STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676107	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corpus Christi Nursing and Rehabilitation Center	2735 Airline Rd Corpus Christi, TX 78414

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 Based on observation, interview and record review the facility failed to treat residents with respect and dignity for 2 of 6 (Resident #35, and Resident #35)) residents reviewed for resident rights in that: The facility failed to ensure Resident #14, and Resident #35 were treated with dignity in that: Resident #14 and Resident #35's room had a strong odor of urine. Resident #35's floor mat was saturated in urine Resident #35's mattress was saturated in urine, had discoloration, and was stained. Resident #14 and Resident #35's floor was sticky This failure could place residents at risk of feeling uncomfortable, a diminished quality of life, and decline in self-worth. The findings included: 1. Record review of Resident #35's face sheet dated 04/10/2024 with an admitted [DATE] and an original admitted [DATE] reflected he was an [AGE] year-old male with diagnoses of dementia, repeated falls, cognitive communication deficit (difficulty with thinking and how someone uses language), hypertension, kidney failure, and cerebral infarction (disrupted blood flow to the brain). Record review of Resident #35's quarterly MDS assessment dated [DATE] reflected a BIMS score of 05, which indicted he had a severe cognitive impairment. Resident #35 was coded as being urinary continent. Record review of Resident #35's quarterly comprehensive care plan reflected Resident #35 was: Focus: At risk of skin integrity related to decreased skin elasticity, diabetes with/or potential for fluctuating blood sugar levels, impaired circulation or sensation. Interventions/Tasks: provide timely incontinent care; provider and/or encourage good skin care (keeping skin clean, conditioned, and reducing excess moisture). Date initiated 01/06/2023. (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focus: [Resident #35] requires assistance for meeting emotional, intellectual, physical, and social needs r/t Cognitive deficits, Physical Limitations (date initiated 01/06/2023). Interventions/Tasks: All staff to converse with resident while providing care. Focus: [Resident #35] has a communication problem r/t aphasia (language disorder that affects a person's ability to communicate) date initiated 01/04/2023. Interventions/Tasks: anticipate and meet needs. Focus: Resident #35 has a Urinary Tract Infection r/t to 03/28/24 Resident #35 has a UTI r/t Staphylococcus Scuiri. Interventions/Taks: check at least every 2 hours for incontinence, wash, rinse and dry soiled areas. Date revised: 03/29/2024. Focus: [Resident #35] has bladder occasional incontinence r/t to physical and cognitive limitations. [Resident #35] uses urinal, but will urinate on floor, in wheelchair, or trash can at times. Date initiated 01/04/2023. Interventions/Tasks: Incontinent: check q shift and as required for incontinence. Wash, rinse, and dry perineum. Change clothing PRN after incontinence episodes. Date initiated: 01/04/2023 Record review of Resident #35's Crown Rounds Checklist reflected that on 04/01/2024, his ambassador had indicated a strong odor in his room. On 04/02/2024 there was odor in room and bathroom. In an interview on 04/11/2024 at 4:30 p.m., the Administrator said he did not have Crown Rounds Checklist for the months of January 2024, February 2024, or March 2024 because he was not able to retrieve them from the program they use. 2. Record review of Resident #14's face sheet dated 04/12/2024 with an admitted [DATE] and an original admitted [DATE] reflected he was a [AGE] year-old male with diagnoses of dementia, parkinsonism, dysphagia (difficulty speaking or using words properly, and acute cough. Record review of [Resident #14's] quarterly MDS assessment dated [DATE] reflected a BIMS score of 00 which indicated he had a severe cognitive impairment. Record review of [Resident #14's] quarterly care plan dated 01/26/2024 reflected a focus of [Resident #14] has a communication problem r/t CVA with dysphasia. Interventions/Tasks: Communication: ask yes/no questions if appropriate, use simple, brief, consistent wors/cues, use alternative communication tools as needed. Date initiated: 01/04/2019. An observation on 04/09/2024 at 2:00 pm revealed Resident #35 was observed asleep on his bed, his bed was set to the lowest position and his call light was within reach. There was a urinal full of urine under his bed and an empty one next to his bed. There was a strong smell of urine. There was a laundry hamper with no lid that had holes on the sides (by design) full of clothes. The floor in the room was sticky. An observation on 04/09/2024 at 2:08 p.m., revealed Resident # 14 was asleep on his bed, his bed was set to the lowest position and his call light was within reach. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 04/10/2024 at 8:35 a.m., revealed there was a foul odor in the room. Resident #14 was eating his breakfast in bed and Resident #35 was lying in bed awake. CNA B, and HK A were observed standing on Resident #35's side of the room. The floor in the room was sticky. In an interview on 04/10/2024 at 8:37 a.m., CNA B said the foul odor in the room was urine and it was coming from Resident #35's area. She said Resident #35 had a behavior problem of urinating on the floor, on his bed, on Resident #14's side of the room (floor), and on the trash can. CNA B said Resident #35 would also pour the urine from his urinal on his laundry hamper. As surveyor approached Resident #35's floor mat, CNA B advised surveyor not to step on the floor mat because it was saturated in urine. Surveyor asked CNA B about the condition of Resident B's mattress, her response was it's not good. CNA B said Resident #35 had been having issues with urinating in different areas of the room causing the room to have a foul smell since February 2024. CNA B said Resident B's family members were supposed to be picking up his laundry (per their request) but had not done in 2-3 weeks. CNA B said the clothes in the laundry hamper were soaked in urine. CNA B said when she delivered the breakfast tray to Resident #35, she almost slipped on the floor mat because it was saturated in urine. She said wiped the mat down with a white towel and after she was done, the towel was yellow. CNA B said the mat was saturated in urine. CNA B said earlier that day, the Administrator had ordered the housekeeping manager to deep clean Resident #35's and Resident #14's room because there was a strong smell of urine. She said the reason they were all gathered in their room was because they were waiting for Resident #14 to finish his breakfast to start the deep cleaning. In an interview on 04/10/2024 at 9:00 a.m., the Administrator was called to Resident #35's and Resident #14's room by surveyor. As soon as he approached their room, he said I already ordered a deep clean for this room. The Administrator said he had ordered a deep clean of their room because of the smell (did not say what it smelled like). He said, today was the first day I noticed a foul odor. He said when he walked in that morning the odor was noticeable, so he had asked housekeeping to go in and do a deep clean. He said he also had a nurse call Resident 35's family members to bring a hamper with a lid. The administrator said he was going to order for Resident #35's clothes be laundered as soon as possible The Administrator said also ordered a new floor mat for Resident #35 and if necessary he would also order a new mattress. The Administrator said he had never asked Resident #35 or Resident #14 if the foul smell bothered them. In an interview on 04/10/2024 at 9:30 a.m., the DON said Resident #35 was confused and had started having behavior issues 3 months ago. She said Resident #35 would urinate on the floor, on himself, on the trash can and also poured his urine from the urinal he has on the side of the bed on the trash can and the laundry hamper. The DON said the interventions put in place were to re-educate Resident #35 to stop that behavior. She said she lost her ability to smell back in November 2023 when she got Covid, so she was not able to tell if there was a foul odor in their room. She said she had been told by different staff members there was a foul odor in Resident #35's and Resident #14's room but she was not sure when she was first told. The DON said each time staff would complain of the smell in their room, she would order a deep cleaning. The DON said she was not aware of the condition of Resident #35's mattress or floor mat. The DON said Resident #14 was not able to talk and was not sure how he felt about the foul odor in his room. The DON said she had never asked Resident #35 or Resident #14 if the foul smell bothered them. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/10/2024 at 9:36 a.m., the BOM said the facility had what they called the ambassador program and what that entailed was all department heads were assigned several rooms that they needed to visit daily. She said she was in charge of visiting Resident #35's and Resident #14's daily. The BOM said she had last been in their room on 04/09/2024 between 8:45 and 9:00 am and had not noticed a foul smell in the room. She said her responsibilities as an ambassador were to make sure the rooms were clean, to ensure all tubing were dated and changed weekly. The BOM said she would also ask Resident #35 and resident #14 if they are in pain, and if they had any issues. The BOM said Resident #35 had not voiced any concerns and Resident #14 was not able to talk. The BOM said she had never asked Resident #35 or Resident #14 if the foul smell bothered them. In an observation/interview on 04/10/2024 at 9:45 a.m. HK A picked up Resident #35's floor mat and a clear liquid began to seep out. The Administrator was also present, and he immediately ordered a new floor mat for Resident #35 and instructed for the mat to be disposed. When Resident #35 was transferred to his wheelchair and taken to the shower room, surveyor asked HK A to remove the linen from Resident #35's bed to see the condition of the mattress. The HK A said the linen was soaked in urine. The mattress had discoloration in the mid-section and the wording on the mattress had faded. The mid-section of the mattress had visible signs of a clear liquid. The HK A said that clear liquid was urine. When HK A lifted the mattress to reveal the bottom side of the mattress a clear liquid started seeping down the mattress. The HK A said the liquid seeping down was urine. The bottom of the mattress had some discoloration which HK A identified as urine stains. In an interview on 04/10/2024 at 10:00 a.m., HK A said she was ordered by her supervisor to do a deep cleaning in Resident #35's and Resident #14's room because it smelled like urine. She said the last time she had deep cleaned their room was back in March (not sure of the exact date) 2024 because it smelled like urine. HK A said during the March 2024 deep cleaning, she noticed there was urine in the trash can that was next to Resident 35's bed. She said Resident B would pour the urine from his urinal in the trash can. She said she had to wash the trash can with bleach regularly because the smell was penetrated. HK A said she would clean their room daily, but it continued to smell like urine. She said there were times in which she noticed the floor mat was saturated in urine, she said she would have to scrub the floor mat with a with a wet towel, then mop it with water and bleach. HK A said she notified her supervisor several times of the strong smell of urine, the condition of the floor mat and the laundry hamper with clothes soaked in urine in Resident #35's and Resident #14's room. The HK A said she did not recall her supervisor's response. The HK A said the odor of urine in Resident #35's and Resident #14's room had been going on for at least 2-3 months. In an interview on 04/10/2024 at 12:50 p.m., NP A said she would see Resident #35 once a month and the last time she saw him was on 04/08/2024. She said the times she had visited him, there was no foul odor in the room. NP A said, Resident #35 had a diagnoses of dementia and there would times in which he did not make it to the urinal. She said Resident #35 did not have any skin breakdown, no discoloration, and no skin infection as of 04/08/2024. NP A said the negative outcome for Resident #35 laying on mattress saturated in urine would be skin breakdown, discoloration of the skin, infection and the smell would be obnoxious. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/10/2024 at 1:00 p.m., NP B said the last time she saw Resident #35 was on 03/10/2024 and she did not notice any foul odor in his room. NP B said she would see Resident #35 every 60 day or as needed. NP A said Resident #35 was incontinent (bladder) and at times he would pee on the floor. She said he could also be combative and said his overall health was declining. NP B said she had been told by the nursing staff; Resident #35 had a history of behavior issues. NP B said Resident #35 was on Lasix, Flomax and in March he had been treated for a UTI (not on contact precaution). NP B said Resident did not have any skin breakdown, no redness, and no pressure ulcers. NP B said there were no negative outcome for Resident #35 due to the four odor in the room, having a floor mat and bed mattress saturated in urine. In an interview on 04/11/2024 at 12:55, ADON A said if Resident #35 got mad at someone, he dumped his urine in the trash can, the floor, or on his wheelchair. She said his behavior had been care planned and the interventions were to assist resident with emotions, opportunities to stop and talk to him, re-educate resident to ask for assistance. ADON A said Resident #35 had a history of UTI's and was on antibiotics from 03/28/24 and 04/04/24. She said the facility has had a big turnover in the housekeeping department and it's suffering and had been for months. She said Resident #14 was non-verbal. ADON A said if a floor mat were saturated in urine, it did not happen overnight, and it could harbor bacteria. She said the facility had ambassadors. ADON A said the role of the ambassador was to visit residents daily to check how they feel, their mood, their environment. ADON A said multiple people go into Resident #35 and Resident #14's room a day and if the floor mat was saturated in urine, and the room had a foul odor, someone overlooked it. In an interview on 04/11/2024 at 1:15 p.m., ADON B said CNA B had informed her on 04/10/2024 at about 8: 15 a.m. that she almost slipped on Resident #35's floor mat because it was saturated in urine and the room had a foul odor. She said she followed CNA B to Resident #35's room and witnessed Resident #35's boxers were down to his ankles. She said she instructed CNA B to change him. ADON B said she did not check Resident #35's floor mat but did instruct housekeeping to do a deep clean of the room. ADON B said that was not the first time she had been advised Resident #35's room had a foul smell. ADON B said she went back to her office to call the overnight CNA C to see if anything had happened overnight with Resident #35. She said the overnight CNA C said he had done several rounds to Resident #35's room and that during peri-care he had given him a hard time. She said the overnight CNA C said Resident #35 did not want his boxers and kept on pulling them down to his ankles. ADON B said the overnight CNA said he did not notice the foul smell in the room because he had become used to it. ADON B said everybody from the CNA's to nursing staff are responsible to change the bed linens and if they noticed any shearing or discolorations they needed to inform the ADON, DON or the Administrator immediately. In an interview on 04/11/2024 at 1:54 p.m., the ES said on 04/10/2024 at about 9:00 a.m., the Administrator ordered for housekeeping to deep clean Resident #35's and Resident #14's room because it had a high urine smell. She said HK A told her 2 to 3 weeks ago that Resident #35 had was urinating in the trashcan and the strong odor of urine in the room. She said housekeepers clean each resident's room daily and deep clean between 4 rooms daily. ES said housekeepers are in-serviced to pick up the floor mats and spray with an odor neutralizer. She said she had personally gone into Resident #35's room and seen his urinals were always full of urine. She said she saw Resident #35's old mattress and floor mat and the looked pretty bad and had a strong odor. ES said their room was considered a focused room which meant housekeeping needed to be more vigilant when it came to cleaning. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/10/2024 at 1:30 p.m., CNA B said she rounded Resident #35's and Resident #14's room every 15-20 minutes because Resident #14 would constantly press the call light, and while she was there, she would check on both residents. She said Resident #35 preferred boxers and refused to wear briefs. She said Resident #35 was incontinent at times but there were days in which he was continent and was able to self-transfer to the rest room. CNA B said they keep 2 urinals at Resident #35's bedside for him to use at his convenience. She said when she worked, she would make sure to check his urinals and empty them several times a day. She said the issue with the strong smell of urine started 2 to 2 1/2 months ago. She said she had notified her charge nurse and ADON B in the past about the foul smell in their room. She said the hospitality aide was responsible for changing the linens effective April 2024. She said earlier that day, when she delivered Resident 35's breakfast meal tray she almost slipped on that mat because it was saturated in urine. She said she had immediately notified ADON B. CNA B said Resident #35 did not have any skin breakdown, redness, or pressure ulcers. CNA B said Resident #14 had never complained of the smell of urine in the room, she said he is just there and doesn't complain. CNA B said she had never asked Resident #35 or Resident #14 if the foul smell bothered them. In an interview on 04/10/2024 at 1:45 p.m., HA A said part of his responsibilities were to change resident's linen while they were being showered or when they got up from the bed. He said he last changed Resident 35's linen on 04/05/2024 because Resident #35 had not gotten up from his bed since then. He said he did not notice any discoloration or urine saturation on the mattress on 04/05/2024. HA A said, Resident #35's and Resident #14's room had always had the smell of urine even when it was clean. HA A said the urine smell had penetrated the room. In an interview on 04/10/2024 at 2:00 p.m., RN A said she was the charge nurse for Resident #35's and Resident #14's hall. She said Resident #35 had recently had a decline due to his diagnoses of Alzheimer's. She said Resident #35 was continent in bowel and bladder but sometimes would have episodes of incontinence with his bladder. She said Resident #35 had several issues going on like being a diabetic, he was on Lasix and is on blood pressure medication. She said he was just treated for a UTI which did not require him to be on contact precaution. She said she wanted to lean toward the fact that his Alzheimer's was getting worse. She said the cna's and nurses should round every 2 hours. She said there have been times where he has urinated on the floor, on the bed, on his trashcan and laundry hamper. She said Resident #35 does not have any skin breakdown, no discoloration, and no pressure ulcers. She said the negative outcome for a resident who was not being changed often (brief) and/or lays on a urine saturated mattress could be skin breakdown and redness. She said Resident B or Resident #14 had never complained of the smell of urine in his room. In an observation on 04/11/2024 at 8:15 a.m., the Surveyor witnessed the SW interview Resident #35 (the surveyor gave the SW a list of questions to ask Resident #35): 1. How do you feel today? Resident #35 said fine. 2. Do you wear underwear or briefs? Resident #35 said I have boxers. 3. Where do you urinate? Resident #35 said sometimes in the bathroom, and sometimes I use the urinals by my bed. Sometimes I throw the urine in the trashcan. 4. Do you sometimes have accidents? Resident #35 said I wet my bed only when I'm asleep and there have been times I get the bed wet. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/11/2024 at 12:55, ADON A said if Resident #35 gets mad at someone, he dump his urine in the trash can, the floor, or on his wheelchair. She said his behavior had been care planned and the interventions were to assist resident with emotions, opportunities to stop and talk to him, re-educate resident to ask for assistance. ADON A said Resident #35 had a history of UTI's and was on antibiotics from 03/28/24 and 04/04/24. She said the facility has had a big turnover in the housekeeping department and it's suffering and had been for months. She said Resident #14 was non-verbal. ADON A said if a floor mat were saturated in urine, it did not happen overnight, and it could harbor bacteria. She said the facility have ambassadors. ADON A said the role of the ambassador was to visit residents daily to check how they feel, their mood, their environment. ADON A said multiple people go into Resident #35 and Resident #14's room a day and if the floor mat was saturated in urine, and the room had a foul odor, someone overlooked it. In an interview on 04/11/2024 at 1:15 p.m., ADON B said CNA B had informed her on 04/10/2024 at about 8: 15 a.m. that she almost slipped on Resident #35's floor mat because it was saturated in urine and the room had a foul odor. She said she followed CNA B to Resident #35's room and witnessed Resident #35's boxers were down to his ankles. She said she instructed CNA B to change him. ADON B said she did not check Resident #35's floor mat but did instruct housekeeping to do a [NAME] clean of the room. ADON B said that was not the first time she had been advised Resident #35's room had a foul smell. ADON B said she went back to her office to call the overnight CNA C to see if anything had happened overnight with Resident #35. She said the overnight CNA C said he had done several rounds to Resident #35's room and that during peri-care he had given him a hard time. She said the overnight CNA C said Resident #35 did not want his boxers and kept on pulling them down to his ankles. ADON B said the overnight CNA said he did not notice the foul smell in the room because he had become used to it. ADON B said everybody from the CNA's to nursing staff were responsible for changing the bed linens and if they noticed any bulging or discolorations they needed to inform the ADON, DON or the Administrator immediately. In an interview on 04/11/2024 at 1:54 p.m., the ES said on 04/10/2024 at about 9:00 a.m., the Administrator ordered for housekeeping to deep clean Resident #35's and Resident #14's room because it had a high urine smell. She said HK A told her 2 to 3 weeks ago that Resident #35 was urinating in the trashcan and the strong odor of urine in the room. She said housekeepers clean each resident's room daily and deep clean between 4 rooms daily. ES said housekeepers are in-serviced to pick up the floor mats and spray with an odor neutralizer. She said she had personally gone into Resident #35's room and seen his urinals were always full of urine. She said she saw Resident #35's old mattress and floor mat and the looked pretty bad and had a strong odor. ES said their room was considered a focused room which meant housekeeping needed to be more vigilant when it came to cleaning. In an interview on 04/11/2024 at 4:01 p.m., BOM said she was Resident #14 and Resident #35's ambassador. She said there had been times in the past where the room had a foul odor and it smelled like fish. She said she would ask both Resident #14 and Resident #35 if do you smell that, and they would say/nod no. The BOM said she did not receive any training on being an ambassador but was given a sheet to complete for each resident titled Crown Rounds Checklist. The BOM said there were several times in March and April in which she discussed the foul smell during the morning meetings with the Administrator, the DON, the ADON's, and the Environmental Supervisor. She said each time she would mention the foul smell in their room, a deep cleaning was ordered. (continued on next page)

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	676107	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corpus Christi Nursing and Rehabilitation Center	2735 Airline Rd Corpus Christi, TX 78414

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/11/2024 at 4:24 p.m., The DON said Resident #14 and Resident #35's ambassador had mentioned several times during their morning meetings (in the span of 2 to 3 weeks) that their room had an odor. The DON said a deep clean was ordered each time it was brought up and the ES was responsible to follow up to make sure it was taken care of. The DON said it did not raise a red flag to her because she knew Resident #35 was incontinent and he would pee on the floor, he would empty his urinal in his trashcan and laundry hamper. She said she had never asked Resident #14 or Resident #35 if the odor of urine bothered them. The DON said she was not sure who was in charge of inspecting the residents mattresses. In an interview on 04/12/2024 at 8:57 a.m., Dr. A said Resident #35 was a long-term resident at the facility and had beginning stages of dementia. Dr. A said Resident #35 had a UTI on 03/23/2024 and was given antibiotics from 03/23/24 to 04/04/2024. Dr. A said the UTI infection he had did not require him to be on contact precaution. Dr. A said Resident #35 may be getting more demented. He said, social services need to talk to resident and take the whole picture and try to do as much as possible. He said in his opinion, it was more than a behavior issue, Resident #35 could be having other health issues. He said he would be going to facility on 04/12/2024 to see Resident #35. Dr. A said Resident #35 did not have any negative outcomes related to having his floor mat saturated in urine or his mattress being discolored because he had no skin breakdown, he had no redness, and he had no ulcers. In an interview on 04/12/2024 at 10:13 a.m., the Administrator said the condition of Resident #35's floor mat felt like it was wet, and it was probably wet underneath. He said he had ordered a new floor mat and a new mattress for Resident #35. The Administrator said he had in serviced all department heads that if they ever was a time when a mattress looked soaked or smelled to let him know immediately. Record review of facility's policy on Promoting/Maintaining Resident Dignity dated 01/13/2023 reflected: Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, which maintain or enhances resident's quality of life by recognizing each resident's individuality. Compliance Guidelines: 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. 5. When interacting with a resident, pay attention to the resident as an individual. 15. Random observations and/or verifications are conducted by the Director of Nursing Services (DNS), or designee, to ensure compliance with this policy. Record review of facility's General Housekeeping Policies, with no effective date reflected: (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All housekeeping personnel utilize the accepted practices and procedures to keep the facility free from offensive odors, accumulations of dirt, rubbish, dust, and hazards as well as participate in ongoing education and training to maintain or increase their competency. Each occupied resident room is cleaned and put in order daily and as needed. Floors are maintained in good condition and cleaned regularly. Deodorizers are not used to cover up odors caused by unsanitary conditions or poor housekeeping practices. Odor control is achieved by prompt cleaning of bedpans, urinals, and commodes by prompt and proper care of residents and soiled linens, by good housekeeping procedures, and by approved ventilation.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 Based on observation, interviews and record review, the facility failed to ensure each resident had a right to a safem clean, comfortable environment for two (Resident #14, and Resident #35) of six residents reviewed for resident rights. -Resident #14 and Resident #35's room had a strong odor of urine. -Resident #35's floor mat was saturated in urine -Resident #35's mattress was saturated in urine, had discoloration, and was stained. -Resident #14 and Resident #35's floor was sticky This failure could place residents at risk of feeling uncomfortable, a diminished quality of life, and decline in self-worth. The findings included: 1. Record review of Resident #35's face sheet dated 04/10/2024 with an admitted [DATE] and an original admitted [DATE] reflected he was an [AGE] year-old male with diagnoses of dementia, repeated falls, cognitive communication deficit (difficulty with thinking and how someone uses language), hypertension, kidney failure, and cerebral infarction (disrupted blood flow to the brain). Record review of Resident #35's quarterly MDS assessment dated [DATE] reflected a BIMS score of 05, which indicted he had a severe cognitive impairment. Resident #35 was coded as being urinary continent. Record review of Resident #35's quarterly comprehensive care plan reflected Resident #35 was: Focus: At risk of skin integrity related to decreased skin elasticity, diabetes with/or potential for fluctuating blood sugar levels, impaired circulation or sensation. Interventions/Tasks: provide timely incontinent care; provider and/or encourage good skin care (keeping skin clean, conditioned, and reducing excess moisture). Date initiated 01/06/2023. Focus: [Resident #35] requires assistance for meeting emotional, intellectual, physical, and social needs r/t Cognitive deficits, Physical Limitations (date initiated 01/06/2023). Interventions/Tasks: All staff to converse with resident while providing care. Focus: [Resident #35] has a communication problem r/t aphasia (language disorder that affects a person's ability to communicate) date initiated 01/04/2023. Interventions/Tasks: anticipate and meet needs. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focus: Resident #35 has a Urinary Tract Infection r/t to 03/28/24 Resident #35 has a UTI r/t Staphylococcus Scuiri. Interventions/Taks: check at least every 2 hours for incontinence, wash, rinse and dry soiled areas. Date revised: 03/29/2024. Focus: [Resident #35] has bladder occasional incontinence r/t to physical and cognitive limitations. [Resident #35] uses urinal, but will urinate on floor, in wheelchair, or trash can at times. Date initiated 01/04/2023. Interventions/Tasks: Incontinent: check q shift and as required for incontinence. Wash, rinse, and dry perineum. Change clothing PRN after incontinence episodes. Date initiated: 01/04/2023 Record review of Resident #35's Crown Rounds Checklist reflected that on 04/01/2024, his ambassador had indicated a strong odor in his room. On 04/02/2024 there was odor in room and bathroom. In an interview on 04/11/2024 at 4:30 p.m., the Administrator said he did not have Crown Rounds Checklist for the months of January 2024, February 2024, or March 2024 because he was not able to retrieve them from the program they use. 2. Record review of Resident #14's face sheet dated 04/12/2024 with an admitted [DATE] and an original admitted [DATE] reflected he was a [AGE] year-old male with diagnoses of dementia, parkinsonism, dysphagia (difficulty speaking or using words properly, and acute cough. Record review of [Resident #14's] quarterly MDS assessment dated [DATE] reflected a BIMS score of 00 which indicated he had a severe cognitive impairment. Record review of [Resident #14's] quarterly care plan dated 01/26/2024 reflected a focus of [Resident #14] has a communication problem r/t CVA with dysphasia. Interventions/Tasks: Communication: ask yes/no questions if appropriate, use simple, brief, consistent wors/cues, use alternative communication tools as needed. Date initiated: 01/04/2019. An observation on 04/09/2024 at 2:00 pm revealed Resident #35 was observed asleep on his bed, his bed was set to the lowest position and his call light was within reach. There was a urinal full of urine under his bed and an empty one next to his bed. There was a strong smell of urine. There was a laundry hamper with no lid that had holes on the sides (by design) full of clothes. The floor in the room was sticky. An observation on 04/09/2024 at 2:08 p.m., revealed Resident # 14 was asleep on his bed, his bed was set to the lowest position and his call light was within reach. An observation on 04/10/2024 at 8:35 a.m., revealed there was a foul odor in the room. Resident #14 was eating his breakfast in bed and Resident #35 was lying in bed awake. CNA B, and HK A were observed standing on Resident #35's side of the room. The floor in the room was sticky. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/10/2024 at 8:37 a.m., CNA B said the foul odor in the room was urine and it was coming from Resident #35's area. She said Resident #35 had a behavior problem of urinating on the floor, on his bed, on Resident #14's side of the room (floor), and on the trash can. CNA B said Resident #35 would also pour the urine from his urinal on his laundry hamper. As surveyor approached Resident #35's floor mat, CNA B advised surveyor not to step on the floor mat because it was saturated in urine. Surveyor asked CNA B about the condition of Resident B's mattress, her response was it's not good. CNA B said Resident #35 had been having issues with urinating in different areas of the room causing the room to have a foul smell since February 2024. CNA B said Resident B's family members were supposed to be picking up his laundry (per their request) but had not done in 2-3 weeks. CNA B said the clothes in the laundry hamper were soaked in urine. CNA B said when she delivered the breakfast tray to Resident #35, she almost slipped on the floor mat because it was saturated in urine. She said wiped the mat down with a white towel and after she was done, the towel was yellow. CNA B said the mat was saturated in urine. CNA B said earlier that day, the Administrator had ordered the housekeeping manager to deep clean Resident #35's and Resident #14's room because there was a strong smell of urine. She said the reason they were all gathered in their room was because they were waiting for Resident #14 to finish his breakfast to start the deep cleaning. In an interview on 04/10/2024 at 9:00 a.m., the Administrator was called to Resident #35's and Resident #14's room by surveyor. As soon as he approached their room, he said I already ordered a deep clean for this room. The Administrator said he had ordered a deep clean of their room because of the smell (did not say what it smelled like). He said, today was the first day I noticed a foul odor. He said when he walked in that morning the odor was noticeable, so he had asked housekeeping to go in and do a deep clean. He said he also had a nurse call Resident 35's family members to bring a hamper with a lid. The administrator said he was going to order for Resident #35's clothes be laundered as soon as possible The Administrator said also ordered a new floor mat for Resident #35 and if necessary he would also order a new mattress. The Administrator said he had never asked Resident #35 or Resident #14 if the foul smell bothered them. In an interview on 04/10/2024 at 9:30 a.m., the DON said Resident #35 was confused and had started having behavior issues 3 months ago. She said Resident #35 would urinate on the floor, on himself, on the trash can and also poured his urine from the urinal he has on the side of the bed on the trash can and the laundry hamper. The DON said the interventions put in place were to re-educate Resident #35 to stop that behavior. She said she lost her ability to smell back in November 2023 when she got Covid, so she was not able to tell if there was a foul odor in their room. She said she had been told by different staff members there was a foul odor in Resident #35's and Resident #14's room but she was not sure when she was first told. The DON said each time staff would complain of the smell in their room, she would order a deep cleaning. The DON said she was not aware of the condition of Resident #35's mattress or floor mat. The DON said Resident #14 was not able to talk and was not sure how he felt about the foul odor in his room. The DON said she had never asked Resident #35 or Resident #14 if the foul smell bothered them. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/10/2024 at 9:36 a.m., the BOM said the facility had what they called the ambassador program and what that entailed was all department heads were assigned several rooms that they needed to visit daily. She said she was in charge of visiting Resident #35's and Resident #14's daily. The BOM said she had last been in their room on 04/09/2024 between 8:45 and 9:00 am and had not noticed a foul smell in the room. She said her responsibilities as an ambassador were to make sure the rooms were clean, to ensure all tubing were dated and changed weekly. The BOM said she would also ask Resident #35 and resident #14 if they are in pain, and if they had any issues. The BOM said Resident #35 had not voiced any concerns and Resident #14 was not able to talk. The BOM said she had never asked Resident #35 or Resident #14 if the foul smell bothered them. In an observation/interview on 04/10/2024 at 9:45 a.m. HK A picked up Resident #35's floor mat and a clear liquid began to seep out. The Administrator was also present, and he immediately ordered a new floor mat for Resident #35 and instructed for the mat to be disposed. When Resident #35 was transferred to his wheelchair and taken to the shower room, surveyor asked HK A to remove the linen from Resident #35's bed to see the condition of the mattress. The HK A said the linen was soaked in urine. The mattress had discoloration in the mid-section and the wording on the mattress had faded. The mid-section of the mattress had visible signs of a clear liquid. The HK A said that clear liquid was urine. When HK A lifted the mattress to reveal the bottom side of the mattress a clear liquid started seeping down the mattress. The HK A said the liquid seeping down was urine. The bottom of the mattress had some discoloration which HK A identified as urine stains. In an interview on 04/10/2024 at 10:00 a.m., HK A said she was ordered by her supervisor to do a deep cleaning in Resident #35's and Resident #14's room because it smelled like urine. She said the last time she had deep cleaned their room was back in March (not sure of the exact date) 2024 because it smelled like urine. HK A said during the March 2024 deep cleaning, she noticed there was urine in the trash can that was next to Resident 35's bed. She said Resident B would pour the urine from his urinal in the trash can. She said she had to wash the trash can with bleach regularly because the smell was penetrated. HK A said she would clean their room daily, but it continued to smell like urine. She said there were times in which she noticed the floor mat was saturated in urine, she said she would have to scrub the floor mat with a with a wet towel, then mop it with water and bleach. HK A said she notified her supervisor several times of the strong smell of urine, the condition of the floor mat and the laundry hamper with clothes soaked in urine in Resident #35's and Resident #14's room. The HK A said she did not recall her supervisor's response. The HK A said the odor of urine in Resident #35's and Resident #14's room had been going on for at least 2-3 months. In an interview on 04/10/2024 at 12:50 p.m., NP A said she would see Resident #35 once a month and the last time she saw him was on 04/08/2024. She said the times she had visited him, there was no foul odor in the room. NP A said, Resident #35 had a diagnoses of dementia and there would times in which he did not make it to the urinal. She said Resident #35 did not have any skin breakdown, no discoloration, and no skin infection as of 04/08/2024. NP A said the negative outcome for Resident #35 laying on mattress saturated in urine would be skin breakdown, discoloration of the skin, infection and the smell would be obnoxious. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Where do you urinate? Resident #35 said sometimes in the bathroom, and sometimes I use the urinals by my bed. Sometimes I throw the urine in the trashcan. 4. Do you sometimes have accidents? Resident #35 said I wet my bed only when I'm asleep and there have been times I get the bed wet. 5. Do you let anybody know when you get the bed wet? Resident #35 he said, the rubber mat gets wet, I can tell by the way it looks and when I step on it. He said, I can also feel when the bed is wet. He said, before I thought, you know in the beginning I thought someone would come in and pour urine on me, but no-it was me getting the bed wet. 6. How does that make you feel? Resident #35 said, I try to hold it as much as I can. He said the nursing staff don't even want to cross the line because of the stink of urine. He said, when people pass by and do not stop it is because it stinks, they do not want to come in here and change me. I do not care what-what do you think how I feel? I just look at myself. I do not see what they see in me-they just walk away. I have seen them look at me and turn around because they are busy. 7. Does the smell in your room bother you? Resident #35 answered of course it does. I am a stinker. He asked, have you ever been where they sell cows? Oh my God, it is the worse smell. It just smells bad. He said his mattress gets wet because I peed on it, the urine just comes out without control. 8. how does your room smell today? Resident #35 said today the room smells clean. An observation on 04/11/2024 at 8:30 a.m., the Surveyor witnessed the SW interview Resident #14, (the surveyor asked the SW to ask Resident #14 the following questions): 1. Does the smell in your room bother you? Resident #14 nodded yes and pointed in the direction of Resident #35's area and pinched his nose. 2. Has Resident #35 ever come to your area and urinate? Resident #14 nodded yes. 3. Would you like to move to another room? Resident #14 nodded yes. 4. Would it make you happy to move? Resident #14 nodded yes. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corpus Christi Nursing and Rehabilitation Center	2735 Airline Rd Corpus Christi, TX 78414

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/11/2024 at 8:49 a.m., the SW said, I had never interviewed Resident #35 or Resident #14 in that detail. The SW said the type of assessments she does on residents was to establish their BIMS score and mood assessments. She said she did not have a set scheduled of when she met with residents adding if I see them, I will talk to them. She said that could be in their rooms, the dining room or in the halls. The SW said the last time she spoke with Resident #35 and Resident #14 was a week ago. The SW said after talking to Resident #35 on 04/11/2024, she felt he was ok. She said I feel like he feels like staff do not want to care for him, that they are not caring for him in a timely manner and that staff do go in his room but do not care for him. I feel like staff can do more, with his response I feel like he is blaming himself. The SW said with what Resident #35 answered, tells her the facility need to in-service staff to actually care for him and to actually have conversations with him. She said Resident #35 deserved to live comfortably. The SW said she did not know the smell was a big concern for Resident #14. She said she had never noticed a foul smell in their room. The SW said now the Resident #14 voiced a concern, she wanted to make sure he was in a comfortable environment and will be working on getting him a new room. The SW said she would not like to be in Resident #14' position, she said the facility was his home and he deserved to be comfortable. In an interview on 04/11/2024 at 1:15 p.m., ADON B said CNA B had informed her on 04/10/2024 at about 8:15 a.m. that she almost slipped on Resident #35's floor mat because it was saturated in urine and the room had a foul odor. She said she followed CNA B to Resident #35's room and witnessed Resident #35's boxers were down to his ankles. She said she instructed CNA B to change him. ADON B said she did not check Resident #35's floor mat but did instruct housekeeping to do a [NAME] clean of the room. ADON B said that was not the first time she had been advised Resident #35's room had a foul smell. ADON B said she went back to her office to call the overnight CNA C to see if anything had happened overnight with Resident #35. She said the overnight CNA C said he had done several rounds to Resident #35's room and that during peri-care he had given him a hard time. She said the overnight CNA C said Resident #35 did not want his boxers and kept on pulling them down to his ankles. ADON B said the overnight CNA said he did not notice the foul smell in the room because he had become used to it. ADON B said everybody from the CNA's to nursing staff were responsible for changing the bed linens and if they noticed any bulging or discolorations they needed to inform the ADON, DON or the Administrator immediately. In an interview on 04/11/2024 at 1:54 p.m., the ES said on 04/10/2024 at about 9:00 a.m., the Administrator ordered for housekeeping to deep clean Resident #35's and Resident #14's room because it had a high urine smell. She said HK A told her 2 to 3 weeks ago that Resident #35 was urinating in the trashcan and the strong odor of urine in the room. She said housekeepers clean each resident's room daily and deep clean between 4 rooms daily. ES said housekeepers are in-serviced to pick up the floor mats and spray with an odor neutralizer. She said she had personally gone into Resident #35's room and seen his urinals were always full of urine. She said she saw Resident #35's old mattress and floor mat and the looked pretty bad and had a strong odor. ES said their room was considered a focused room which meant housekeeping needed to be more vigilant when it came to cleaning. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/11/2024 at 4:01 p.m., BOM said she was Resident #14 and Resident #35's ambassador. She said there had been times in the past where the room had a foul odor and it smelled like fish. She said she would ask both Resident #14 and Resident #35 if do you smell that, and they would say/nod no. The BOM said she did not receive any training on being an ambassador but was given a sheet to complete for each resident titled Crown Rounds Checklist. The BOM said there were several times in March and April in which she discussed the foul smell during the morning meetings with the Administrator, the DON, the ADON's, and the Environmental Supervisor. She said each time she would mention the foul smell in their room, a deep cleaning was ordered. In an interview on 04/11/2024 at 4:24 p.m., The DON said Resident #14 and Resident #35's ambassador had mentioned several times during their morning meetings (in the span of 2 to 3 weeks) that their room had an odor. The DON said a deep clean was ordered each time it was brought up and the ES was responsible to follow up to make sure it was taken care of. The DON said it did not raise a red flag to her because she knew Resident #35 was incontinent and he would pee on the floor, he would empty his urinal in his trashcan and laundry hamper. She said she had never asked Resident #14 or Resident #35 if the odor of urine bothered them. The DON said she was not sure who was in charge of inspecting the residents mattresses. In an interview on 04/12/2024 at 8:57 a.m., Dr. A said Resident #35 was a long-term resident at the facility and had beginning stages of dementia. Dr. A said Resident #35 had a UTI on 03/23/2024 and was given antibiotics from 03/23/24 to 04/04/2024. Dr. A said the UTI infection he had did not require him to be on contact precaution. Dr. A said Resident #35 may be getting more demented. He said, social services need to talk to resident and take the whole picture and try to do as much as possible. He said in his opinion, it was more than a behavior issue, Resident #35 could be having other health issues. He said he would be going to facility on 04/12/2024 to see Resident #35. Dr. A said Resident #35 did not have any negative outcomes related to having his floor mat saturated in urine or his mattress being discolored because he had no skin breakdown, he had no redness, and he had no ulcers. In an interview on 04/12/2024 at 10:13 a.m., the Administrator said the condition of Resident #35's floor mat felt like it was wet, and it was probably wet underneath. He said he had ordered a new floor mat and a new mattress for Resident #35. The Administrator said he had in serviced all department heads that if they ever was a time when a mattress looked soaked or smelled to let him know immediately. Record review of facility's policy on Promoting/Maintaining Resident Dignity dated 01/13/2023 reflected: Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, which maintain or enhances resident's quality of life by recognizing each resident's individuality. Compliance Guidelines: 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. When interacting with a resident, pay attention to the resident as an individual. 15. Random observations and/or verifications are conducted by the Director of Nursing Services (DNS), or designee, to ensure compliance with this policy. Record review of facility's General Housekeeping Policies, with no effective date reflected: All housekeeping personnel utilize the accepted practices and procedures to keep the facility free from offensive odors, accumulations of dirt, rubbish, dust, and hazards as well as participate in ongoing education and training to maintain or increase their competency. Each occupied resident room is cleaned and put in order daily and as needed. Floors are maintained in good condition and cleaned regularly. Deodorizers are not used to cover up odors caused by unsanitary conditions or poor housekeeping practices. Odor control is achieved by prompt cleaning of bedpans, urinals, and commodes by prompt and proper care of residents and soiled linens, by good housekeeping procedures, and by approved ventilation.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748 Based on observations, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 4 Residents (Resident's #10, #68, #70, and #91) of 9 reviewed for care plans. 1. Resident #10's comprehensive care plan dated 03/23/23 did not reflect he was a smoker nor had a Smoking Safety Screen 2. Resident #68's comprehensive care plan dated 09/28/23 did not reflect she was a smoker nor had a Smoking Safety Screen 3. Resident #70's comprehensive care plan dated 02/27/23 did not reflect he was a smoker nor had a Smoking Safety Screen 4. Resident #91's comprehensive care plan dated 05/11/23 did not reflect he was a smoker nor had a Smoking Safety Screen These deficient practices could place residents at risk of not receiving proper care and services. The findings included: 1. Record review of Resident #10's Face Sheet revealed an admitted [DATE]. Diagnoses included stroke, muscle wasting, difficulty walking, lack of coordination, assistance with personal care, right sided non-dominant weakness and paralysis, speech and language deficits, and seizures. Record review of Resident #10's quarterly MDS dated [DATE] revealed a BIMS of 10 which indicated he had moderately impaired cognition. He required set-up assistance with eating and oral hygiene, supervision with toileting, partial/moderate assistance with dressing and personal hygiene, and substantial assistance with showering and footwear. He utilized a wheelchair for mobility that he could self-propel. He was always continent of bladder and bowel. There was no smoking assessment. Record review of Resident #10's care plan dated 03/23/23 and revision dated 07/14/23 had no focus, goals, or interventions regarding smoking. Record review of Resident #10's electronic health records revealed no Smoking Safety Screen. 2. Record review of Resident #68's Face Sheet revealed an admitted [DATE] with a re-admitted [DATE]. Diagnoses included muscle wasting, abnormalities of gait and mobility, lack of coordination, cognitive communication deficit, need for assistance with personal care, diabetes, depression-bipolar, and COPD (chronic obstructive pulmonary disease) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #68's quarterly MDS dated [DATE] revealed a BIMS of 12 which indicated she had moderately impaired cognition. She required supervision with eating, oral hygiene, toileting, and showering. She required partial/moderate assistance with dressing, footwear, and personal hygiene. She utilized a wheelchair for mobility that she could self-propel. She was always continent of bowel and occasionally incontinent of bladder. There was no smoking assessment. Record review of Resident #68's care plan dated 09/28/23 and revision dated 11/01/23 had no focus, goals, or interventions regarding smoking. Record review of Resident #68's electronic health records revealed no Smoking Safety Screen. 3. Record review of Resident #70's Face Sheet revealed an admitted [DATE] with re-admitted s of 02/26/23 and 07/06/23. Diagnoses included muscle wasting, difficulty walking, unsteadiness on feet, need for assistance with personal care, diabetes, heart failure, colon cancer, end stage renal disease (kidney failure), stroke with subsequent left non-dominant side weakness and paralysis, anxiety, depression, and obstructive sleep apnea (periods of stopping breathing in his sleep). Record review of Resident #70's annual MDS dated [DATE] revealed a BIMS of 15 which indicated he had no impaired cognition. He required supervision with eating, oral hygiene, toileting, and showering. He required set-up assistance with all ADL's. He utilized a wheelchair for mobility that he could self-propel. He was always continent of bladder and occasionally incontinent of bowel. There was no smoking assessment. Record review of Resident #70's care plan dated 02/27/23 and revision dated 03/30/24 had no focus, goals, or interventions regarding smoking. Record review of Resident #70's electronic health records revealed no Smoking Safety Screen. 4. Record review of Resident #91's Face Sheet revealed an admitted [DATE]. Diagnoses included muscle wasting, difficulty walking, lack of coordination, pressure ulcer, wheezing, diabetes, and amputation of the right leg above the knee. He had an ostomy (an opening in the abdomen to the bowel for bowel movements) and an indwelling catheter for bladder. Record review of Resident #91's quarterly MDS dated [DATE] revealed a BIMS of 15 which indicated he had no impaired cognition. He had moderately impaired vision. He required set-up assistance with eating, supervision with oral hygiene and upper body dressing. He required partial/moderate assistance with personal hygiene, and substantial assistance with toileting, showering, and lower body dressing. He was dependent for footwear. He utilized a wheelchair for mobility that he could self-propel. He was always continent of bladder and occasionally incontinent of bowel. There was no smoking assessment. Record review of Resident #91's care plan dated 05/11/23 and revision dated 04/09/24 had no focus, goals, or interventions regarding smoking. Record review of Resident #91's electronic health records revealed no Smoking Safety Screen. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interviews with Residents #10 and #68 in the smoking area on 04/12/24 at 9:00 AM revealed Resident #10 stated no one ever spoke with him about safe smoking. Resident #68 stated she thought they did an assessment but did not know for sure. Interview with the Activity Aide on 04/12/24 at 9:00 AM stated the process for smoking was the residents were supposed to have a safe smoking assessment done by the nurses, but she did not know where to find one. Interview with LVN A on 04/12/24 at 9:05 AM stated she did not know if residents were safe to smoke. LVN A stated she was not sure the residents who smoked had to have a safe smoking assessment done and had never looked for one. LVN A stated she was not sure the residents who smoked had to have smoking in their Care plans. In an interview on 04/12/24 at 11:01 AM ADON A stated the Activity Aide did not usually take the residents out to smoke and usually the nursing staff were the ones assigned to the smoking tasks, but the Activity Aide was trying to help since everyone was busy. ADON A stated the Activity Aide was not educated on making sure care plans were being followed correctly. ADON A stated it was important to follow all care plans as they were person centered and could lead to poor quality of care. ADON A stated the ADON's oversaw care plans, but nurses did the initial care planning. As far as smoking assessments, it was the ADON's job to make sure the care plan and assessments were done, and it could have just been missed. ADON A stated an in-service on care plans would be conducted immediately. ADON A stated there was no specific policy for following environmental smoking procedures. Record review of the facility's policy, Resident Smoking dated 10/24/22 under Policy Explanation and Compliance Guidelines: 5. All residents will be asked about tobacco use during the admission process, and during each quarterly or comprehensive MDS assessment process. 6. Residents who smoke will be further assessed, using the Smoking Safety Screen to determine safety with smoking. 8. Any resident who is deemed safe to smoke will be allowed to smoke in designated smoking areas at designated times and in accordance with their care plans. 10. All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident's care plan. 15. Documentation to support decision making will be included in the medical record, including but not limited to a. Resident's wishes, or those of the resident's representative b. Assessment of relevant functional and cognitive factors affecting ability to smoke safely c. Response to smoking cessation interventions d. Compliance with smoking policy.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 49301 Based on observation, interviews, and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, to include providing and obtaining clinical laboratory services to meet the needs of its 28 residents who receive insulin services. The facility failed to keep a log documenting the control solution testing results for the facility's glucometers. This failure could result in not determining if the glucometers were functioning properly and/or obtaining false glucometer readings. The findings included: Record review of the facility's Resident Matrix dated 4/9/24 revealed the facility had 28 resident's who were insulin dependent. Record review of the facility's Blood Glucose Monitoring System User's Guide for Control Solution Testing revealed that the purpose of the control solution testing was to validate that the Meter was working properly with the test strips and that the control solution test should be performed at the following times: When using the meter for the first time When using a new package of blood glucose test strips At least once per week to verify that the meter and test strips were working properly together. For vial strips, if the test strip bottle was left open. When the meter was dropped. When suspect meter and test strips were not working properly together. When a patient's readings appear to be abnormally high or low. When test strips have been exposed to a condition outside the specified storage conditions. When practicing your testing technique. On 4/10/24 at 3:22 pm during an interview with ADON B while performing the medication storage and labeling task, she stated that the glucometer logs for control solution testing should be located at the nurse's station. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/10/24 at 3:23 pm observation of the one nurse's station for the glucometer logs, revealed no glucometer log at the nurse's station. On 4/10/24 at 3:40 pm during an interview with DON, she stated that the glucometer logs for control solution testing should be located at the nurse's medication carts. On 4/10/24 at 3:50 pm observation of 4 medication carts revealed no glucometer logs found on the medication carts. On 04/11/24 9:17 AM DON stated the night shift nurses checked glucometer controls, and she was informed that the logs were not kept. She stated she would be in-servicing on this and was currently going to have all glucometers checked and logged. On 4/11/24 at 10:20 am observed RN A perform glucometer control solution testing on the glucometer for the medication cart located on the 400 Hall. The glucometer registered a reading of 214 mg/dL. Test strips with an expiration date of 5/8/2025 revealed measurements should read between 175 mg/dL - 237 mg/dL. This was the first entry documented in the quality control log. On 4/11/24 at 12:00 pm, a record review of a document provided by the facility that was not dated or signed revealed the facility did not have a specific Glucometer Policy, the facility follows the Glucometer Manual. On 4/12/24 at 10:05 am interviewed RN B and she said that if glucometer logs were not completed, they could not determine if they were getting false readings of blood sugars on their residents. She said if she noticed a reading that was not typical of a resident, she would look at glucometer calibration logs. If no logs were available, she would do her own control check and replace the glucometer if necessary. On 4/12/24 at 10:27 am interviewed the DON stated in a previous interview that the night shift nurses checked the glucometer controls. The DON said that if glucometer logs were not completed it could have a negative effect on the readings. If no log, staff could not know for sure if glucometer was working properly. She said for now, the facility would be following the glucometer's manual for control solution testing. On 4/12/24 at 10:36 am interviewed the ADON B said that if the glucometer logs were not completed, one could have a false reading from the glucometer. She said she would calibrate herself to ensure glucometer was working properly if there was no log available to reference. She said that Central Supply always kept glucometers in stock in case one was needed. 4/12/24 at 10:27 am interviewed the DON said that if glucometer logs are not completed it could have a negative effect on the readings. If no log, cannot know for sure if glucometer is working properly. She said for now, facility will be following the glucometer manual for control solution testing. 4/12/24 at 10:36 am interviewed the ADON B, she said that if the glucometer logs are not completed, one could have a false reading from the glucometer. She said she would calibrate herself to ensure glucometer was working properly if there was no log available to reference. She said that Central Supply always keeps glucometers in stock in case one is needed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748 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 and 1 of 1 nutrition room reviewed for sanitation in that: 1. The facility failed to ensure a juice dispenser gun was sanitary 2. The facility failed to ensure equipment was clean and sanitized 3. The facility failed to ensure dry goods were dated, labeled, and sealed. 4. The facility failed to ensure spices were not left open to the air 5. The facility failed to ensure items in the nutrition room's refrigerator were labeled, dated, and not expired 6. The facility failed to ensure items in the nutrition room were labeled, dated, and not expired 7. The facility failed to ensure the kitchen was following their policies These failures could place residents at risk of foodborne illnesses. Findings included: Observation and initial tour of the kitchen on [DATE] beginning at 11:05 AM revealed 2 unlabeled and undated sippy cups in the refrigerator-one was filled with a red liquid, the other with an opaque white liquid. A juice gun was hanging with the nozzle touching the outside of a cabinet and not in its holder, which was near the juice gun. 7 of 21 16-ounce containers of spice were open to air. There was a large, unsealed bag in dry storage that contained 4 smaller unsealed and partially filled dry cereals. None of the bags were dated or labeled. 2 of 5 steam table wells were crusted on the inside walls and bottom with a whitish substance. Observation of the nutrition room by the nurse's station on [DATE] at 1:12 PM revealed 1 large bag of dried cereal with [DATE] handwritten on the outside was otherwise unlabeled and open to air. There were 2, 8-quart plastic containers with lids that were partially full, undated, and unlabeled. There was 26, 1.51-oz. pouches of instant oatmeal in a box with a best before date of [DATE]. In the nutrition room freezer there was an unlabeled, undated ice cream treat from a local treat store, 2 48-oz. partially full cartons of ice cream unlabeled and undated. In the nutrition room refrigerator, there were 2, 4 oz. containers of yogurt and 1, 5. 3-oz. of yogurt all unlabeled and undated. There was a ,d+[DATE] gallon of almond milk undated and unlabeled. There was an opened 16-oz. container of peanut butter undated and unlabeled. There was 1, 1-gallon open container of whole milk undated and unlabeled. There was a 22.3-oz. bag of pre-mixed salad, unlabeled and undated. There was an opened 28-oz. bottle of electrolyte drink with a name, handwritten on it. There was 22, 8-oz. containers of tube feeding with expiration dates of [DATE]. (continued on next page)

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Corpus Christi Nursing and Rehabilitation Center	2735 Airline Rd Corpus Christi, TX 78414

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the COOK on [DATE] at 11:20 AM stated the sippy cups in the refrigerator were for certain residents, and kitchen staff knew who they belonged to because the cups were different looking. The COOK stated the spices should not have been open to air because one never knew what was in the air and it could affect the residents-maybe make them sick or cause some kind of reaction. An interview with the DM on [DATE] at 11:25 AM stated the juice gun should have been in its holder so the nozzle did not touch anything. The DM stated if the nozzle got dirty, it could transfer germs into the glasses and it could make residents sick. The DM stated the spices should not have been open to air because it could cause clumping. An interview with RN A on [DATE] 01:20 PM stated she had worked at the facility for 6 years. RN A stated the nutrition room was for the residents. RN A stated a resident came into the nutrition room to warm his tea in the microwave almost every morning. RN A stated staff opened the door for him (via keypad lock) and did not supervise him when he was in there. RN A stated the food in the refrigerator and freezer should be labeled, as well as dry storage type food such as cans of soup. RN A stated the room number and name of the resident should be labeled on all resident items. RN A stated she did not know who the ice cream belonged to. The RN stated the milks were for the residents. RN A stated the 1-gallon carton of whole milk was not labeled like the other one that came from the kitchen. RN A stated she had no idea who the salad belonged to because it did not have a name on it. RN A stated it was likely the unlabeled items belonged to staff. RN A stated employees were not to store their food in this refrigerator because staff had a designated refrigerator in the break room. RN A stated the break room was in the 300 hall, not far from the nutrition room. RN A stated she would have to look up the roster to see if the facility had an employee or resident with the [NAME] on the electrolyte drink. RN A stated the yogurts were not labeled. RN A stated resident's items should not be co-mingled with employee items because they (resident's) could get mixed up and take something that did not belong to them, or because of the resident's diets, such as pureed versus regular food, a resident could choke or aspirate. RN A stated cross contamination could also occur. RN A stated when she picked up a pouch of the instant oatmeal, it felt swollen and not soft and could not shake the contents of the packet. RN A stated the dry cereal was not labeled or dated. RN A stated the open dry cereal should definitely not be in the cabinet and stated it had an expiration date of [DATE]. RN A stated she did not know who was responsible for the nutrition room. An interview with RN A on [DATE] at 2:08 PM stated the name on the electrolyte drink was a resident who was discharged a month ago. RN A stated when staff came to work, they were too busy to check the nutrition rooms, refrigerators, and freezers when they arrived to work. RN A stated if they (management) assigned the duty to check the nutrition rooms, refrigerators, and freezers, then they would. RN A stated she always checked expiration dates on tube feeding but could not speak for everyone else. Record review of the facility's policy, Potluck Meals and Foods from Home dated [DATE]: Guidelines: 1. When outside foods are brought into the facility by resident family or friends, it must be labeled to clearly distinguish it from the food purchased or prepared by the facility and stored separately from the facility's food by placing on a distinguished shelf, labeled bag, or in a bin labeled resident food with the resident name on the items. Foods must be dated with food safety guidelines followed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy, Food Storage revised [DATE] reflected, To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal, and US Food Codes an HACCP guidelines. Procedure: 1. Dry storage rooms d. To ensure freshness, store opened and bulk items in tightly covered containers. All containers must be labeled and dated. c. Use all leftovers within 72 hours. Discard items that are over 72 hours old. 2. Refrigerators d. Date, label, and tightly seal all refrigerated foods . In-services for kitchen staff training was requested but not provided. Reference: TAC 554.1111 (b) The facility must store, prepare, and serve food under sanitary conditions, as required by the Texas Department of State Health Service sanitation requirements.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 44748 Based on observation, interview and record review, the facility must dispose of garbage and refuse properly for 3 of 3 dumpsters (dumpsters A, B, and C) reviewed for garbage disposal. The facility failed to ensure the dumpsters A, B, andC's lids and doors were secured. The facility failed to ensure the dumpsters A, B, and C's were not overflowing This failure could place residents at risk of infection from improperly disposed garbage. Findings included: Observation of the dumpsters A, B, and C on 04/11/24 at 1:04 PM revealed all 3 had the lids open and all 3 were overflowing; one was leaking an unknown liquid onto the ground. In an interview with the MS on 04/11/24 at 2:16 PM, he stated the dumpster doors and sides should have been closed and should not be overflowing at any point because of infection control. The MS stated it was important to keep the lids and doors closed on the dumpsters to keep biohazards from flying out or leaking. The MS stated, The leaking fluid could be tracked back into the building and that's the nasty of the nasty ; gnats, bugs, and rodents could be attracted to the leaking fluid and because rats in general could spread disease. The MS stated keeping the facility and grounds clean was for the people that live here. The MS stated the resident's safety was the number one responsibility and all staff members, not just maintenance, had the responsibility to keep the dumpster doors closed. In an interview with the ADM on 04/11/24 at 3:30 PM, he stated the dumpsters were not supposed to be open except when someone was using them. The ADM stated everyone using the dumpsters were responsible for keeping the doors and lids closed, as well as keeping the area around the dumpsters clean. Record review of the facility's policy, Garbage Receptacles revised 06/01/19 reflected The facility will maintain garbage receptacles in a clean and sanitary manner to minimize the risk of food hazards. Under Outdoor receptacles: Shall be constructed to have tight fitting lids, doors, or covers and stored in a manner that is inaccessible to insect and rodents with doors/lids kept closed and no waste outside of the receptacle. Refuse shall be removed from the premises at a frequency that will minimize the development of objectionable odors and attract insects and rodents.

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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. 46038 Based on observation, record review, and interview, the facility failed to establish and maintain an infection prevention and control program, designed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections, for 3 residents (Resident #13, Resident #29, and Resident #55) of 26 residents that were reviewed for infection control and transmission-based precautions policies and practices, in that: The facility failed to ensure ADON A, HR personnel, and CNA A did not grab resident's' cups and bowls by the rim with bare hands, contaminating the tops of the rims, during the lunch meal serving process. These failures could place residents at risk for infection through cross contamination of pathogens. The findings include: During a lunch dining observation on 04/09/24 at 12:50 PM ADON A, HR personnel, and CNA A were observed touching the rims of the resident's cups and bowls with bare hands during the meal serving process. In an interview on 04/09/24 at 12:54 PM ADON A stated that there is usually not that many people in the dining room to help serve food to the residents and there has not been training on how to properly serve food to the residents. ADON A stated that after removing the lid off the cups, the cups should be grabbed on the side and offered to the resident as the rim of the cups should not be touched by staff bare hands as it could lead to cross contamination when the resident goes to drink out of it. ADON A stated infection control and meal service in-service would be conducted right away. In an interview on 04/09/24 at 01:07 PM CNA A stated there was no training on how to serve the tray and how to properly handle the items while serving meals to residents. CNA A stated she just watched how other staff members served items from the resident trays and started doing it that way. CNA A stated she should have grabbed the resident's bowls on the outside instead of grabbing from the rim and should have told the resident where the placement of each item is. CNA A stated she was not sure how drinks or bowls are supposed to be handled but stated by grabbing the rim of the resident's cups and bowls could lead to germs and cross contamination. CNA A stated she did not know when the last infection control in-service was as she had only been employed with the facility for about a month. In an interview on 04/09/24 at 04:50 PM, the HR personnel stated she did not realize she was grabbing the resident's' cups by the rim area while serving. The HR personnel stated she was not trained on how to properly serve items from the meal trays and was just trying to help. The HR personnel stated by grabbing resident cups by the rim with bare hands could lead to cross contamination and possibly the residents getting introduced to germs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 4/9/24 at 4:58 PM, the Administrator stated he did not know if serving meal training had been conducted for staff as he was new and had only been working at the facility for less than a month. Record review of the facility's Infection Prevention and Control Program policy dated 05/13/23 stated:Record review of Infection Prevention and Control Program dated 05/13/23 stated: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of transmission of communicable diseases and infections as per accepted national standards and guidelines. 16. Staff Education a. All staff. Shall receive training, relevant to their specific roles and responsibilities, regarding the facilities, infection prevention and control program, including policies and procedures related to their job function. b. All staff shall demonstrate competence in relevant infection control practices. c. Direct care staff. Shall demonstrate competence in resident care procedures established by our facility.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46038 Based on observations, record reviews and interviews the facility failed follow their own established smoking policy for 1 of 9 residents (Resident #30) reviewed for smoking and compliance in that: The facility failed to ensure Resident #30 was wearing a smoking apron the facility implemented as part of their resident's Smoking Policy assessment. This deficient practice could affect residents who smoke and require a smoking apron byand contributeing to a smoking-related injury, fire, and an unsafe smoking environment. The findings were: Record review of Resident #30's Face Sheet dated 04/12/24 reflected an admitted [DATE] and a readmitted [DATE]. Diagnoses included Dementia (general decline in cognitive abilities that impacts a person's ability to perform everyday activities), schizophrenia (a serious mental disorder in which people interpret reality abnormally), and heart failure. Record review of Resident #30's smoking evaluation dated 03/1/2024 reflected adaptive equipment needed was a smoking apron and one-on-one assistance. Record review of Resident #30's Annual MDS dated [DATE] reflected Resident #30 had a BIMS score of 8 (Moderate Cognitive Impairment). Record review of Resident #30's care plan dated 09/3/2021 with a revision date of 4/9/2024 stated Resident #30 was a smoker and would not smoke without supervision. Resident #30 required one-to-one supervision, was instructed about smoking risks, hazards, smoking cessation, facility policy on smoking, locations, and times, safety concerns. Resident #30 required to wear a smoking apron while smoking. During and observation in the smoking area on 04/12/24 at 9:00 AM revealed Resident #30 did not have a smoking apron on while smoking but was provided one by the Activity Aide after questioning. In an interview on 04/12/2024 at 9:01 AM Resident #30 stated he was supposed to have a smoking apron on but did not know for sure. Resident stated he had not had any burn injuries that he could remember (incident and accident record review confirmed Resident #30 did not have any burn injuries). In an interview on 04/12/24 at 9:00 AM the Activity Aide stated Resident #30 was supposed to have a smoking apron on while smoking. The Acitvity Aide stated Resident #30 shakes a lot and hot ashes could drop on him and could possibly cause an injury. The Activity Aide stated the smoking aprons were kept in the activities department, at which time she left the designated smoking area to retrieve a smoking apron for Resident #30. The Activity Aide stated he did not have an apron on because he did not like it. On 04/12/24 at 9:04 AM observation of the Activity Aide placing a smoking apron on Resident #30 was explaining to him that he must wear the smoking apron every time he smoked. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/12/24 at 11:01 AM ADON A stated the Activity Aide does not usually take the residents out to smoke and usually the nursing staff are the ones assigned to the smoking tasks, but the Activity Aide was trying to help since everyone was busy. ADON A stated the Activity Aide was not educated on making sure Resident #30's care plan was being followed correctly by placing the smoking apron on Resident #30 as indicated. ADON A stated since Resident #30 did not have his smoking apron on, Resident #30 could possibly burn himself or become injured and in-service on following care plans would be conducted immediately. ADON A stated the DON as well as ADON's were responsible for ensuring the smoking policy and assessments were being followed. ADON A stated there was no specific policy for following environmental smoking procedures. Record review of the facility's policy, Resident Smoking dated 10/24/22 under Policy reflected: Explanation and Compliance Guidelines: 5.All residents will be asked about tobacco use during the admission process, and during each quarterly or comprehensive MDS assessment process. 6. Residents who smoke will be further assessed, using the Smoking Safety Screen to determine safety with smoking. 8. Any resident who is deemed safe to smoke will be allowed to smoke in designated smoking areas at designated times and in accordance with their care plans. 10. All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident's care plan. 15. Documentation to support decision making will be included in the medical record, including but not limited to: a. Resident's wishes, or those of the resident's representative b. Assessment of relevant functional and cognitive factors affecting ability to smoke safely c. Response to smoking cessation interventions d. Compliance with smoking policy.