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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>676098  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY COMPLETED<br><br>05/09/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>The Plaza at Richardson  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1301 Richardson Dr<br>Richardson, TX 75080 |  |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |   |  |
| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35747</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible for one (Resident #42) of six residents reviewed for accidents and hazards.</p> <p>The facility failed to ensure Resident #42 did not have access to a disposable razor.</p> <p>This failure could place residents at risk of injury or harm, as well as contribute to avoidable accidents.</p> <p>Findings included:</p> <p>Review of Resident #42's Face Sheet, dated 05/09/24, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE].</p> <p>Review of Resident #42's MDS Assessment, dated 04/13/24, reflected she had diagnoses including stroke (damage to the brain from interruption of its blood supply), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). Resident #42 was identified as being moderately cognitively impaired.</p> <p>Review of Resident #42's Care Plan, dated 07/21/22, reflected Resident #42 required one staff member to assist her with personal hygiene tasks.</p> <p>Observation of and interview with Resident #42 on 05/07/24 at 9:30 AM revealed she was lying in her bed, while shaving her chin with a disposable razor. Resident #42 stated an unknown staff member provided her with the disposable razor to shave her face. She said there were times in which facility staff would shave her face for her; however, she believed staff members were currently busy because they allowed her to shave herself.</p> <p>Interview with RN A on 05/07/24 at 9:42 AM revealed facility staff were responsible for shaving residents. He said residents were not supposed to have access to disposable razors, as that would put residents at risk for injury. RN A located the disposable razor in Resident #42's room and disposed of it.</p> <p>(continued on next page)</p> |   |  |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Interview with the Administrator on 05/09/24 at 7:22 AM revealed facility staff were responsible for shaving residents. He said residents were not supposed to have access to disposable razors, as that would put residents at risk for injury.</p> <p>Review of the facility's Hazardous Areas, Devices, and Equipment policy, dated July 2017, reflected,</p> <p>.all hazardous areas, devices and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible .and a hazard is defined as anything in the environment that has the potential to cause injury or illness .</p> |   |  |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 28637</p> <p>Based on observation, interview and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (Resident #35) of 8 residents reviewed for pharmacy services.</p> <p>The facility failed to obtain the routine scheduled pain medication for Resident #35, who was to receive it every 4 hours, from her hospice company. Resident #35 missed 7 doses of her scheduled pain medication placing her at risk for unnecessary pain. The medications were received after surveyor inquiry.</p> <p>This failure could place residents who require pain medication at risk of suffering pain due to lack of medication availability.</p> <p>Findings included:</p> <p>Record review of Resident #35's Admission Record revealed the resident was a [AGE] year-old female admitted to the facility on [DATE].</p> <p>Record review of Resident #35's Quarterly MDS assessment dated [DATE] revealed her diagnoses included cancer, cancer related pain, hypertension (high blood pressure), depression, and anxiety. The MDS also reflected she had severe cognitive impairment, she ambulated with a walker, received scheduled and PRN pain medication, and experienced occasional pain.</p> <p>Record review of Resident #35's Care Plan revealed an entry dated 07/11/23 which reflected: Focus: The resident requires pain management chronic pain r/t Malignant neoplasm [cancer] of .bronchus or lung, bil [bilateral-both sides] shoulder pain .Interventions/Tasks: Anticipate the resident's need for pain relief and respond immediately to any complaint of pain .Evaluate the effectiveness of pain interventions (FREQ). Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition</p> <p>Record review of Resident #35's Order Summary Report dated 05/08/24 revealed it included the following orders:</p> <p>Oxycodone HCL [narcotic pain medication] Oral Tablet 30 mg give 2 tablet by mouth every 4 hours for pain .</p> <p>Methocarbamol [muscle relaxer] Oral Tablet 500 mg give 2 tablet by mouth three times a day related to neoplasm related pain .</p> <p>Lidocaine external patch [a pain relieving patch] 4% apply to bilateral shoulders topically in the morning for pain wear for 12 hours on then 12 hours off and remove per schedule</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>The orders also revealed orders for Morphine sulfate (narcotic pain medication) 20 mg/ml 0.25-1 ml every hour as needed for pain.</p> <p>Record review of Resident #35's MAR dated May 2024 revealed an entry for Oxycodone HCL Oral Tablet 30 mg give 2 tablets by mouth every 4 hours as needed for pain. The doses were scheduled to be administered at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM.</p> <p>The doses were initialed as administered from 05/01/24 through 05/06/24 at 12:00 PM. The doses scheduled at the following dates/times were coded with a 9 indicating to see the nurses notes:</p> <p>05/06/24 at 4:00 PM</p> <p>05/06/24 at 8:00 PM</p> <p>05/07/24 at 12:00 AM</p> <p>05/07/24 at 4:00 AM</p> <p>05/07/24 at 8:00 AM</p> <p>05/07/24 at 12:00 PM</p> <p>05/07/24 at 4:00 PM</p> <p>The MAR reflected Resident #35 had received morphine for pain management between 05/06/24 and 05/08/24.</p> <p>Record review of Resident #35's nursing Progress Notes revealed the following entries:</p> <p>05/06/24 at 1:05 PM: Resident out of Oxycodone. Hospice notified reminded and promised to bring ASAP Entered by LVN D</p> <p>05/06/24 at 4:47 PM: oxyCODONE HCl Oral Tablet 30 MG Give 2 tablet by mouth every 4 hours for Pain pending delivery Entered by LVN D.</p> <p>05/06/24 at 11:24 PM: oxyCODONE HCl Oral Tablet 30 MG Give 2 tablet by mouth every 4 hours for Pain pending delivery Entered by LVN H.</p> <p>05/07/24 at 3:17 AM: oxyCODONE HCl Oral Tablet 30 MG Give 2 tablet by mouth every 4 hours for Pain Oxycodone is on order, waiting for delivery of the medicine [sic]. Entered by LVN H.</p> <p>05/07/24 at 7:25 AM: oxyCODONE HCl Oral Tablet 30 MG Give 2 tablet by mouth every 4 hours for Pain pending delivery. Entered by LVN D.</p> <p>05/7/24 at 10:57 AM: [Hospice company] called in regard to resident's pain medications and notified that resident is out of medication at this time, response is that the nurse will called and medication will be sent as soon as possible Entered by DON.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>05/07/24 11:42 AM: oxyCODONE HCl Oral Tablet 30 MG Give 2 tablet by mouth every 4 hours for Pain pending delivery. Entered by LVN D.</p> <p>Observation and interview on 05/07/24 at 10:23 AM revealed Resident #35 ambulating in the hall using her walker, she entered her room and requested to talk. Resident #35 stated she was upset with her hospice company because they have not come through with my medications for 24 hours. She stated she was missing her oxycodone. She stated she knew her roommate received medications on time from a different hospice company and she was frustrated with her company. Resident #35 stated she was receiving morphine for pain which was effective but she preferred to take the oxycodone and use her morphine for breakthrough pain. Resident #35 stated she had spoken with the DON on 5/6/24 about it and he was looking into it. She requested this surveyor to check on it for her and get the DON.</p> <p>Interview on 05/07/24 at 10:36 AM with the DON stated he was the acting DON for the facility and had only been there for five days. He stated the facility's usual DON was on leave due to a family emergency. When asked about Resident #35's pain medications, the DON entered her room and told her, I just checked on you this morning, you said you had a good night. Resident #35 stated she did but was upset that the hospice company had not delivered her medications yet. The DON stated they called the hospice company regarding the medications on 5/6/24 and he was not aware the medications still had not been delivered. The DON stated he would look into the situation. After leaving the room, the DON stated, after speaking with Resident #35 earlier that morning, he thought the medications had arrived and he would check her medication cart.</p> <p>Observation and interview on 05/07/24 at 1:20 PM revealed Resident #35 lying in bed with her eyes closed and opened them upon knocking. She stated she had received some morphine for her pain and wanted to go to sleep. She declined to discuss her pain scale.</p> <p>Interview on 05/07/24 at 1:25 PM with LVN D and the ADON, LVN D stated Resident #35 had run out of her oxycodone during her shift on 5/6/24. She stated she called the hospice company and was told they were working on it. She stated that was her first shift caring for her and she had been told by a previous nurse the medications had been ordered. She stated she believed either LVN E or LVN I had previously contacted the hospice company about the medications. LVN D stated she did not call the pharmacy because the hospice company was responsible for delivering the medications. She stated she did not call the resident's physician because, It's still a hospice order. She stated the resident was receiving other pain medications including morphine which was controlling her pain. LVN D stated Resident #35 rated her pain the same way whether or not she received her oxycodone and they continued to assess her. The ADON stated they did not carry oxycodone in the facility's Ekit [emergency kit of medications kept by the facility]. LVN D stated medications were usually reordered when they reached the last row on the medication card. If a resident was on hospice, they called the provider. If a resident was not on hospice, they medications were reordered through their computer software or the pharmacy could be called. The ADON stated they did not call her physician because, they would just tell us to call hospice. When asked if that was the case when a resident missed any dose of a scheduled medication, the ADON replied, I see your point and stated the physician should be called if a medication was not available and so that they would know doses were missed and could provide guidance. LVN D stated the risk for missing pain medication doses included increased pain and a change in condition.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Interview on 05/07/24 at 1:45 PM, LVN E stated she had previously cared for Resident #35 but had not seen her since the previous week as she had transferred to another hall. She stated they did not typically have any issues getting medication refills and she usually called the hospice company before they ran out and they would send them STAT. She stated she had to call the hospice company for Resident #35 a few weeks prior because she was running out of her oxycodone. She stated the resident went through the supply quickly because she was getting them every 4 hours and they only sent about 45 doses at a time. She stated she recalled telling the hospice nurse the last time she saw her she needed to send more and was told she needed to call them every week. She stated the hospice nurse usually checked her cart asked them if they needed any supplies when they came to see the residents. LVN E stated the risk for missing pain medications included the resident suffering severe pain that could not be moderated, and they could possibly need to be sent to the hospital for pain control. She stated she did not typically have issues moderating Resident #35's pain because she was also on muscle relaxers and had PRN medications available.</p> <p>Interview with the DON on 05/07/24 at 2:33 PM, he stated he had spoken with Resident #35's hospice provider again including their Administrator and DON. He stated he also spoke with the NP for Resident #35's attending physician who was in the facility at that time. She told him Resident #35's charge nurse had called and her and she planned to visit the resident. He stated the NP planned to order some from their pharmacy as well. The DON stated he spoke with Resident #35's charge nurse on 5/6/24 and learned she was out of her oxycodone. He stated he had called them as well as the charge nurse and was told they were sending it. He was not aware if had not arrived until speaking with this surveyor and the resident that morning.</p> <p>Interview on 05/07/24 at 2:42 PM, NP J stated she had received a call from Resident #35's charge nurse about her running out of Oxycodone. She stated she had already called the attending physician and ordered some from the facility pharmacy. NP J stated since the medication was ordered from the resident's hospice provider, she would expect the facility staff to contact them initially if a resident ran out of medication. She stated she would expect a call if the hospice company was not providing the ordered medications. NP J stated there were concerns with her ordering the medications because they were controlled and required triplicate prescriptions and there could be a problem with the pharmacy accepting the order if duplicates were sent. NP J stated the risk for residents running out of pain medications included exacerbating the pain making it more difficult to control and they also run the risk of experiencing withdrawal symptoms. She stated, if that were the case, they should have called and let her know. NP J stated, with Resident #35, she was not as concerned because she had other medications available. She stated she was sound asleep and in no distress when she checked on her. She stated she expected the staff to use her as a back-up if they were not getting a proper response from the hospice nurse.</p> <p>Interview with the DON on 05/07/24 at 3:19 PM revealed he spoke with the hospice company again and was told Resident #35's oxycodone had been sent out STAT with an approximate 3 hour delivery window. He stated they never explained why the medication was not sent on 5/6/24 after they were notified. The DON stated medications should be re-ordered a minimum of 72 hours before the last dose.</p> <p>Observation on 05/07/24 at 3:45 PM revealed Resident #35 was ambulating in the hall with her walker following a nurse who was pushing a medication cart. Resident #35 stated she was doing fine and denied complaints.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Interview with the Administrator on 05/07/24 at 4:38 PM, he stated the DON had informed him of the events surrounding Resident #35's medications. He stated his usual DON was out of the country for a family emergency and the acting DON had only been there 5 days. The Administrator stated he expected medications to be ordered 5-7 days out whether or not they were dealing with a hospice resident. He stated pain medications could take longer to arrive as they needed special prescriptions. He stated the night nurses were responsible for ensuring medications were reordered and the DON and ADON were responsible for ensuring it was done. He stated anyone could reorder medications at any time. He stated for controlled medications, the pharmacy should be called to see if refills were available and, if not, the physician should be called. The Administrator stated if the resident was on hospice, they hospice nurse should be notified and they were responsible for getting the medications to the facility. He stated he expected the nurses to leave a progress note whenever they were contacting the hospice company. He stated risks of not having pain medications available included increased pain, anxiety, a change in condition and behaviors.</p> <p>Observation and interview on 05/08/24 at 7:13 AM, LVN F stated Resident #35's oxycodone had arrived from hospice the evening before on 5/7/24. Two cards containing 45 doses each were observed in her medication cart. She stated the facility pharmacy had sent a supply as well and it was locked up on another cart. She stated she had received her doses as scheduled beginning at 8:00 PM on 05/07/24.</p> <p>Interview with the DON on 05/07/24 at 7:40 AM, revealed hospice had delivered Resident #35's medications on 5/7/24 at 6:55 PM.</p> <p>Interview on 05/09/24 at 5:57 AM, LVN F stated she had taken care of Resident #35 on 5/3/24 when her hospice nurse had been there to visit the resident. She had also cared for her on 5/5/24. She stated the hospice nurses usually checked the supplies but she could not recall whether they discussed her oxycodone. She stated she still had medications available but went through them quickly because they were administered every 4 hours. She stated they usually ordered the medications when they got down to last section of the card but sooner if they were getting them that often. She stated she did not always document when she communicated with the hospice nurses but would be doing so moving forward. LVN F stated the risk of not having pain medications available included pain getting out of control and the resident could end up in the hospital for relief.</p> <p>Interview on 05/09/24 at 8:09 AM, LVN I stated she had taken care of Resident #35 before she moved out of the secured unit on 05/03/24. She stated they would occasionally run low on medications but had never run out. She stated she made sure to check the supplies when the hospice nurses were there to see if they needed anything from them. She stated she always reordered 7 days ahead especially for pain medications because they could take longer. She did not recall if she had contacted hospice when she worked on 5/3/24 to alert them Resident #35 was within 7 days of running out. She stated the risks for running out of medications included increased pain, behaviors, blood pressure and other symptoms depending on the medications.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Interview with the Hospice Administrator for Resident #35's hospice company on 05/09/24 at 9:34 AM, she stated she had spoken with the DON. She stated they were notified on 5/6/24 that Resident #35 needed a medication refill and the message was relayed to Hospice RN G. She stated Hospice RN G acknowledged the message and had stated she had been at the facility on 05/03/24 and asked if anyone needed anything. The Hospice Administrator stated Hospice RN G failed to take care of it. She stated they did not receive another call from the facility until 05/07/24. She stated their office manager sent a message that they were working on it and when she was told the ETA was going to take a while, she called their chaplain to have him drive the medications over as soon as possible. The Hospice Administrator stated the hospice nurses were responsible for checking with the facility nurses to see if they needed anything. She stated they just changed their policy and are now requiring the nurses to personally check the medication stocks for both routine and PRN medications. She stated it was both their's and the facility nurses responsibility to ensure the residents had the medications they needed. She stated the risk for not having pain medications available when needed. She stated, fortunately for Resident #35, she had an abundance of PRN pain medications available. She stated they should have known when Resident #35 was going to run out of medications as they were scheduled. The Hospice Administrator stated she was checked her call log and could see they received a call on 05/06/24 at 4:08 AM and another at 11:00 AM.</p> <p>Interview with Hospice RN G on 05/09/24 at 10:00 AM, she identified herself as being Resident #35's hospice nurse. She stated she always checked with the charge nurse when she visited her residents to see if they needed anything. She stated she visited on Resident #35 on 05/03/24 and she had just moved to her new room. She stated she did check in with her new nurse but could not recall her name. Hospice RN G stated she did not check to see how many medications Resident #35 had remaining during her visit. She stated her company had just implemented a new process and they were directed to physically check the amount of medications available to the resident. When asked why she wouldn't have known the date Resident #35 would run out of a scheduled medication they provided, Hospice RN G stated they recently changed to a new computer system for ordering medications. She stated the previous system would flag if a reorder was needed but she was not used to the new system yet. She stated she did not get the message when the facility called on 5/6/24 at 4 AM. When she received the call later around 9 or 10 AM, she was working in the field and thought her Administrator had taken care of it. She stated she did not find out until the next day that it was never ordered. She stated she was unaware of Resident #35 missing any other medications, she stated she knew she had morphine available and it had been administered. Hospice RN G stated the risk for not having pain medications available would be withdrawal symptoms if no other pain medications were available for them.</p> <p>Record review of the facility's policy and procedure titled Medication Orders and Receipt Records dated Revised April 2007 reflected:</p> <p>Policy Statement: The facility shall document all medications that it orders and receives.</p> <p>Policy Interpretation and Implementation: 1. The Charge Nurse will maintain the medication order and receipt records .3. The Director of Nursing Services will designate individuals to be responsible for completing medication order/receipt forms. 4. Medications should be ordered in advance, based on the dispensing pharmacy's required lead time</p> <p>Record review of the facility's policy and procedure titled, Hospice Program dated revised July 2017 reflected:</p> <p>(continued on next page)</p> |   |  |

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| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |  |   |  |
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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Policy Statement: Hospice services are available to residents at the end of life.</p> <p>Policy Interpretation and Implementation:</p> <p>1. Our facility has an agreement in place with at least one Medicare-certified hospice to ensure that residents who wish to participate in a hospice program may do so .5. Hospice providers who contract with this facility: a. must have a written agreement with the facility outlining (in detail) the responsibilities of the facility and the hospice agency; and b. are held responsible for meeting the same professional standards and timeliness of service as any contracted individual or agency associated with the facility .9. In general, it is the responsibility of the hospice to manage the resident's care as it relates to the terminal illness and related conditions, including: .e. Providing medical supplies, durable medical equipment, and medications necessary for the palliation of pain and symptoms. 10. In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. These include: .b. Administering prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care; .d. Communicating with the hospice provider (and documenting such communication) to ensure that the needs of the resident are addressed and met 24 hours per day</p> |   |  |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35747</b></p> <p>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 for 1 of 1 kitchen reviewed for food and nutrition services.</p> <p>1. The facility failed to ensure foods in the refrigerator, freezer, and dry storage were properly stored, labeled, and dated.</p> <p>These failures could place residents at risk for food borne illness.</p> <p>Findings included:</p> <p>Observation of the facility's only kitchen on [DATE] at 8:37 AM, revealed the following:</p> <ul style="list-style-type: none"> <li>-1 opened jar of barbeque sauce in dry storage that had instructions to refrigerate after opening,</li> <li>-1 opened and exposed 25-pound bag of brown sugar,</li> <li>-1 plastic cup filled with peaches in the reach-in refrigerator that was covered but was not labeled or dated,</li> <li>-4 tomatoes in the walk-in refrigerator that appeared to be rotten with visible bruising and open holes in the flesh,</li> <li>-1 opened jar of jalapenos in the walk-in refrigerator that had a black substance around the lid and had a written expiration date of ,d+[DATE],</li> <li>-1 opened container of buttermilk in the walk-in refrigerator that had an expiration date of [DATE], and</li> <li>-1 container of sliced vegetables in the walk-in freezer that was covered but was not labeled or dated.</li> </ul> <p>(continued on next page)</p> |   |  |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>During an interview with the Dietary Director on [DATE] at 8:48AM, she stated she was responsible for ensuring foods which were expired and/or rotten were thrown away. She stated she attempted to check for expired and rotten foods frequently; she said the expired jar of jalapenos, the expired container of buttermilk, and the rotten tomatoes must have been an oversight. The Dietary Director stated whichever staff member was prepping a given food was responsible for labeling any leftovers or prepared foods with the contents and the date in which the food was prepped. She stated the plastic cup filled with peaches and the sliced vegetables should have been labeled and dated. The Dietary Director also stated the barbeque sauce should have been stored in the refrigerator, as there were instructions to refrigerate after opening. The Dietary Director said the facility had ordered a storage bin for the 25-pound bag of brown sugar; however, it had not yet arrived so the bag was being stored as is, even though it had already been opened. The Dietary Director stated the potential risk of not properly labeling, dating, and storing foods included residents being infected with foodborne illnesses.</p> <p>Review of the facility's Food Receiving and Storage policy, dated ,d+[DATE], reflected, .foods shall be received and stored in a manner that complies with safe food handling practices . and .all foods stored in the refrigerator or freezer are covered, labeled and dated (use by date) .</p> <p>The Food and Drug Administration Food Code dated 2017 reflected, XXX,d+[DATE].12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food ,d+[DATE].11 Food Storage. (A) .food shall be protected from contamination by storing the food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination .(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety .</p> |   |  |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 28637</p> <p>Based on observations, interviews, and record reviews the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for one of five residents (Resident #32) reviewed for infection control.</p> <p>CNA C failed to perform hand hygiene while providing incontinence care to Resident #32 and between resident rooms.</p> <p>This failure could place the residents at risk for infection.</p> <p>Findings included:</p> <p>Record review of Resident #32's Admission Record dated 05/09/24 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE].</p> <p>Record review of Resident #32's Quarterly MDS assessment dated [DATE] revealed he had severe cognitive impairment, he had impaired range of motion of his arm and leg on one side and required maximum assistance with toileting and personal hygiene. The MDS Assessment reflected his diagnoses included hypertension (high blood pressure); peripheral vascular disease or peripheral arterial disease (reduced blood flow to arms and legs); end stage renal disease (kidneys are unable to function properly to remove waste and balance fluids); non-Alzheimer's dementia; and aphasia following cerebral infarction (disability with speech following a stroke).</p> <p>Record review of Resident #32's Care Plan reflected the following entry dated 3/23/23: Focus: [Resident #32] has an ADL Self Care Performance Deficit r/t impaired balance. Goal: [Resident #32] will maintain current level of function in (Bed Mobility, Transfers, Eating, Dressing, Toilet Use, and Personal Hygiene .). Interventions/Tasks: .Toilet Use: The resident requires (X1) staff participation to use toilet .Personal Hygiene: The resident requires (X1) staff participation with personal hygiene and oral care</p> <p>During an observation on 5/9/24 at 4:53 AM, Resident #32 was observed sitting up in bed watching television. He agreed to allow this surveyor to observe care. CNA C entered the room carrying supplies and donned gloves. He informed Resident #32 he was going to change his brief. CNA C removed the resident's blankets, lowered the resident's brief and cleaned him. The CNA assisted Resident #32 to position on his side and continued to clean him and remove his brief. CNA C replaced Resident #32's brief and bagged the trash. CNA C removed his gloves, donned a new pair and covered Resident #32 with his blankets. CNA C removed the bag of trash from the room, entered the spa room, discarded and immediately returned to the hallway. CNA C was observed retrieving a pair of gloves from his pocket, he donned the gloves without washing or sanitizing his hands. He walked down the hall and entered another resident's room. CNA C was observed moving things around the resident's room and speaking with the resident. He removed his gloves and left the room, and returned to the hallway without washing his hands or using the hand sanitizer available in the hallway.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During an interview on 5/9/24 at 5:15 AM, CNA C stated he did not use hand sanitizer during or after providing incontinent care for Resident #32 because there was no hand sanitizer in the room. He stated he could just change his gloves. CNA C stated he should wash his hands between resident rooms to prevent the spread of germs. When asked why he did not wash his hands after leaving Resident #32's room and entering another resident's room, he stated he forgot but he did use gloves .</p> <p>During an interview with the DON on 5/9/24 at 6:07 AM, he stated, when providing incontinent care, he expected the CNAs to gather supplies, wash their hands, and put on gloves. He stated they should clean the resident and wash their hands if they became visibly soiled or use hand sanitizer if not heavily soiled. The DON stated the CNAs must wash their hands between residents because they risked spreading infections from resident to resident.</p> <p>During an interview on 5/9/24 at 6:42 AM, the Administrator was asked about his expectation for staff during incontinent care. He stated staff should always wash their hands, gather equipment, explain the care to the resident and don gloves. He stated they should clean the resident in the front, change gloves and sanitize their hands, and clean the back of the resident. The Administrator stated the staff should replace their gloves place a new brief, bag the soiled items, wash their hands and leave. The Administrator stated staff must always sanitize their hands between resident rooms. He stated the risks included spreading infections. The Administrator stated he was a nurse and provided in-service training himself almost every two weeks.</p> <p>Record review of an Inservice Training Report dated 4/17/24 revealed the subject was Perineal Care. The sign-in sheet revealed CNA C was in attendance. The facility's policy/procedure titled Perineal Care revised February 2018 was attached and reflected the following:</p> <p>Purpose: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin conditions .Steps in the procedure 1/ Place the equipment on the bedside stand. Arrange the supplies so they can be easily reached. 2. Wash and dry your hands thoroughly . 7. Put on gloves 9. Discard disposable items into designated containers. 10. Remove gloves and discard into designated container. 11. Wash and dry your hands thoroughly. 12. Reposition the bed covers. Make the resident comfortable. 13. Place the call light within easy reach of the resident. 14. Clean wash basin and return to designated storage area. 15. Clean the bedside stand. 16. Wash and dry your hands thoroughly.</p> |   |  |