25 indicated she had an accident where she spilled hot coffee on her inner thighs and was currently being treated with Silvadene cream along with twice daily wound care. The note indicated Resident #3 was without pain to area at that time. The note indicated in the review of systems skin section that she had a burn from hot coffee to inner thighs and had a diagnosis of burn by hot liquid. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #3's History & Physical Examination dated 1/07/25 and signed by the Medical Director on 1/22/25 indicated she had diagnoses including burn of unspecified body region, unspecified degree, burn of third degree of left thigh, initial encounter, burn of third degree of right thigh, initial encounter, COPD, and dementia; she had independent decision-making skills; and the skin status area did not indicate Resident #3 had burns. Record review of Resident #3's Wound Evaluation and Management Summary dated 1/08/25 indicated she had a burn of the left thigh full thickness that measured 14 cm by 6 cm by 0.1 cm with a dressing treatment plan to apply silver sulfadiazine once daily and cover with gauze roll (kerlix) for 30 days; she had a burn wound of right thigh full thickness that measured 9 cm by 8 cm by 0.1 cm with a dressing treatment plan to apply silver sulfadiazine once daily and cover with gauze roll (kerlix) for 30 days. Record review of Resident #3's Progress note from the Wound Physician that indicated on his initial examination on 1/08/25 Resident #3's burns to her thighs were 2nd degree burns with a combination of superficial 2nd and deep 2nd degree burns. The Progress note indicated there were no areas of eschar (dead tissue) which would represent a 3rd degree burn and need for excision (removal) and skin grafting. During an observation and interview on 1/27/25 at 2:04 PM, Resident #3 was sitting up in her wheelchair in her room. Resident #3 said the facility took pretty good care of her most of the time. Resident #3 had bandages to her upper right thigh visible through a slit in her dress. Resident #3 said she spilled her coffee in her lap and was burned. Resident #3 said she went to take a sip of the coffee and it was too hot and she spilled it into her lap. Resident #3 repeated three times it was too hot. Resident #3 had a contracture to her left elbow and left hand was closed in a fist, but she was able to open her left hand with her right hand. Resident #3 was holding a cup with a handle and a lid that had an opening on one side of lid. Resident #3 held the cup handle and flipped the cup around and tried to drink from it and then realized the opening was on the other side of lid and she flipped it back around and turned it up to get a drink. During an observation on 1/29/25 at 11:35 AM, Resident #3 was feeding herself in the assisted dining room and drank clear liquid from a cup with a lid and straw and no handle without difficulty. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/27/25 at 4:03 PM, RN K said Resident #3 came to the nurses' station and asked her for coffee. RN K said Resident #3 drank coffee all day long. RN K said they always have coffee out in the dining room for the residents. RN K said she gave Resident #3 coffee from the pump coffee canister in the dining room that was for all the residents to use. RN K said she went and got Resident #3 some coffee in a regular coffee cup and sat it on a table in the dining room and then brought Resident #3 to the table. RN K said she told Resident #3 to wait a few minutes before drinking the coffee to let it cool some due to it was hot and Resident #3 agreed to wait. RN K said she then was walking back to the nurses' station located just outside the dining room area and before she reached the nurses' station, Resident #3 started hollering. RN K said Resident #3's nurse LVN M went to check on her and that was when LVN M realized Resident #3 had spilled the coffee in her lap. RN K said she had worked at the facility since February of 2024 and Resident #3 had always drank her coffee in a regular coffee cup and was totally with it. RN K said now Resident #3 had to use a coffee mug with a lid and they cool it down before giving it to her. RN K said she guessed whoever was giving the resident coffee would be responsible for temping the coffee to ensure it was a safe temperature and there was a thermometer in the break room that they could have used. RN K said she did not know what their policy was on temping the coffee, but she did not temp the coffee before giving it to Resident #3. During an observation and interview on 1/27/25 at 4:13 PM, the Dietary Manager said the coffee was temped every time before putting the coffee in the pump canisters in the dining room for the residents' use. The Dietary Manager said they do not keep temperature logs of the coffee. The Dietary Manager pumped coffee into a cup from the coffee canister in the dining room and placed a digital thermometer into a coffee cup and it temped at 146 degrees F. The Dietary Manager said they do not put the coffee out for the residents if the temp was over 150. The Dietary Manager said they had a resident that spilled her coffee on herself a few weeks ago and she asked then about keeping a coffee temperature log, but her Regional Dietary Manager said they no longer had to keep a temperature log on coffee. The Dietary Manager said they did not change any of their processes after the resident spilled her coffee, but the resident now has a cup with a lid. The Dietary Manager said they did not have a policy related to temping coffee or hot liquids. During an interview on 1/27/25 at 4:17 PM, the DON said Resident #3 spilled her coffee on herself, her wounds were looking good, and they now have her a cup with a lid. The DON said Resident #3 had no previous issues prior to this incident with her coffee and she was cognitively aware and made her own decisions. The DON said the kitchen was responsible for temping the coffee prior to putting out for the residents to access. The DON said she did not think it was a requirement to temp coffee anymore. The DON said she asked the Dietary Manager for a coffee temp log when Resident #3's incident happened. The DON said the Dietary Manager said they did not have to keep a coffee temp log anymore, since they got the new pump coffee canisters. The DON said the Dietary Manager said she reached out to their Regional Dietician, who said it was not a requirement anymore. The DON said the interventions following the coffee spill were specific to Resident #3 and no other residents were assessed because she did not identify a need for further assessments. The DON said she did not know if they did hot liquid assessments and had not seen one, since she had worked at the facility. During an interview on 1/27/25 at 4:55 PM, MA U said she was familiar with Resident #3, but she did not know of anything different that she required if she wanted coffee. MA U said she had never gotten coffee for Resident #3. MA U said she guessed she would have to ask the resident's nurse or look in her chart to see if she had any special restrictions of liquid or diet. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/27/25 at 5:00 PM, LVN L said he was aware of Resident #3's incident with spilling her coffee. LVN L said Resident #3 had to have a cup with a lid now and it should be care planned. LVN L said Resident #3 had not had any issues with her coffee prior to this incident to his knowledge. During an interview of 1/27/25 at 5:05 PM, CNA V said she had worked at the facility for seven months and was familiar with Resident #3. CNA V said Resident #3 had to have a cup with a lid for her coffee now. CNA V said she was not sure how she knew that she had to have a cup with a lid with her coffee, but thought they had an in-service on it after Resident #3 spilled her coffee. During an observation and interview on 1/28/25 at 7:58 AM, the Dietary Manager said the kitchen staff got to work at about 6:00 AM and the 1st coffee canister probably came out to the dining room at approximately 6:15 AM. The Dietary Manager temped coffee out of a pump coffee canister, located in the dining room for resident use, by pumping coffee out of the canister into cup and placed a digital thermometer in the coffee and the 1st reading temped at 172 degrees F. During an interview on 1/28/25 at 8:06 AM, DA W said she was responsible for putting the coffee in the canisters for the residents on 1/28/25. DA W said she just brewed the coffee in the kitchen and then put the coffee in the in canisters and then set the coffee canisters out in the dining room. DA W said she did not temp the coffee prior to putting the coffee canisters out in the dining room for the residents. DA W said they have to replace the coffee in the canisters probably every 10 minutes or so due the residents drink a lot of coffee. During an interview on 1/28/25 at 8:14 AM, DA X said she had worked at the facility since 7/2024. DA X said she brewed the coffee in the kitchen, then put the coffee in the canister and put the coffee canister out in dining room. DA X said they do not temp the coffee prior to putting the coffee canisters in the dining room for the residents to use. DA X said they do not have policy for temping coffee. She has worked here since 7/24. During an interview on 1/28/25 at 8:38 AM, LVN M said she had worked at the facility since 4/2024. LVN M said Resident #3 was a character and: had her own mindset, used a wheelchair, was totally dependent for transfers, had a contracted left arm, had some dysphagia, could feed herself, and could only have coffee if it was in a mug with a lid and they cool it when giving coffee to Resident #3. LVN M said they put ice in her coffee prior to giving it to her due to Resident #3 got burned. LVN M said Resident #3 was in her right mind but had to pay attention to her when she was talking due to, she was hard to understand. LVN M said Resident #3 was able to have coffee in a regular cup prior to the incident and they would just tell her to let it cool 1st. LVN M said Resident #3 was told to let the coffee cool 1st and the nurse did not even get back to the nurse's station when Resident #3 picked up the coffee and apparently spilled it in her lap. LVN M said she assessed Resident #3 and cleaned her up after the coffee spill. LVN M said Resident #3 had redness to left thigh and she did not notice any redness to right inner thigh at time of assessment. LVN M said the CNA's notified her when they were cleaning Resident #3 up and Resident #3 had blisters. LVN M said they had a verbal in-service and everyone was aware that Resident #3's coffee had to be cooled and in a cup with a lid. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Briarcliff Skilled Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 4054 Northwest Loop Carthage, TX 75633	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/28/25 at 9:18 AM, CNA E said she had worked at the facility for seven months. CNA E said if Resident #3 asked for coffee, they had to get her personal cup with the lid. CNA E said she did not put ice in Resident #3's coffee to cool it. CNA E said Resident #3 drank coffee all day and they had to refill her cup frequently throughout the day. CNA E said Resident #3 liked her coffee. CNA E said Resident #3 sometimes had trouble holding a coffee cup and could have spilled it on herself before they got her a cup with a lid. CNA E said Resident #3 had trouble holding a cup at times and she could have definitely spilled a regular cup at times. CNA E said she did not know anything about Resident #3 spilling coffee in her lap or burns. CNA E said she knew Resident #3 had dressings to her upper legs, but she did not know why. CNA E said she just kept Resident #3 clean and dry and tried to meet her needs. During on observation on 1/28/25 at 5:42 PM, two pump coffee canisters were still in the dining room with regular coffee cups beside it for resident access. On 1/29/25 at 9:15 AM, the DON provided a wound care note addendum from the wound MD with clarification of Resident #3's wounds to 2nd degree burns. During an interview on 1/29/25 at 10:02 AM, the Medical Director said she was notified related to the IJ related to Resident #3's burn and was included in developing the POR. The Medical Director said she did not observe Resident #3's burns on the day she saw her on 1/7/25 and she did not give a diagnosis of 3rd degree burns. The Medical Director said the diagnosis looked like it was put in Resident #3's chart on 1/11/25 and if her note was not closed until after that, then all the diagnosis history would pull to her note that was in the resident's chart. During an interview on 1/30/25 at 10:40 AM, the Regional Dietician said they have always said a safe serving temperature for coffee was 170 degrees F or below. The Regional Dietician said the test tray report was a weekly standard but was not a policy and the dietician reported temps monthly. The Regional Dietician said she was due to perform a test tray and obtain her monthly coffee temperature. The Regional Dietician said coffee had to brew at 190-210 degrees to brew correctly and then transferred to the air pots and there was heat distribution. The Regional Dietician said it depends on the circumstances, clothing, time, etc to determine what the potential risk to the resident would be if the coffee was served above their standard temperature, if the resident spilled the coffee on themselves. Record review of the facility's Incident Report log with a date range of 7/01/24-1/27/25 did not reveal any other incidents related to burns or coffee spills. On 1/27/25 at 4:42 PM, requested policies on Accidents/Hazards/Supervision, Coffee Temperature policy, Hot liquid temperature policy, and Hot liquid Risk Assessment, along with any in-services done related to Resident #3's coffee spill from the ADM and the DON. On 1/27/25 at 5:35 PM, the ADM and the DON provided a policy on Accident/Incident Reporting and stated they did not have policies on temping coffee or Hot liquid Assessments. The DON said she did not do any in-services related to Resident #3's coffee spill, but they put it on the 24-hour Report (correspondence given to oncoming nursing staff) and updated Resident #3's care plan. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's 24-Hour Report dated 1/07/25 indicated on .1/05/25 Resident #3 had 2nd degree burns on both medial upper legs/thigh, groin areas . incident report done . wound care orders . nurse please ensure travel pillow was donned on contract side to keep from elbow scrapping her wheelchair, also please make sure that leg rest was on the contracture side . new coffee cup with lid to used . Record review of the facility's document titled Test Tray Report with a revised date of 12/2022 indicated . each week, complete steps 1-4 and report findings below . criteria reviewed . 1 B. Hot Liquids, evaluate delivery temperature of hot soups, coffee, etc . maximum 170 degrees . Record review of the facility's policy titled Incident/Accident Reporting dated January 12, 2018, indicated . unusual events, accidents, and occurrences would be reported, documented, and investigated to determine what changes, if any, need to be initiated within the facility . Record review of the SOM - Appendix PP accessed on 2/4/25 indicated . burns related to hot water/liquids could also be due to spills . many residents in long-term care facilities had conditions that put them at increased risk for burns . conditions included . decreased skin thickness, decreased skin sensitivity, peripheral neuropathy (weakness, numbness, and pain from nerve damage, usually in hands and feet), . reduced reaction time . decreased cognition . the degree of injury depends on factors including water temperature, amount of skin exposed, and the duration of exposure . water temperature and time required for a 3rd degree burn to occur: 155 degrees F/1 second; 148 degrees F/2 seconds; 140 degrees F/5 seconds, 133 degrees F/15 seconds, 127 degrees F/1 minute . based upon the time of the exposure and the temperature of the water, the severity of the harm to the skin was identified by the degree of burn . Second-degree burns involved the first two layers of skin . these may present as deep reddening of the skin, pain, blisters, glossy appearance from leaking fluid, and possible loss of some skin . third-degree burns penetrate the entire thickness of the skin and permanently destroy tissue . these present as loss of skin layers, often painless . and dry, leathery skin . skin may appear charred or have patches that appear white, brown, or black . The ADM, DON, and the Regional Nurse were notified of an IJ on 1/28/25 at 11:49 AM and a Plan of Removal (POR) was requested. The IJ template was emailed to the ADM at 11:54 AM. The POR was accepted on 1/28/25 at 5:15 PM and included the following: Summary of Details which lead to outcomes: On 1/28/25, during annual survey initiated at the facility, a surveyor provided an IJ Template notification that the Survey Agency had determined that the conditions at the center constituted immediate jeopardy to resident health. F689. The notification of the alleged immediate jeopardy stated as follows: F689 Free of Accidents and Hazards/supervision/devices Resident #3 was a [AGE] year-old female, who admitted to the facility on [DATE] with diagnoses of Chronic Obstructive pulmonary disease, Parkinson's disease, History of a stroke, contracture to left upper extremity, and 3rd degree burns to right and left thighs (later clarified to 2nd degree burns). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility failed to: *Assess residents for safe consumption of hot liquids. -28 residents drink coffee and 14 require staff assistance to get them coffee. *Implement measures to prevent other coffee spills with burns. -Coffee was available to all residents at all times throughout the day. *Monitor temperatures of hot liquids served to residents. *Identify at risk residents. *Educate staff on temping coffee. *Have a policy in place to temp coffee or address hot liquids. *Ensure Resident #3 did not get 3rd degree burns. How other residents with the potential to be affected by the same deficient practice would be identified: *Hot liquid risk assessments would be completed on 1/28/25 by the DON/designee on all residents . What measures would be put in place or what systemic changes would be made to ensure that the deficit practice does not recur: *In-service and training provided by DON/Designee to all nursing staff to implemented interventions for affected resident on 1/28/25. Specifically-this resident should not be served hot coffee in a cup without a lid. If the cup with a lid was not available, resident should be offered an alternative beverage, and her charge nurse should be notified of need for cup with a lid. *Care plans to be updated by DON/Designee for residents identified as having a hot liquid risk potential and interventions to be implemented 1/28/25. *Nursing staff educated by DON/Designee on interventions for residents identified as at risk and assessing risk and implementing interventions on 1/28/25. *Nutrition Services staff would be educated by Administrator/Designee on temping coffee in air pots (pump coffee canister) prior to placing air pots in service in the dining room to ensure coffee temperature is at or below 170 degrees. Staff has been educated to allow coffee to cool to at or below 170 degrees before placing air pots in dining room. Staff will log coffee temperatures on Coffee Temp Log with date, time, and temperature each time fresh coffee is served. *Staff that did not receive education before 10:00 PM on 1/28/25 will be educated prior to the start of their next shift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	How the corrective action(s) will be monitored to ensure the deficient practice is being corrected and will not recur (i.e., what program will be put into place to monitor the continued effectiveness of the system changes): *ADM/DON will monitor checking of temperatures daily for two weeks, then weekly for four weeks, and will report findings to the QA Committee and adjustments will be made for continued monitoring for compliance for 90 days. Involvement of Medical Director: *The Medical Director was notified and reviewed plan with an ad hoc QAPI meeting. The plan will be reviewed in Monthly QA meeting with the Medical Director thereafter for further compliance. Involvement of QA: *Facility policies were reviewed by the QA committee and will be updated by 1/28/25 to reflect changes in process related to coffee temping procedures and hot liquid assessments: 1. Specifically, the Nutrition Services policy states, The temperatures of the food and hot beverage items will be taken and properly recorded on the Food Beverage Temperature Log to ensure safe holding and serving temperatures. 2. Nursing Services policy related to Hot Liquid Risk Assessment states, The community will evaluate residents for hot liquid risk potential in accordance with standard practice guidelines . the licensed nurse completes the Hot Liquid Risk Assessment on paper or in the HER and presents the information to the Interdisciplinary Team for further interventions. Please accept this letter as our plan of removal for the determination of Immediate Jeopardy issued on 1/28/25. The surveyor verification of the Plan of Removal from 1/29/25 was as follows: *Record review of a Training In-Service Form indicated an in-service was held on 1/28/25. The in-service was presented by the Dietary Manager. The in-service stated all coffee is transferred to air pot after brewing and dietary staff is to check temp of air pots prior to setting them out for service to ensure temp is below 170 degrees. The in-service included signatures of DA X, DA W, and the Dietary Manager. The policy titled Taking Food Temperatures, dated revised August 1, 2024, was attached to the in-service. *Record review of a Training In-Service Form indicated an in-service was held on 1/28/25. The in-service was presented by the DON. The in-service stated residents were to have a hot liquid risk assessment completed on admission, re-admission, quarterly, and if the resident had a change in condition (COC) that would impact their abilities to handle hot liquids safely, ex. Broken arm or new stroke, new tremors, etc . Any resident with increased risk for injury was to be reviewed by the IDT (Interdisciplinary Team) for appropriate interventions. Care plan to be updated and staff to implement interventions deemed appropriate. The in-service included signatures of ADON, RN K, LVN M, DON, ADM, LVN L, and LVN R. The policy titled Hot Liquid Risk Evaluation dated reviewed 1/28/25 was attached to the in-service. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*Record review of a Training In-Service Form indicated an in-service was held on 1/28/25. The in-service was presented by the DON. The in-service stated to review resident list for any increased risk for injury with hot liquid prior to assisting residents with coffee. If at increased risk, use cup with lid. The in-service included signatures of ADON, RN K, LVN M, DON, ADM, LVN L, CNA V, CNA E, MA U, DA X, DA W, DM, and LVN R. *Record review of Residents At Risk for Hot Liquid Injury lists were observed at the nurses' station and in a red folder located behind the air pot/coffee canisters in the dining room on 1/29/25 at 10:45 AM. On 1/29/25 at 10:10 AM, the DON said she in-serviced the nurses listed on the in-service on the Hot Liquid Risk assessment and when it should be completed. On 1/29/25 at 10:13 AM, the Regional Nurse said she assisted on in-servicing the Hot Beverage List and informed the nurses when to perform a hot liquid assessment and how often. The Regional Nurse said she in-serviced all staff on the list of the Hot Beverage List and if the resident was at risk of injury, they should have a lid with hot beverages such as coffee and tea. On 1/29/25 at 9:57 AM, the ADM said there was three in-services on temping the coffee after it comes out of the air pot until at 170 degree and staff were to log them temp before putting the air pot in service for the residents. All [TRUNCATED]

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observation, interview, and record review the facility failed to ensure respiratory care was provided with professional standards of practice for 1 of 2 residents reviewed for respiratory care (Resident #30) The facility failed to administer Resident #30's oxygen as ordered by the physician. This failure could place residents who receive respiratory care at risk for developing respiratory complications. Findings included: Record review of Resident #30's face sheet dated 01/29/25, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (group of lung diseases that block airflow and make it difficult to breathe), convulsions (condition in which muscles contract and relax quickly and cause uncontrolled shaking of the body), and angina (chest pain). Record review of Resident #30's quarterly MDS dated [DATE], indicated Resident #30 was able to make herself understood and understood others. Resident #30 had a BIMS score of 14, which indicated her cognition was intact. Resident #30 required substantial/maximal assistance with toileting and showering, and set-up or clean-up assistance with eating, oral hygiene and personal hygiene. The MDS did not indicate Resident #30 received oxygen therapy. Record review of Resident #30's care plan updated 12/07/24, indicated Resident #30 had a diagnosis of COPD and chronic bronchitis (long-term inflammation of the airways that leads to persistent cough and mucus production) as evidence by oxygen at 2 liters per minute via nasal cannula as needed for shortness of breath. The care plan interventions indicated to administer medications, respiratory treatments, and oxygen as ordered. Record review of Resident #30's consolidated orders dated 01/29/25, indicated she had an order for oxygen at 2 liters per minute via nasal cannula as needed for shortness of breath with an order start date of 05/23/23. Record review of Resident #30's PRN medication administration record dated 01/01/25-01/29/25, indicated Resident #30 had an order for oxygen at 2 liters per minute via nasal cannula as needed for shortness of breath. The medication administration record was not marked that Resident #30 had received any oxygen. During an observation on 01/27/25 at 10:15 AM, Resident #30 was in her room sitting in her recliner and was receiving oxygen at 3.5 l/min via nasal cannula. During an observation on 01/27/25 at 2:34 PM, Resident #30 was in her room sitting in her recliner and was receiving oxygen at 3.5 l/min via nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 01/28/25 at 8:40 AM, Resident #30 was in her room sitting in her recliner and was receiving oxygen at 3.5 l/min via nasal cannula. During an observation on 01/29/25 at 8:29 AM, Resident #30 was in her room sitting in her recliner and was receiving oxygen at 3.5 l/min via nasal cannula. During an observation on 01/29/25 at 2:26 PM, Resident #30 was in her room sitting in her recliner and was receiving oxygen at 3.5 l/min via nasal cannula. During an observation and interview on 01/29/25 at 2:31 PM, LVN L, said he was Resident #30's nurse. LVN L entered Resident #30's room and observed the settings on the concentrator and he said Resident #30 oxygen was set at 4 l/min. LVN L reviewed Resident #30's physician orders and said Resident #30's oxygen should have been set at 2 l/min. LVN L said since Resident #30 oxygen was only for as needed, it did not show on the electronic MAR as a task to check her oxygen settings. LVN L said by not having Resident #30's oxygen at the prescribed rate, she was at risk for not receiving enough oxygen or receiving too much oxygen. LVN L said the nurse was responsible for ensuring the oxygen was set at the ordered rate. During an interview on 01/30/25 at 8:49 AM, the DON said she expected oxygen to be set at the ordered amount. The DON said the nurse was responsible for following physician orders and for ensuring the oxygen was set at the ordered rate during their morning rounds. During an interview on 01/30/25 at 9:33 AM, the Administrator said he expected physician's orders to be followed. The Administrator said failure to set the oxygen at the ordered rate could cause respiratory failure if too little oxygen was received and unsure of what could happen if the resident received too much oxygen. The Administrator said nursing staff was responsible for ensuring the oxygen was set at the ordered rate. Record review of the facility's policy and procedure Applying an oxygen delivery device revised January 12, 2020, indicated . Staff will apply oxygen delivery devices in accordance with standard practice guidelines. Procedure: Identify the resident. Validate physician orders . Attach oxygen delivery device as required . Verify setting on flowmeter and oxygen source and the prescribed flow rate . Record the procedure in the record .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observation, interview and record review, the facility failed to establish a system of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation and determine that drug records were in order and that an account of all controlled drugs were maintained and periodically reconciled for 1 of 1 storage area reviewed for expired and discontinued medications. The facility failed to keep a record of receipt of controlled medications awaiting disposition to allow accurate and periodic reconciliation. This failure could place residents at risk for loss of prescribed medications, resident's safety, and drug diversion. Findings included: During an observation and interview on [DATE] at 11:17 AM, the following medications were observed in the controlled medication storage room located in the DON's office and were awaiting to be disposed: * Lorazepam 0.5mg- 35 tablets RX# N5629921 * Acetaminophen-codeine #3- 30 tablets RX# N5606503 * Clonazepam 0.5mg- 13 tablets RX# N5726939 * Lorazepam 2mg/ml- 30mls- RX N5736902 * Acetaminophen-codeine #3- 21 tablets RX# N5731934 * Tramadol 50mg- 25 tablet RX# N5726277 The DON said the controlled medications awaiting to be disposed were kept in the closet in her office behind a double locked door. The DON said she was the only one with the keys to the closet. The DON said her process when she reconciled medications that needed to be disposed of was as follows: when medications were brought to her, she checked the narcotic medication count and verified the count with the nurse, and then placed the medications in a basket in the closet. The DON said she did not log the narcotic medications until the pharmacist came for drug destruction and was how she had been taught to do. The DON said there was no risk for misappropriation or a drug diversion since she was the only one with the keys. Record review of the facility's pharmacy binder on [DATE] indicated the last medication destruction was completed on [DATE] . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 09:33 AM, the Administrator said he was unsure of the facility's narcotic medication policy or procedure. The Administrator said he expected the DON to follow their policy and procedure to meet regulations. The Administrator said a risk for medication diversion could happen at many levels but could not speak if their policy was effective on that. Record review of the facility's policy Disposal of Medications, Syringes, and Needles- Disposal of Medications dated [DATE], indicated . Policy . 2. Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances (or those classified as such by state regulation) are subject to special handling, storage, disposal, and record keeping in the nursing center in accordance with federal and state laws and regulations . Procedure . 2. Controlled Substances listed in Schedules II, III, IV, and V remaining in the nursing center after the order has been discontinued are retained in the nursing care center in a securely double locked are with restricted access until destroyed as outlined by state regulation . c. A controlled medication disposition log, or equivalent form, shall be used for documentation and shall be retained as per federal privacy and state regulations. This log shall contain the following information: Resident's name, medication name and strength, prescription number, quantity/amount disposed, date of disposition, signatures of the required witnesses .

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F 0761

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46928

Based on observation, interview and record review the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in a locked compartments, under proper temperature controls, and permitted only authorized personnel to have access to the keys for 1 of 8 residents (Resident #30) and 2 of 6 medication carts (Hall A nurse's cart and Hall B nurse's cart) reviewed for medication storage.

1. The facility failed to ensure Resident #30 did not have medications stored in her room.

2. The facility failed to ensure the Hall A nurse's cart was secured and unable to be accessed by unauthorized personnel on 01/27/25.

3. The facility failed to ensure LVN M secured Hall B nurse's cart when she left it unattended on 01/28/25.

These failures could place residents at risk for not receiving drugs and biologicals as needed and drug diversions.

Findings include:

1. Record review of Resident #30's face sheet, dated 01/29/25, indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #30 had diagnoses which included chronic obstructive pulmonary disease (group of lung diseases that block airflow and make it difficult to breathe), convulsions (condition in which muscles contract and relax quickly and cause uncontrolled shaking of the body), and angina (chest pain).

Record review of Resident #30's quarterly MDS, dated [DATE], indicated Resident #30 was able to make herself understood and understood others. Resident #30 had a BIMS score of 14, which indicated her cognition was intact. Resident #30 required substantial/maximal assistance with toileting and showering, and set-up or clean-up assistance with eating, oral hygiene and personal hygiene.

Record review of Resident #30's care plan, updated 12/07/24, indicated Resident #30 had chronic constipation related to magnesium hydroxide/aluminum hydroxide (antacid medication used to relive heartburn, acid indigestion, and upset stomach). The care plan interventions indicated to give medications as ordered.

Record review of Resident #30's consolidated orders, dated 01/29/25, indicated she had an order for aluminum-magnesium hydroxide 200mg/5mls oral suspension give 30 mls by mouth one time a day as needed for constipation with an order start date of 10/31/24. Resident #30 did not have an order for a powder.

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NAME OF PROVIDER OR SUPPLIER Briarcliff Skilled Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 4054 Northwest Loop Carthage, TX 75633	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #30's PRN medication administration record, dated 01/01/25-01/29/25, indicated Resident #30 had an order for aluminum-magnesium hydroxide 200mg/5mls oral suspension give 30mls one time a day as needed. The record did not indicate Resident #30 received any aluminum-magnesium hydroxide. During an observation on 01/27/25 at 10:15 AM, Resident #30 was in her room and sitting in her recliner. There was a bottle of Geri Lanta sitting on the bedside table next to her. During an observation and interview on 01/27/25 at 2:34 PM, Resident #30 was in her room sitting in her recliner. The bottle of Geri Lanta continued to sit on the bedside table next to her. Resident #30 said she had heartburn at times and preferred to have the bottle of Geri Lanta on the bedside table because she could take it herself when she needed it. Resident #30 said she had not had an assessment completed to see if she was able to self-medicate. Resident #30 said she was unaware she could not have the bottle of Geri Lanta in her room, since staff had just brought it to her. Resident #30 said she was unable to recall which staff had brought the Geri Lanta. During an observation and interview on 01/28/25 at 8:40 AM. Resident #30 was in her room sitting in her recliner, the bottle of Geri Lanta was not sitting on her bedside table. Resident #30 said yesterday staff (unknown) had put the Geri Lanta in the drawer of her nightstand because it could not be out per state regulations. Resident #30 allowed the state surveyor to view the second drawer of her nightstand where the bottle of Geri Lanta was located. During an observation and interview on 01/29/25 at 8:29 AM, Resident #30 was in her room sitting in her recliner and said the Geri Lanta was still in her drawer. There was a medicine cup, that was halfway full of a white powder, sitting on top of her nightstand. Resident #30 said she did not know what the powder was or who had brought it in. During an observation and interview on 01/29/25 at 2:26 PM, Resident #30 was in her room sitting in her recliner and said the Geri Lanta was still in her drawer. The medicine cup with a white powder was sitting on top of her nightstand. During an observation and interview on 01/29/25 at 2:31 PM, LVN L went to Resident #30's room and obtained the medicine cup with the white powder and the bottle of Geri Lanta from her room after surveyor informed him of the medications. LVN L said Resident #30 should not have had any medications in her room unless there was a specific order that indicated she could self-administer her medications . LVN L said Resident #30 did not have an order to self-administer her medications. LVN L said he did not know what the white powder was or who put it in Resident #30's room. LVN L said by having medications at the bedside, Resident #30 could over medicate or not take the medication as prescribed. LVN L said the nurse or the medication aide was responsible for ensuring medications were not left at the bedside. 2. During an observation on 01/27/25 at 1:47 PM, the Hall A nurse's cart was unlocked and unattended. Staff and family members were noted to be walking next to the unlocked cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 01/27/25 at 1:51 PM, RN K went to Hall A's nurse's cart and said that was her cart. RN K said she retrieved something from her cart, went to the nurse's station and forgot to lock it. RN K said medication carts should not be left unlocked when left unattended because anyone could access it and residents could take medications that did not belong to them. RN K said it was her responsibility to ensure the cart was kept locked when left unattended. 3. During an observation and interview on 01/28/25 at 11:22 AM, revealed LVN M retrieved supplies, to obtain Resident #31's blood sugar, from Hall B nurse's cart. LVN M left the cart unlocked when she walked to Resident #31's room to obtain her blood sugar. LVN M said she realized she had left the nurse's cart unlocked when she came back from obtaining Resident #31's blood sugar. LVN M said she was nervous because the state surveyor was observing her with her medication pass and she must have forgotten. LVN M said the medication carts should not be left unlocked when left unattended because anyone could get ahold of something they should not get ahold of. LVN M said she was responsible for ensuring the carts were locked when leaving them unattended. During an interview on 01/30/25 at 08:36 AM, the ADON said she expected medication carts to be locked when left unattended and medications not to be left at the bedside. The ADON said by leaving the medication cart unlocked anyone could get into the cart and could cause a danger to a resident if they took something they were not supposed to. The ADON said by leaving medications at the bedside, staff would be unaware of who had taken the medication and would not be able to accurately monitor the resident. The ADON said it was the nurses and medication aides' responsibility to ensure carts were locked when left unattended and no medications were left at bedsides. During an interview on 01/30/25 at 8:49 AM, the DON said medications carts should not be left unlocked when left unattended. The DON said by leaving the medication cart unlocked anyone could get into them. The DON said medications should not be left at the bedside because residents should not be administering medications by themselves. The DON said the nurses and medication aides were responsible for ensuring medication carts were locked when left unattended and mediations were not left at the residents' bedside. During an interview on 01/30/25 at 09:33 AM, the Administrator said medication carts were not to be left unlocked when leaving them unattended. He said there was a potential for medications to go missing, residents or staff members getting to them, or resident harm if they consumed a medication that was not theirs. The Administrator said medications should not be left at the bedside because the facility needed to ensure the residents received the right medication and right medication dose. The Administrator said the nurse or medication aide was responsible for ensuring the carts were locked when left unattended but any staff member, when passing by, could lock them if they noticed they were unlocked. The Administrator said all staff were trained to take note medications were not at bedsides and to remove them if found. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy Medication Storage, dated January 2024, indicated .Medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations, to keep their integrity and to support safe, effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. 1. The provider pharmacy dispenses medications in containers that meet state and federal labeling requirements, including those established by the United States Pharmacopeia (USP). Medications are to remain in these containers and stored in a controlled environment. This may include such containers as medication carts, medications rooms, medication cabinets, or other suitable containers .3. In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medication carts. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended to by persons with authorized access Record review of the facility's policy and procedure Medication Administration- General Guidelines, dated January 2024, indicated .17. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019 Based on observation, interview and record review, the facility failed to ensure each resident received and the facility provided food and drink that was palatable, attractive, and at a safe and at a safe and appetizing temperature for 4 of 22 residents (Resident #1, Resident #57, Resident #58, and Resident #64) reviewed for palatable food. The facility failed to provide palatable food served at an appetizing temperature for Resident #1, Resident #57, Resident #58 and Resident #64. This failure could place residents at risk for weight loss, altered nutritional status, and diminished quality of life. Finding include: 1. Record review of Resident #1's face sheet, dated 1/29/2025, revealed a [AGE] year-old female who was readmitted to the facility on [DATE]. Resident #1 had diagnoses which included Peripheral vascular disease (refers to any disease or disorder of the circulatory system outside of the brain and heart), muscle weakness (decreased strength in the muscles), muscle wasting and atrophy (the loss of muscle mass and strength) and radiculopathy, lumbar region (a condition that affects the nerve roots in the low back). Record review of Resident #1's quarterly MDS, dated [DATE], revealed a BIMS of 15, which indicated cognitively intact. Resident #1 had no signs or symptoms of swallowing disorder, did not have any dental concerns and was able to eat independently. Record review of the care plan, updated last on 11/14/2023, revealed Resident #1 had altered nutritional status with a goal to maintain wight over the next 90 days. The care plan intervention included allowing Resident #1 to eat at own pace, assist with eating, encourage performance, preferences would be accommodated through personal choice and the selective menu process, provide favorite foods and beverages, and provide alternatives and snacks, and update residents food preferences updated on 1/22/2025. During an interview on 1/27/2025 at 10:41 AM, Resident #1 said the food was not good and the facility had cut back on portions. Resident #1 did not elaborate on the food complaint. 2. Record review of Resident #57's face sheet, dated 1/29/2025, revealed Resident #57 was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #57 had diagnoses which included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) , asthma (a condition in which a person's airways become inflamed, narrow and swell and produce extra mucus which make it difficult to breathe), hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone), diabetes mellitus with hyperglycemia (a chronic condition where the body does not produce enough insulin or does not us it effectively), chronic kidney disease (longstanding disease of the kidneys leading to renal failure) and hypertensive heart disease (a number of complications of high blood pressure that affect the heart). (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #57's quarterly MDS, dated [DATE], for revealed a BIMS of 14, which indicated the resident was cognitively intact. Resident #57 had no signs or symptoms of swallowing disorder, did not have any dental concerns and was able to eat independently. Record review of the care plan, updated on 1/15/2025, indicated Resident #57 had altered nutrition which indicated Resident #57 had a significant weight gain over 3 months. The care plan interventions, dated 1/8/2024, included Dietitian referral as indicated, monitor oral intake of food and fluid, and provide snacks between meals as preferred. During an interview on 1/27/2025 at 03:05 PM, Resident #57 said the food was terrible and whoever made the menu did not consider they are Senior citizens with dentures, few teeth or no teeth and the flavor was not good. She said she could not eat pizza. Resident #57 said the breakfast was usually good. 3. Record review of Resident #58's face sheet, dated 1/29/2025, revealed a [AGE] year-old female who was readmitted to the facility on [DATE]. Resident #58 had diagnoses of Multiple sclerosis (a disease that causes breakdown of the protective covering of nerves that can cause numbness, weakness, trouble walking, vision changes and other symptoms), muscle weakness (decreased strength in the muscles), hypotension (a condition in which blood pressure is abnormally low), paraplegia (a form of paralysis that mostly affect the movement of the lower body). Record review of Resident #58's quarterly MDS, dated [DATE], for Resident # 58 revealed a BIMS of 15, which indicated the resident was cognitively intact. Resident #58 had no signs or symptoms of swallowing disorder, did not have any dental concerns and was able to eat independently. Record review of Resident #58's care plan, updated on 1/15/2025, indicated Resident #58 had altered nutrition which indicated Resident #58 had a significant weight gain over last 6 months. The care plan goal, last reviewed on 1/15/2025, revealed snacks between meals as preference daily and interventions for a dietician referral as indicated, monitoring oral intake of food and fluids and provide snacks between meals as preferred. During an interview on 01/27/25 at 10:24 AM, Resident #58 said the food had gone down in the last 5 weeks or so and before it was a five star but now it dropped to a one star. Resident #58 said corporate changed the menu and was not good and did not taste good. 4. Record review of Resident #64's face sheet, dated 1/29/2025, revealed a [AGE] year-old female who was readmitted to the facility on [DATE]. Resident #64 had diagnoses of essential hypertension (is high blood pressure with no clear cause), Gastro-esophageal reflux disease without esophagitis (happens when acidic stomach contents flow back into the esophagus) insomnia (a common sleep disorder that can make it hard to fall asleep or stay asleep), hypothyroidism (a condition where the thyroid gland does not produce enough hormones), major depressive disorder (a mental disorder characterized by at least 2 weeks of pervasive low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities), and hypokalemia (when you have low levels of potassium in your blood). Record review of Resident #64's quarterly MDS assessment, dated 11/22/2024, indicated Resident #64 had a BIMS of 15, which indicated she was cognitively intact. Resident #58 had no signs or symptoms of swallowing disorder, did not have any dental concerns and was able to eat independently. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Briarcliff Skilled Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE: 4054 Northwest Loop Carthage, TX 75633	

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #64's care plan, updated 1/15/2025, indicated Resident #64 had altered nutrition. The care plan interventions included dietician referral as indicated, monitor oral intake of food and fluid, and provide snacks between meals as preferred. During an interview on 01/27/25 at 11:34 AM, Resident #64 said she had no complaints other than the food. Resident #64 said it was not good. She said usually breakfast was fine, lunch was fair and supper was the one not that good. Resident #64 said ever since corporate changed the menu, it had not been good, and food was her only complaint. During an observation and interview on 1/28/2025 at 12:55 PM, the Dietary Manager and four state surveyors sampled a lunch tray. The sample tray consisted of a pork chop, mixed veggies, German potato salad, tossed side salad with ranch dressing, roll, and pureed pork chop. The Dietary Manager sampled each portion and said she felt the tray was a good tray. During the test tray, the four state surveyors indicated the meal did not present appetizing with bland mixed veggies, pureed pork chop was too salty and lacked palatability and was received lukewarm. During an interview on 1/30/2025 at 8:49 AM, CNA N said she assisted residents with passing and setting up meal trays. She said she assisted with feeding when needed. CNA N said the residents did complain about the food. She said a resident complained about being served pizza and then some would say their food was cold and hard. She said the residents would report to her the food did not have any taste and being the same menu. CNA N said residents who complained did not ask for the alternative menu because they had food in their room and would tell her not to worry about it. CNA N said she had not mentioned to ADM or Dietary Manager about the residents' concerns. CNA N said she would observe residents not eating or skipping lunch and then eating breakfast or dinner. CNA N said some residents would ask for a sandwich. CNA N said whoever was serving was responsible for offering or asking a preference for an alternative meal. CNA N said the residents could have weight loss and it could affect their health and overall attitude. CNA N said the menu changed after a state lady came in. CNA N said the CNA's document under the how much eat resident consumes. During an interview on 1/30/2025 at 9:11 AM, MA O said some residents wanted food like their own kitchen. MA O said the residents were able to choose what they would like, but then when they got it, they did not like it, or the residents would see something another resident was eating and want that. MA O said the staff would provide an alternative prior to meal service and this allowed residents to choose what they wanted. MA O said a resident could lose weight. She said the staff would offer snacks or other food items. MA O said she would notify the charge nurse if a resident had concerns with the food served. MA O said the residents got what they asked for. MA O said the staff was responsible for making sure the residents were satisfied with meals and received adequate nutrition. During an interview on 1/30/2025 at 9:21 AM, LVN D said she cared for residents on the memory care unit. LVN D said the staff were able to provide the residents with something different if they did not like the food served. She said she had a couple of residents on hospice, and they have communicated. LVN D said she had a resident who liked to eat at a different time and the facility accommodated the time he liked to be served dinner. LVN D said a resident could lose weight and start to decline if they refused to eat the foods served. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/30/25 at 09:44 AM, the Dietary Manager said the residents complained about the food but that was prior to the new menu. The Dietary Manager said the residents liked the new menu better. The Dietary Manager said the kitchen staff offered an alternative if they did not like the food. The Dietary Manager said everybody was responsible for ensuring the residents were eating and satisfied with meals. The Dietary Manager said she would take suggestions from residents during her rounds. The Dietary Manager said she would ask residents to write on their meal ticket if there was something specific, they would like, and the facility staff would honor their wishes. The Dietary Manager said she was responsible for ensuring the meals were palatable and warm. The Dietary Manager said she felt the test tray was a good tray. During an interview on 1/30/2025 at 10:01 AM, Social Worker F said the residents complained about food. She said residents complained the food was cold and they did not like their choices. The Social Worker F said she reported to the ADM and Dietary Manager. Social Worker F said the facility had a new menu and the complaints started increasing. Social Worker F said the ADM would need to be asked what the facility was doing to address the complaints. Social Worker F said the residents could have a weight loss. She said dietary was responsible for ensuring the residents were satisfied with the meals being palatable and warm. Social Worker F said she was aware of some grievances, and they were written up. Social Worker F was only able to provide one grievance from a discharged resident. There were no grievances listed on the grievance log regarding food. Social Worker F said she expected the staff to report to her using the grievance forms outside her door any concerns with meals. During an interview on 1/30/2025 at 10:21 AM, the ADON said she had not received any complaints about the food. She said some residents are not fond of certain foods on the menu. The ADON said the menu and system changed and it provided more options to the residents. She said she thought there was one complaint that was reported to the Social Worker. The ADON said it was discussed with staff about making sure the food was warm. The ADON said the staff were responsible for making sure the residents were satisfied with the food and were eating. The ADON said the facility tried to accommodate and find substitutes the resident liked. The ADON said a resident could have weight loss if they did not like what was served. During an interview on 1/30/2025 at 10:31 AM, the DON said the facility did not have any food complaints. The DON said there were several complaints when they rolled out the new system where the menu had ounces on the menu and the resident did not like that. The DON said if a resident did not like something, the facility offered them something different. The DON said she expected the food to be warm when served. If the resident continued to dislike the food, they would not eat and if they were not eating, it could cause weight loss. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/30/2025 at 10:37 AM, the ADM said he expected the residents to receive their trays served at a papabile temperature and expected the kitchen to follow recipes. The ADM said he did not know if it met the residents' expectations. He said the facility asked the residents to report to staff and they fix what they could. The ADM said they were looking to replace some of the thermal lids. He said he had an improvement projected on QAPI that was ongoing. The ADM said the metal domed lids were not holding heat well. The ADM said the facility tried to address each complaint directly and residents were asked to let staff know of any concerns. The ADM said when the residents had complained, the facility offered alternatives. He said the nutritional services were responsible for ensuring the residents enjoyed their food. The ADM said he emailed and called the corporate Regional Dietician when there were issues. The ADM said he did not write up any grievances on the food concerns. The ADM said food complaints could cause a decrease in the quality of life and weight loss if a resident consistently did not like the food that was served. The ADM said the facility completed a test tray monthly and not weekly as the instructions indicated. The ADM provided the last test tray report dated 12/10/2024. During an interview on 1/30/2025 at 10:53 AM, the Corporate Regional Dietician said she talked to the resident about the menu. She said she sat down with residents to discuss changes being made and conversations she had with residents. The Corporate Regional Dietician felt there was a lot of valuable feedback during her conversation with the residents. The Corporate Regional Dietician said the staff were following the recipes and the kitchen staff prepared the pureed with the regular food. She said she had individual conversation with residents to address their concerns and needs when they would arise. The Corporate Regional Dietician said the facility did not have a specific policy over palatability. Record review of the facility's policy, dated August 1, 2018, titled Hot and Cold food temperatures. Policy: The temperatures of the food items will be managed to conserve maximum nutritive value and flavor and to be free of harmful organism and substances. Procedure .5. All hot food items must be served to the resident at a palatable temperature .6. All cold food items must be served to the resident at a palatable temperature. Record review of the facility's Test Tray Report, dated 12/10/2024, revealed criteria reviewed 1. A food temperature .B Hot liquids .2. Texture of foods .3. Taste of foods .4. Menu compliance .5. Portion size .6. Accuracy of meals delivered .7. Garnish Instructions for completing the test tray report each week: 1. At the serving line .a. verify portion sizes, starting temperatures and menu compliance .2. During delivery .a. Select random samples of regular and pureed meals . b. assesses accuracy, presentation, garnish, and portions served .3. At the end of meal service: a. Obtain and sample of each food from the regular and pureed b. Hold the sample for an appropriate amount of time .c. Identify compliance to the 7 review points .4. In the space provided at the end of the form, add details of any corrective actions taken and other comments as needed.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcliff Skilled Nursing Facility	4054 Northwest Loop Carthage, TX 75633

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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. 49019 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food safety requirements. 1. The facility failed to ensure there was minimal carbon buildup on approximately 6 baking sheet pans. 2. The facility failed to ensure the stove was clean from debris and black carbon buildup on the stove top. These failures could place residents at risk of foodborne illness and food contamination. Findings include: During initial tour observations in the kitchen on 1/27/2025 beginning at 10:05 AM and accompanied by the Dietary Manager , there was approximately 6 baking sheet pans with thick black carbon buildup on the rims of the pans. Black carbon build up was observed on the stove top. During observation during kitchen rounds on 1/28/2025 at 8:03 AM, revealed black carbon build up on pans stored below the food preparation table near the stove. There were white, yellow, and brown substances down the left side of the stove top and carbon build up on stove top. A pot located on top of stove had a brown and black substance located where the handle attached to the pot. During an interview on 1/29/2025 at 2:09 PM, Nutritional Aide S said she did not clean the pans. She said she cleaned the dishes such as plastics and dishes and ensured the dish room was clean. During an interview on 1/29/2025 at 2:08 PM, [NAME] T said she was responsible for cleaning the pots, pans, and cooking sheets. [NAME] T said she should have reported the black carbon build up on the pans and pots to the supervisor . [NAME] T said the black carbon build up had been on the pots, pans and baking sheets for some time but could not provide a time frame. [NAME] T said the black carbon buildup on the pans could cause a fire. [NAME] T said she cleaned the stove top one time a month and used a grill cleaner and a stainless-steel scrubbing pad. She said she wiped down the side of the stove one time monthly. [NAME] T said the carbon buildup on the stove could cause a fire. [NAME] T said the Dietary Manager was responsible for ordering new pots and pans. During an interview on 1/29/2025 at 2:15 PM, the Dietary Manager said the black carbon build up was on the stove. She said the staff would do a deep clean on the stove one time monthly. The Dietary Manager said the residue on the sides of the stove was on there and would not come off. The Dietary Manager contacted the Maintenance, and he told her the stove was last serviced sometime in August to October 2024. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Briarcliff Skilled Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE: 4054 Northwest Loop Carthage, TX 75633	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 1/30/2025 at 8:39 AM, the Maintenance Supervisor said he thought the stove had been serviced sometime in August to October . He said he did not have records and those records would be with the Dietary Manager. The Maintenance Supervisor said the facility did not have any maintenance records on the stove. The Maintenance Director said staff could experience respiratory problems with black carbon buildup on the stove. The Maintenance Supervisor said the Dietary Manager was responsible for ensuring the stove, pots and pans were cleaned and serviced. He said he only assisted with the stove if he was made aware of an issue. He denied any recent issues with the stove and the last time there was an issue was in September and October when he had to adjust the pilot on the burner. During an interview on 1/30/2025 at 9:44 AM, the Dietary Manager said the kitchen did not usually receive the requisition on the stove when it was last serviced. The Dietary Manager said the company came out to do the work. She said she did not have records and would contact the regional manager. The Dietary Manager said the black carbon buildup could cause a fire. She said the kitchen was short staffed and she tried to complete tasks in the kitchen, that the kitchen staff was not able to accomplish . During an interview on 1/30/2025 at 9:35 AM, Nutritional Aide Q said the cook was responsible for cleaning the stove . Nutritional Aide Q said he observed black carbon buildup on the stove . He said the kitchen staff would take the stove top off and clean them with oven cleaner and a stainless-steel brush. He said black carbon buildup on the stove could cause a fire in the kitchen or stop the gas from blowing out the pilot. Nutritional Aide Q said the black carbon buildup could get in the food. During an interview and record review on 1/30/2025 9:49 AM, the Maintenance Supervisor reviewed a maintenance record, dated 8/13/2024, indicated a complaint on the right oven door hinge replaced and the griddle burner issue with need to replace the pilot . The Maintenance Supervisor said this requisition was for the griddle and not the stove. During an interview and record review on 1/30/2025 at 10:30 AM, the ADM provided a service requisition dated 12/8/2023, which indicated a complaint the range was not cooking right and had to turn the temperature up higher to perform. The ADM provided a copy of the work history report, dated 1/30/2025 at 10:18 AM, revealed preventive maintenance inspection on kitchen and any food preparation or serving area last performed on 1/16/2025. The kitchen inspection instructions included the following: Visually inspect all appliances and equipment. Test equipment for proper function. Check for abnormal sounds or vibrations. Check all electrical cords and connections for fraying or other issues. Check walk-in cooler/freezers for ice build-up around door or on floors. Check heat on doors. Make sure doors latch properly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Check to make sure all pilot lights are burning. Vent hood. Check filters for tight fit. Check cleanliness, particularly grease build up. Make sure grease cups are present. Flooring-cleanliness and slip and fall risks. Make sure stored materials are not on the floor. The record provided did not reveal a checklist, requisition, or work order for the inspections by the Maintenance Supervisor. The task completion only revealed the inspection was completed. During an interview on 1/30/2025 at 10:37 AM, the ADM said he did not know the standard on the black carbon buildup on pans, pots, and stove. He said he did not know if the pots, pans, or stove would need to be out of service. The ADM said he did not know what the black carbon buildup could do if it continued to build up on the surface of pots, pans, or the stove. He said he expected the kitchen to be cleaned according to the facility policy and proper maintenance of equipment. During an interview on 1/30/2025 at 10:53 AM, the Corporate Regional Dietician said some of the pans could be replaced and the carbon build up was on the underside of the pans. The Corporate Regional Dietician said she could not say what could happen with black carbon build up on the surfaces of the pans or stove. She said she expected the black carbon buildup to be cleaned or discarded. She said the facility would need to add additional areas to clean the sides of the stove more frequently. The Corporate Regional Dietician said she expected the ranges to be cleaned per the facility policy. During an interview on 1/30/2025 at 11:38 AM, the Corporate Regional Dietician said the facility did not have a specific policy over equipment cleaning or cleaning schedule. Record review of facility Cooks Daily/Weekly Duties checklist dated January 2025 revealed Ovens (inside outside, top and bottom) should be cleaned daily with No Exception handwritten on the checklist. The [NAME] initialed daily the task was completed . Record review of U.S. Food and Drug Administration Code Dated 2022 Section 4-6, 4-602.12 Cooking and Baking Equipment. (A)The food-contact surfaces of cooking and baking equipment shall be cleaned at least every 24 hours. This section does not apply to hot oil cooking and filtering equipment if it is cleaned as specified in Subparagraph 4-602.11(D)(6). (B)The cavities and door seals of microwave ovens shall be cleaned at least every 24 hours by using the manufacturer's recommended cleaning procedure. 4-101.18 Nonstick Coatings, Use Limitation. Multiuse kitchenware such as frying pans, griddles, saucepans, cookie sheets, and waffle bakers that have a perfluorocarbon resin coating shall be used with nonscoring or nonscratching utensils and cleaning aids.

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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** 48958 Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 7 of 8 residents (Residents #2, #5, #14, #31, #55, #62 and #74) reviewed for infection control practices. 1. LVN G failed to remove her dirty gloves and perform hand hygiene during Resident #55's wound care. 2. The facility failed to ensure the proper disinfectant cleaner was used to clean Resident #62's isolation room with clostridium difficile (bacteria that causes infection in the large intestine). 3. The facility failed to ensure CNA A performed proper hand hygiene while feeding Resident #2 and Resident #5 during lunch meal service on 1/27/25 to prevent cross contamination between each resident. 4. The facility failed to ensure LVN C applied enhanced barrier precautions when she administered medications via a gastrostomy tube (feeding tube) to Resident #5 on 01/28/25. 5. The facility failed to ensure RN K applied enhanced barrier precautions when she administered an IV medication to Resident #14 on 01/28/25. 6. The facility failed to ensure the Treatment Nurse applied enhanced barrier precautions when she provided tracheostomy (surgical procedure that creates an opening in the trachea [(windpipe]) to allow air to enter the lungs) care to Resident #74 on 01/28/25. 7. The facility failed to ensure LVN M performed hand hygiene before and after obtaining Resident #31's fingerstick blood sugar and before she administered Resident #31's insulin on 01/28/25. These failures could place residents at risk for cross contamination and the spread of infection. Findings included: 1. Record review of Resident #55's face sheet, dated 2/4/25, indicated a[AGE] year-old female who initially admitted to the facility on [DATE]. Resident #55 had diagnoses which included altered mental status, weakness, acquired absence of left leg below knee and acquired absence of right leg below knee. Record review of Resident #55's quarterly MDS assessment, dated 12/26/24, indicated she was able to make herself understood and could understand others. Resident #55 had a BIMS score of 12, which indicated her cognition was moderately impaired. Resident #55 required maximal assistance with bed mobility and toileting. Resident #55 was frequently incontinent of bowel. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #55's order summary report, dated 12/13/24, indicated the following order: cleanse wound day shift (10am-10pm) sacrum, with wound cleanser, pat dry, pack with 1/2 strength dakins gauze, apply collagen powder cover with absorbent dressing. Record review of Resident #55's care plan, dated 1/23/25, indicated skin breakdown: at risk for/ actual. Interventions cleanse wound day shift (10AM-10PM) sacrum, with wound cleanser, pat dry, pack with 1/2 strength dakins gauze, apply collagen powder cover with absorbent dressing. Record review of LVN G's Nurses: Clean Dressing Change Competency check-off sheet, dated 6/5/24, indicated LVN G met the requirements. The competency was signed by evaluator, RN. Record review of LVN G's Nurses: Clean Dressing Change Competency check-off sheet, dated 8/28/24, indicated LVN G met the requirements. The competency was signed by evaluator, RN. Record review of LVN G's Staff Education/Orientation Policies and Procedures: Dressing, Simple: Application of Wound Care Standards of Practice Manual Change Competency check-off sheet dated 9/5/24 indicated LVN G met the requirements. The competency was signed by evaluator, Regional Nurse J. During an observation on 1/29/25 at 2:29 PM, LVN G performed wound care on Resident #55. LVN G did not change her gloves or sanitize her hands after cleaning the wound and then applied a clean dressing. During an interview on 1/29/25 at 2:40 PM, LVN G said she did not change her gloves or sanitize her hands when she pulled off the dirty dressing, she cleaned the wound and applied a clean dressing. She said she forgot to change her gloves and sanitize her hands. She said she usually did hand hygiene, but she was nervous with someone watching her. She said a negative effect of improper hand hygiene during wound care would be, she could introduce germs back into the wound. During an interview on 1/30/25 at 8:44 AM, LVN B said when a nurse performed wound care, they should perform hand hygiene and change their gloves when going from dirty to clean. She said a negative effect of improper hand hygiene during wound care could spread the infection and the wound could never heal. During an interview on 1/30/25 at 9:26 AM, LVN D said when a nurse performed wound care, when they went from dirty to clean, they should wash or sanitize their hands and apply clean gloves. She said a negative effect of improper hand hygiene during wound care would be the spread of infections. During an interview on 01/30/25 at 9:35 AM, LVN E said when a nurse went from dirty to clean, they should wash their hands and change gloves. She said a negative effect of improper hand hygiene during wound care was introducing a new bacterium into the wound and the risk for infection. 2. Record review of Resident #62's face sheet, dated 1/29/25, indicated a [AGE] year-old female who initially admitted to the facility on [DATE]. Resident #62 had diagnoses which included enterocolitis due to clostridium difficile (bacteria that causes infection in the large intestine), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), muscle weakness, other lack of coordination and cognitive communication deficit. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #62's quarterly MDS assessment, dated 12/26/24, indicated she was able to make herself understood and could understand others. Resident #62 had a BIMS score of 15, which indicated her cognition was intact. Resident #62 required maximal assistance with toileting. Resident #62 was always continent of bowel. Record review of Resident #62's comprehensive care plan, dated 1/23/25 , indicated she had clostridium difficile. The care plan interventions included to administer vancomycin as ordered and contact isolation precautions. Record review of Resident #62's order summary report, dated 01/29/25 indicated the following order: *Contact Isolation precautions for clostridium difficile every shift with a start date of 1/17/25. Record review of the sites following were accessed on 1/29/25 at 2:03 PM and did not indicate the DC 33 disinfectant cleaner was used to kill the clostridium difficile bacteria . Record review of the facility's policy and procedure Isolation Room/Unit Cleaning, dated November 2021, indicated . For a unit of a C-Diff resident, use the appropriate disinfectant that states it is effective against C-diff. Be sure to adhere to the appropriate contact/dwell time (amount of time the surface must remain wet with the disinfectant to be effective During an interview on 1/29/25 at 9:52 AM, Housekeeping I said she used DC 33 to clean Resident #62's room. She said housekeeping cleaned Resident #62's room every day and used a different mop for every resident's room. During an interview on 1/30/25 at 9:35 AM, the ADON said she was the infection preventionist. She said the facility changed to a new chemical but was not sure what it was. She said housekeeping started a new chemical today. She said the facility was not aware that DC 33 was not a disinfectant that killed c-diff until state surveyor intervention. She said a negative effect of using DC 33 was the disinfectant was not killing the spores of c-diff and it had the potential to spread to someone else in the facility . During an interview on 1/29/25 at 1:50 PM, Housekeeping Supervisor H said they used the DC 33 in all the resident's rooms. She said the facility did not have a specific cleaner for c-diff . She said the chemical DC 33 said it disinfected blood and bodily fluids. She said they used the DC 200 and the company changed them to DC 33. She said she did not see on the label that DC 33 killed c-diff. She said the facility had always used the DC 33 and the c-diff had not spread. She said they put the chemicals in a mixing machine with water and disinfect spray for mixing. She said the house keepers used a towel to wipe down everything in the rooms. She said they never used the same mop pad, they used a different mop pad for each resident's room. She said the housekeepers sprayed the mop with disinfectant then mopped the floor with the mop, before entering the resident's rooms, because some of the residents could not handle the strong smell. She said when there was no one in the room and they were doing a deep cleaning they would spray the DC 33 disinfectant on the floor then mop. She said a negative effect of the DC 33 disinfectant was it was not effective in killing the spores for c-diff, it could have a potential to spread and linger in the facility . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/30/25 at 9:43 AM, the ADM notified the state surveyor that the facility had ordered the appropriate disinfectant and had received a disinfectant that killed the spores of c-diff and an in service had been performed to all housekeeping staff. During an interview on 1/30/25 at 10:36 AM, the DON said she expected nurses to change their gloves when going from dirty to clean and to perform hand hygiene. She said negative effect of improper hand hygiene would be the spread of an infection. She said she would expect the housekeeping staff to use a disinfectant that killed the spores of c-diff. She said using a disinfectant that did not kill the spores of c-diff had a potential for the c-diff to spread. During an interview on 1/30/25 at 11:06 AM, the ADM said he expected proper hand sanitizer procedures be performed. He said a negative effect of improper hand hygiene was contamination of an area, spreading infection and resident could become sicker. He said expect for the housekeeping staff to use a chemical effective to kill the pathogens for c-diff. He said a negative effect of not killing the spores of c-diff was it could spread. He said we want to kill the spores and we do not want c-diff to spread throughout the facility. 3. Record review of Resident #2's face sheet, dated 1/28/24, indicated a [AGE] year-old female and admitted to the facility on [DATE]. Resident #2 had diagnoses which included profound intellectual disabilities, Cerebral Palsy (disorder of movement, muscle tone, or posture due to abnormal brain development, often before birth), dysphagia (difficulty swallowing), weakness, and diabetes (high blood sugar). Record review of Resident #2's quarterly MDS assessment, dated 12/20/24, indicated Resident #2 was unable to perform a BIMS due to rarely/never understood. The MDS indicated Resident #2 used a wheelchair for mobility. Resident #2 was dependent on staff for eating. Record review of Resident #2's care plan, with a print date of 1/28/25, indicated she had cognitive deficits related to decision-making and communicating needs. Resident #2 was high risk for falls. Resident #2 had impaired physical mobility. Resident #2 had self-care deficits. Resident #2 had altered nutritional status and was total dependent for eating . 4. Record review of Resident #5's face sheet, dated 1/29/25, indicated a [AGE] years old female who was admitted to the facility initially on 1/24/19. Resident #5 had diagnoses which included Rett's syndrome (rare genetic neurological and developmental disorder that affects the way the brain develops, causing a progressive loss of motor skills and language affecting primarily females), aphasia (complete loss of language abilities), anxiety (persistent worrying, unease, nervousness), weakness, and spastic hemiplegia affecting right dominant side (neuromuscular-nerve and muscle condition of spasticity-stiff or rigid muscles that results in the muscles on one side of the body being in constant state of contraction-limited range of motion and stiffness in affected area). Record review of Resident #5's quarterly MDS assessment, dated 12/18/24, indicated she was rarely/never understood and rarely/never understood others. Resident #5's cognitive skills for daily decision making was severely impaired. Resident #5 was totally dependent on staff with eating, oral hygiene, toileting, showering, dressing, and personal hygiene. The MDS assessment had feeding tube checked as a nutritional approach and indicated Resident #5 had taken anticonvulsant medication within the last 7 days of the look back period. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's comprehensive care plan, dated 05/10/24, indicated Resident #5 had a care area of infection control evidenced by peg tube and enhanced barrier precautions every shift. The care plan interventions indicated enhanced barrier precautions gown and glove use during high contact resident care activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting, wound care, and any skin opening requiring a dressing change. Record review of Resident #5's care plan, with a print date of 1/29/25, indicated she had cognitive deficits related to decision-making. Resident #5 had a speech deficit. Resident #5 was at risk for falls. The care plan indicated Resident #5 had impaired physical mobility. Resident #5 had self-care deficits. Resident #5 had altered nutritional status and was total dependent for eating. Record review of Resident #5's consolidated orders, dated 01/30/25, indicated she had the following orders: o Crush medication may cocktail medication with an order start date of 05/23/23. o Valproic acid (antiseizure medication) 250mg/5ml give 10mls via g-tube three times a day with a order start date of 11/01/23. o Enhances Barrier Precautions every shift reason: peg tube with an order start date of 08/07/24. o Ropinirole (used for restless leg syndrome) 0.25mg tablet one tablet via g-tube daily with a start date of 05/20/23. o Cholecalciferol (vitamin d3) 125mcg give one tablet via g-tube one time a day with a start date of 05/20/23. o Docusate sodium (stool softener) 100mg tablet give 2 tablets via g-tube one time a day with a start date of 05/20/23. o Glycopyrrolate (medication used to reduce saliva and drooling) 1mg give one tablet via g-tube 2 times per day with a start date of 05/20/23. o Lactulose (laxative) 20gm oral packet- give one packet via peg tube three times per day with an order date of 05/01/24. o Levetiracetam (antiseizure medication) 100mg/ml oral solution give 15ml via g-tube twice a day with an order date of 10/08/23. o Midodrine (medication used to treat low blood pressure) 10mg give one tablet via g-tube 3 times per day with an order start date of 06/01/24. o Phenytoin (antiseizure medication) 50mg chewable tablets give 2 tablets chewable by mouth 3 times per day with an order start date of 11/01/23. o Multivitamin with minerals give one tablet via g-tube one time per day with an order start date of 05/20/23. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o Senna Plus (laxative) 8.6-50mg tablet give one tablet via g-tube one time a day with an order start date of 05/20/23. Record review of Resident #5's electronic medication administration record, dated 01/01/25-01/29/25, indicated enhanced barrier precautions as performed twice a day. During an observation of the lunch meal service in the assisted dining room on 1/27/25 beginning at 11:47 AM, CNA A was sitting at a table between Resident #2 and Resident #5 feeding both residents. CNA A was observed feeding Resident #2 a spoonful of food and then sat the spoon down and turned to Resident #5 and picked up her spoon and gave her a spoonful of food with the same hand. CNA A continued to go back and forth between Resident #2 and Resident #5 giving each a spoonful of food. CNA A took her hand and touched Resident #2's chin trying to entice her to take a bite of food and then gave her a spoonful of food and took a napkin and wiped her mouth. CNA A then turned to Resident #5 and picked up her spoon and fed her a spoonful of food. CNA A continued to alternate back and forth between Resident #2 and Resident #5 feeding a spoonful of food with their own spoons and periodically wiping Resident #2's mouth with a reused napkin. CNA A did not sanitize her hands between feeding, touching, or wiping the resident's face for Resident #2 or Resident #5. This practice continued until a second staff member took over feeding Resident #2 at 12:01 PM. CNA A continued to feed Resident #5 and did not sanitize her hands. During an interview on 1/30/25 at 8:42 AM, CNA A said she had worked at the facility off and on since 2014. CNA A said she had worked at the facility for about a year this time. CNA A said she remembered assisting Resident #2 and Resident #5 during the lunch meal service on 1/27/25. CNA A said she did not sanitize her hands between feeding each resident or after wiping their mouths. CNA A said she should have sanitized her hands between transferring between each resident. CNA A said she could have transferred germs back and forth to both residents. CNA A said the residents could get sick if she did not sanitize her hands properly between feeding each resident. During an interview on 1/30/25 at 9:03 AM, LVN B said she had worked at the facility since 2020 and normally worked the 6 AM-6 PM shift. LVN B said when staff assisted and/or feeding two residents at the same time, the staff should sanitize their hands between each resident. LVN B said the staff could spread germs and the residents could get an infection if staff did not sanitize their hands between feeding/assisting each resident with meals. During an interview on 1/30/25 at 10:03 AM, the ADON, who was also the Infection Preventionist, said she had worked at the facility since October 2024. The ADON said she started as the Infection Preventionist in November 2024. The ADON said staff should be sanitizing their hands between going from resident to resident if they were feeding two residents at the same time. The ADON said it would not be appropriate to feed one resident, wipe the resident's mouth, touch the resident's face and then turn and feed the other resident without sanitizing the staff's hands. The ADON said staff really should not be feeding two residents at the same time, but sometimes staff would start until other staff were free to assist. The ADON said the staff could spread bacteria back and forth to residents and it was not good hygiene to not sanitize their hands between feeding each resident. The ADON said it could cause an illness to a resident by introducing bacteria to them from not sanitizing their hands between assisting and/or feeding residents during meal service. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Briarcliff Skilled Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE: 4054 Northwest Loop Carthage, TX 75633	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/30/25 at 10:55 AM, the DON said staff should sanitize their hands between each resident, when assisting and/or feeding residents. The DON said if staff were assisting and/or feeding more than one resident and did not sanitize their hands between feeding/touching each resident, they could be sharing germs between the residents and could cause some kind of infection to the residents. During an interview on 01/30/25 at 11:25 AM, the ADM said staff should be sanitizing their hands before feeding a resident and in between feeding/touching each resident. The ADM said staff could transfer infections from one resident to the other if the staff did not sanitize their hands between assisting and/or feeding more than one resident. The ADM said he would expect staff to follow the facility's infection control and hand hygiene policies. During an observation and interview on 01/28/25 at 09:16 AM, LVN C prepared Resident #5's routine morning medications. LVN C obtained the following mediations: 1 tablet of ropinirole 0.25mg, 2 chewable tablets of phenytoin 50mg, 1 tab of glycopyrrolate 1mg, 1 tab of midodrine 10mg, 1 vitamin d3 125mcg, 2 tabs of stool softener 100mg, 1 tablet of multivitamin with minerals, 1 tab of senna 8.6mg, 15 mls of levetiracetam 100mg/5mls, 10mls of valproic 250mg/5mls, and 1 packet of kristalose 20 grams. LVN C entered Resident #5 room to administer her medications. LVN C performed hand hygiene, applied gloves, administered all medications via peg tube, removed her gloves and washed her hands. LVN C failed to apply a gown. Resident #5 had a 3-drawer plastic bin, with PPE, inside her room to the right side of the door. LVN C said Resident #5 was on EBP precautions which indicated to perform hand hygiene and use gloves when providing direct patient care to prevent infections. LVN C said it was not required to wear a gown when providing care to residents on EBP . 5. Record review of Resident #14's face sheet, dated 01/29/25, indicated a [AGE] year-old female who admitted to the facility on [DATE]. Resident #14 had diagnoses which included acute osteomyelitis (an infection of bone), chronic obstructive pulmonary disease (a group of lung disease that block airflow and make it difficult to breathe), and inflammatory conditions of jaws. Record review of Resident #14's admission MDS assessment, dated 01/10/25, indicated she was able to be understood and understood others. Resident #14 had a BIMS of 12, which indicated her cognition was moderately impaired. Resident #14 received IV medications and had IV access on admission and within the last 14 days while a resident. IV antibiotics and IV access were marked as performed on admission. Record review of Resident #14's comprehensive care plan, updated 01/17/25, indicated Resident #14 required IV therapy related to PICC (a thin flexible tube that is inserted into a vein in the upper arm for IV antibiotics or IV medications) line and antibiotic therapy. The care plan interventions included to monitor catheter site for signs and symptoms of infection and initiate IV therapy as ordered. Record review of Resident #14's consolidated orders, dated 01/29/25, indicated she had the following orders: o Enhanced barrier precautions (EBP) every shift reason: PICC line with an order start date of 01/22/25. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Briarcliff Skilled Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 4054 Northwest Loop Carthage, TX 75633	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o PICC line flush before and after medication administration with 10mls normal saline IV two times per day. o Micafungin (antifungal medication) 100mg/100ml in 0.9% sodium chloride IV piggyback administer 100mg intravenously one time a day with an order start date of 01/07/25. o Vancomycin (antibiotic medication) 500mg/100mls in 0.9% sodium chloride intravenous piggyback give one piggyback intravenously every 12 hours for 16 days with an order start date of 01/20/25. Record review of Resident #14's electronic medication administration record, dated 01/01/25- 01/29/25, indicated Resident #14 received micafungin 100mg IV daily since 01/07/25 and vancomycin 500mg IV twice a day since 01/20/25. The record revealed enhanced barrier precautions for PICC line had been performed twice a day since 01/22/25. During an observation and interview on 01/28/25 at 09:01 AM, RN K entered Resident #14's room to administer micafungin 100mg IV via Resident #14's PICC line. RN K did not apply PPE before she administered Resident #14's medication. RN K performed hand hygiene, applied gloves, primed the IV tubing, flushed Resident #14's PICC line with 10mls of normal saline and set the IV pump at 100mls/hour to administer micafungin medication. RN K removed her gloves and performed hand hygiene. Resident #14 had a 3-drawer plastic bin, with PPE, inside her room to the right side of the door. When RN K was questioned why there was a plastic bin inside Resident #14's room, she said it was probably left there but Resident #14 was not on EBP . There was no signage on the door indicating Resident was on EBP. During an observation and interview on 01/28/25 at 2:26 PM, RN K reviewed Resident #14's physician orders and said Resident #14 was on EBP. RN K said she should have worn a gown and gloves when she administered the IV medication to Resident #14 for her protection. RN K said failure to wear proper PPE placed Resident #14 at risk for infection. RN K said a resident who had an opening was required to be on EBP. RN K said staff should wear gown and gloves when providing care to any resident who required wound care, catheter care, or trach care. RN K said residents did not have a sign on the door that indicated if they were on EBP, but their name outside the door was on a blue tag, which indicated the resident had EBP in place. Resident #14's name tag outside her door was blue. 6. Record review of Resident #74's face sheet, dated 01/29/24, indicated a [AGE] year-old male who admitted to the facility on [DATE]. Resident #74 had diagnoses which included chronic obstructive pulmonary disease (a group of lung disease that block airflow and make it difficult to breathe), pneumonia (infection of the lungs that causes inflammation of the air sacs), malignant neoplasm of larynx (cancer of the voice box), and myocardial infarction (heart attack). Record review of Resident #74's admission MDS assessment, dated 12/31/24, indicated he was able to make himself understood and understood others. Resident #74 had a BIMS score of 15, which indicated his cognition was intact. Resident #74 had tracheostomy care performed within the last 14 days of the look back period. Record review of Resident #74's comprehensive care plan, updated 01/20/25, indicated infection control problem evidenced by enhanced barrier precautions every shift and trach. The care plan interventions indicated enhanced barrier precautions gown and glove use during high contact resident care activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting, wound care, and any skin opening requiring a dressing change. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Briarcliff Skilled Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 4054 Northwest Loop Carthage, TX 75633	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #74's consolidated orders, dated 01/29/25, indicated Resident #74 had the following orders: o Enhanced Barrier Precautions every shift reason: trach and peg (feeding tube) with an order start date of 12/31/24. o Trach care twice a day with an order start date of 12/28/24. Record review of Resident #74's electronic medication administration record, dated 01/01/25- 01/29/25, indicated enhanced barrier precautions for trach and peg was performed twice a day. Record review of Resident #74's electronic treatment administration record, dated 01/01/25-01/29/25, indicated trach care was performed twice a day. During an observation and interview on 01/28/25 at 9:53 AM, the Treatment Nurse entered Resident #74's room to provide trach care. There was a 3-drawer plastic bin with PPE inside Resident #74's room to the left side of the door. There was no signage on Resident #74's door indicating EBP. The Treatment Nurse washed her hands and applied gloves. The Treatment Nurse failed to apply a gown. The Treatment Nurse completed Resident #74's trach care, removed her gloves, and washed her hands. The Treatment Nurse said she forgot to wear appropriate PPE and failure to wear appropriate PPE placed the resident at risk for infections. She said EBP required the use of the gown and gloves when providing direct patient care. The Treatment Nurse said she was responsible for ensuring proper PPE was used with residents on EBP . 7. Record review of Resident #31's face sheet, dated 01/30/25, indicated an [AGE] year-old female who initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #31 had diagnoses which included Parkinson's disease (disorder of the central nervous system that affects movement, often including tremors), anemia (lack of blood), hypertension (high blood pressure) and hypothyroidism (condition in which the thyroid gland doesn't produce enough thyroid hormone). Record review of Resident #31's comprehensive care plan, updated 12/16/24, indicated Resident #31 had diabetes mellitus (group of diseases that result in too much sugar in the blood) with interventions to administer insulin and/or oral hypoglycemics as ordered. Record review of Resident #31's consolidated orders, dated 01/30/25, indicated she had the following order: o Novolin 70-30 (insulin which helps lower blood sugar levels) Flexpen 100unit/ml inject 35 units subcutaneous one times daily before meals. Notify MD if FSBS less than 70 or greater than 300. Hold if FSBS less than 70 with an order start date of 01/22/25. Record review of Resident #31's quarterly MDS, dated [DATE], indicated she was usually understood and usually understood others. Resident #31's has a BIMS score of 08, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #31 received insulin injections 7 days out of the 7-day look back period. Record review of Resident #31's electronic medication administration record, dated 01/01/25-01/30/25, indicated Resident #31 received 35 units of Novolin 70/30 daily at 11:30 AM since 01/23/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 01/28/25 at 11:22 AM, LVN M retrieved supplies, to obtain Resident #31's blood sugar, from Hall B nurse's cart. LVN M entered Resident #31 room, donned gloves and obtained Resident #31's blood sugar. LVN M failed to perform hand hygiene prior to donning gloves. LVN M removed her gloves and went to the nurses' cart and obtained Resident #31's Novolin 70/30 insulin. LVN M failed to perform hand hygiene after she removed her gloves. LVN M drew up 35 units of Novolin 70/30, went to Resident #31's room, donned gloves and administered the insulin to Resident #31. LVN M failed to perform hand hygiene prior to donning gloves. LVN M removed her gloves and performed hand hygiene. LVN M said she should have performed hand hygiene before and after obtaining Resident #31's blood sugar and before administering Resident #31 her insulin. LVN M said she was nervous because the state surveyor was observing her with her medication pass and she must have forgotten. LVN M said failure to perform hand hygiene placed Resident #31 at risk for transmission of bacteria, germs and was not sanitary. LVN M said she was responsible for ensuring proper hand hygiene was performed. During an interview on 01/30/25 at 08:36 AM, the ADON said she was the Infection Preventionist at the facility. The ADON said when a resident was on EBP precautions, their name on the door was on a blue tag, they had kits at the doors, and they had orders in the computer. She said gloves and gown were to be worn when providing trach care, IV medications and medications via peg tube. The ADON said failure to use appropriate PPE placed the residents at risk for infections. The ADON said the staff member providing the care was responsible for ensuring proper PPE was worn when providing care to residents on EBP precautions. The ADON said she expected the nurse to have performed hand hygiene before and after obtaining a resident's blood sugar, and before administering insulin and failure to do so placed the resident at risk for infections. The ADON said the nurse completing the task was responsible for ensuring proper hand hygiene was performed. During an interview on 01/30/25 at 8:49 AM, the DON said EBP should been worn when providing care to residents who were on EBP. The DON said EBP was worn to protect the resident and was a new regulation. The DON said she expected hand hygiene to be performed before and after patient care. The DON said failure to perform hand hygiene placed the resident at risk for infection. The DON said the employee performing the task was responsible for ensuring appropriate PPE was worn when performing direct care to residents with EBP precautions. She said the employee performing a task was responsible for ensuring proper hand hygiene was being performed. During an interview on 01/30/25 at 9:33 AM, the Administrator said he expected his staff to follow policy and procedure with residents who were on EBP, expected blue name tags for residents on EBP, and expected all equipment to be available for staff to use. The Administrator said proper PPE was used with residents on EBP for their protection, staff protection and infection control. The Administrator said the [TRUNCATED]