STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676108	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vidor Health & Rehabilitation Center	470 Moore Dr Vidor, TX 77662

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33460 Based on observation, interview, and record review, the facility failed to ensure resident rights for personal privacy for 1 of 20 (Resident #72) residents. CNA D and CNA E failed to pull the curtain to provide privacy to Resident #72 when providing incontinent care on 04/11/2024 at 11:55 a.m. This failure could place residents at risk for low self-esteem, loss of dignity, and decreased quality of life due to a lack of privacy during their care. Findings included: Record Review of Resident #72's Face Sheet dated 04/01/2024 indicated she was admitted to the facility on [DATE] and was a [AGE] year-old female. Resident #72's diagnoses included diabetes (a disease in which the body's ability to produce and respond to insulin is impaired resulting in elevated levels of sugar in the blood and urine), dementia (a progressive or persistent loss of intellectual functioning), and hepatic encephalopathy (a brain dysfunction caused by liver insufficiency). Record Review of Resident #72's quarterly MDS dated [DATE] indicated her BIMS was 03 which indicated severely impaired cognition. Resident #72 was dependent on 1-2 staff members for toileting hygiene or bathing. Record Review of Resident #72's care plan dated 03/08/24 indicated she was incontinent and was dependent on staff for assistance. During an observation on 04/11/24 at 11:55 a.m., CNA D and CNA E were providing incontinent care for Resident #72. CNA E removed the adult brief and CNA E provided Resident #72 perineal care (washing the genital and rectal areas) without pulling the privacy curtain between this resident and her roommate. Resident #72 was unable to answer questions. Resident #72's roommate was in the room and in her own bed and in view of Resident #72's bed. During an interview on 04/11/24 at 12:10 p.m., CNA D said she had been trained to pull the curtain and said we forgot to pull the privacy curtain between the residents. CNA E said she was trained to provide privacy in CNA school and forgot to pull the privacy curtain. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/11/24 at 2:00 p.m., the DON said her expectation was for all nursing staff to provide privacy when providing any care that exposes the residents' private areas. She said the CNAs had been trained in CNA classes and during in-services the importance of using the privacy curtains. Review of the facility policy Resident rights dated 11/28/16 indicated The resident has a right to be treated with respect and dignity Privacy and confidentiality - The resident has a right to personal privacy of his or her person .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36214 Based on observation, interview, and record review, the facility failed to ensure each resident's person-centered comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 2 of 20 residents reviewed for care plans. (Resident #2 and Resident #85) -The facility failed to ensure Resident #2's care plan accurately address her need to use a fire-resistant smoking apron. -The facility failed to ensure Resident #85's care plan accurately addressed his diagnosis of benign prostatic hyperplasia and urinary retention related to his indwelling urinary catheter. These failures could place residents at risk for staff not being aware of the resident needs and not receiving the care and services to attain or maintain their highest practicable physical, mental, and psychosocial outcome. Findings included: 1. Record Review of a face sheet dated 04/08/24 indicated Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of bipolar disorder (disorder causing mood swings that include emotional highs and lows), anxiety (feelings of worry, anxiety or fear that are strong enough to interfere with one's daily living), diabetes mellitus (a disease that results in too much sugar in the blood) , chronic obstructive pulmonary disease (diseases that block airflow and make it difficult to breathe), and dementia (loss of cognitive functioning). Record Review of a comprehensive MDS dated [DATE] indicated Resident #2 had a BIMS score of 3 indicating severely impaired cognition and current tobacco use. Record Review of Resident #2's Safe Smoking assessment dated [DATE] indicated Resident #2 shakes or had tremors while smoking but did not require a fire-resistant smoking apron while smoking. Record Review of Resident #2's Safe Smoking assessment dated [DATE] indicated Resident #2 shakes or had tremors while smoking and required a fire-resistant smoking apron while smoking. Record Review of a care plan updated 02/29/24 indicated Resident #2 smoked, but it did not include the required fire-resistant smoking apron as an intervention. Record Review of Resident #2's Safe Smoking assessment dated [DATE] indicated Resident #2 shakes or had tremors while smoking and required a fire-resistant smoking apron while smoking. During an observation and interview on 04/08/24 at 01:10 p.m., Resident #2 was observed smoking with a smoking blanket across her chest, staff provided and lit her cigarettes and monitored her during the smoking process. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/24 at 10:36 a.m., LVN C said she was providing caring for Resident #2 today. She said Resident #2 wore a fire-resistant smoking apron every time she smoked. LVN C said care plans were a collective of care required by the resident and nurses did the admissions care plans and the SW, MDS nurse, and DONs did the others. She said Resident #2's fire-resistant smoking apron should have been care planned and it was not. She said it was overlooked. She said she was educated on the care plan process. LVN C said the risk of Resident # 2's fire-resistant smoking apron not being care planned was staff may be unaware it was needed. During an Interview on 04/10/24 at 10:48 a.m., MDS Nurse B said she was educated on care plans. She said all the interdisciplinary team were responsible for care plans. MDS Nurse B said the SW was responsible for the smoking section of care plans. She said the smoking assessment on 03/31/24 indicated Resident #2 was to use a fire-resistant smoking apron while smoking and it should have been care planned as an intervention but was not. MDS Nurse B said it was overlooked. She said it was care planned previously but resolved on 11/01/23. MDS Nurse B said the smoking assessment on 11/26/23 restarted the use of a fire-resistant smoking apron and it should have been care planned then. She said the risk of not having an intervention for a fire-resistant smoking apron care planned was staff may not be aware to use it. During an interview on 04/10/24 at 10:55 a.m., the SW said the MDS nurses and nursing were responsible for care plans. She said she had received education on the care plan process. She said she did some care plans for smoking and advanced directives. The SW said nursing was responsible for smoking assessments. She said when she updated a smoking assessment, she checked the box to add to the care plan into the system. The SW said the risk of a fire-resistant smoking apron not being care planed as an intervention was risk of burns from the staff not using one because they were unaware, she needed one. During an interview on 04/10/24 at 3:00 p.m., the DON said the MDS nurse, the SW, the ADON and DON were responsible for care plans. She said she was ultimately responsible for all care plans. The DON said the SW was responsible for addressing smoking safety needs in the plans. She said nursing did the smoking assessments but did not do care plans. The DON said the MDS Nurse updated care plans according to results of the assessments. She said Resident #2's new assessment was overlooked. The DON said the risk of a fire-resistant smoking apron not being care planned was staff may be unaware of needed care. She said her expectation was for care plans to be updated and audited appropriately During an Interview on 04/10/24 at 3:27 p.m., the Administrator said her expectation was care plans should be accurate and updated appropriately. She said currently the nurses did the smoking assessment on admission and the SW did the other smoking assessments. The Administrator said the new plan was the SW to do all the smoking assessments and smoking care plans. She said she thought the fire-resistant smoking apron was not communicated correctly by staff. The Administrator said the risk of a fire-resistant smoking apron not being care planed was staff may not be aware of the needed care. 2. Record review of a face sheet dated 4/9/24 indicated Resident #85 was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis of benign prostatic hyperplasia A benign {not cancer} condition in which an overgrowth of prostate tissue pushes against the urethra and the bladder, blocking the flow of urine) and retention of urine (difficulty urinating and completely emptying the bladder). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an admission MDS dated [DATE] indicated Resident #85 had a BIMS score of 13 indicating no cognitive impairment and had an indwelling catheter (a catheter which is inserted into the bladder through the urethra and remains inside the bladder to drain urine). Record review of a care plan last revised 04/08/24 indicated Resident #85 had an indwelling catheter but did not address his benign prostatic hyperplasia and urinary retention necessitating the indwelling catheter During an observation and interview on 04/08/24 at 10:06 a.m., Resident #85 was in his room with a catheter bag hung for gravity drainage (below the level of the bladder) at bedside. He said he had trouble urinating without the catheter. During an interview on 04/10/24 at 12:10 p.m., MDS Nurse B said that care plans usually included an indication or diagnosis related to the problem. She said the care plan for Resident #85's catheter did not include an indication or diagnosis because it had been overlooked. She said she and the IDT (interdisciplinary team) were responsible for care plans. She said she did not know what negative outcome could result in not including the diagnosis related to having a catheter. During an interview on 04/10/24 at 12:30 p.m., the DON said the MDS nurse was responsible for adding diagnosis to the care plan. She said she was ultimately responsible because she was the MDS nurse's direct supervisor. She said a possible negative outcome for the diagnosis not being included for a catheter could be staff not being aware of why Resident #85 required a catheter. During an interview on 04/10/24 at 3:27 p.m., the Administrator said her expectation was care plans should be accurate and updated appropriately. She said the MDS nurse did most care plans. She said the ADONs oversee care plans for the residents. She said Resident #85's care plan had not been reviewed properly. She said the risk of no diagnosis on the care plan for the catheter was effects to her quality measures which affect the rating of the facility. Record Review of the undated facility policy titled Comprehensive Care Plans indicated, The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights .to meet the resident ' s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment . Record Review of the facility policy titled, Smoking Policy, dated 11/01/17 indicated, Smoking policies must be formulated and adopted by the facility. 3. If a facility identifies that the resident needs assistance/ supervision and/or additional protective devices for smoking, the facility includes this information in the resident ' s care plan, reviews and revises the plan periodically as needed. 41057

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25779 Based on observation, interview and record review, the facility failed to ensure that a resident, who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for 2 of 20 residents reviewed for respiratory care. (Resident #s 14 and 41) The facility did not ensure Resident #14 had orders for the administration of oxygen . The facility did not ensure Resident #41 received oxygen at 2L NC as ordered . This failure could place the residents at risk of not receiving the care and services to maintain their highest level of well-being. Findings included: 1. Record review of physician orders dated 04/09/24 indicated Resident #14, admitted [DATE], was [AGE] years old with diagnoses of multiple sclerosis (chronic, progressive disease involving damage to the sheaths of the nerve cells in the brain and spinal cord) and neoplasm of the meninges (tumors that develop from the membrane that covers the brain and spinal cord) and was on hospice services. The orders did not indicate the resident was ordered oxygen. Record review of the most recent quarterly MDS assessment dated [DATE] did not indicate Resident #14 received oxygen therapy. Record review of the care plans updated 12/05/23 did not indicate Resident #14 received oxygen therapy. During observations, Resident #14 had oxygen in progress as follows: *on 04/08/24 at 10:24 a.m., at 3L nasal cannula; *on 04/08/24 at 2:15 p.m., at 3L nasal cannula; *on 04/09/24 at 12:26 p.m., at 2.5L nasal cannula; and *on 04/09/24 at 1:07 p.m., at 2.5L nasal cannula. During interview and record review on 04/10/24 at 9:15 a.m., LVN A said Resident #14 had received oxygen for several months. She said the resident had a decline in October 2023, at which time she was placed on Hospice services and received the oxygen. She said the resident did not have orders for the administration of the oxygen but should have orders in place. She said it was the nurse's responsibility to check the oxygen according to the orders every shift and to ensure there were orders for the oxygen. She said the negative outcome of receiving oxygen without orders would be the resident's lungs could be affected and the resident could have increased shortness of breath. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 04/10/24 at 9:17 a.m., upon entering Resident #14's room, the resident's oxygen was in progress at 3L NC. LVN A said Resident #14 did have oxygen in progress at 3L nasal cannula and did not have an order for it. She said the resident should have orders for the oxygen. She said she was unaware the resident did not have orders for the oxygen. 2. Record review of physician orders dated 04/09/24 indicated Resident #41, readmitted [DATE], was [AGE] years old with diagnoses of heart failure (a chronic condition in which the heart cannot pump blood adequately) and emphysema (condition in which the air sacs of the lungs are damaged causing breathlessness). The resident was ordered oxygen at 2L nasal cannula continuously. Record review of the most recent quarterly MDS dated [DATE] indicated Resident #41 had medically complex conditions and heart failure. The resident received oxygen therapy in the last 14 days. Record review of a care plan dated 12/01/23 indicated Resident #41 received oxygen therapy. The first intervention was to administer oxygen as ordered by the physician. During observations, Resident #41 had oxygen in progress as follows: *04/08/24 at 8:44 a.m., at 3L nasal cannula; *04/08/24 at 12:56 p.m., at 3L nasal cannula; *04/09/24 at 8:37 a.m., at 3L nasal cannula; and *04/09/24 at 2:40 p.m., at 3L nasal cannula. During interview and record review on 04/10/24 at 9:15 a.m., upon reviewing Resident #41's clinical record, LVN A said the resident was ordered oxygen at 2L nasal cannula continuously. She said it was the nurses' responsibility to ensure the residents receive oxygen as ordered and the nurses should check the oxygen settings every shift according to the orders. During observation and interview on 04/10/24 at 9:20 a.m., upon entering Resident #41's room, LVN A said Resident #41's oxygen was set at 3L and it should be set at 2L NC as ordered. She said the negative outcome could possibly be the resident's lungs could be affected and the resident could have increased shortness of breath. She said she had not checked the oxygen settings when assessing the resident. During an interview on 04/10/24 at 9:25 a.m., the DON said Resident #14 should have orders in place for her oxygen and Resident #41 should have received the correct dose of oxygen. She said she would need to do an audit on all residents with oxygen and lay eyes on them and compare their dose with the orders on the clinical record. She said nurses should make sure the residents receive oxygen as ordered and have orders for oxygen before administration. She said the negative outcome could be lung over-inflation and injury to the lungs. She said Resident #14's oxygen should have an order, have an assessment in place and be care planned. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an Oxygen Administration policy dated 3/21/23 indicated: Oxygen therapy includes the administration of oxygen (02) in liters per minute (l/min) by cannula or face mask to treat hypoxemic conditions caused by pulmonary and cardiac diseases. 02 therapy is also prescribed to ensure oxygenation of all body organs and systems. The amount of oxygen by percent of concentration or L/min, and the method of administration, is ordered by the physician.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30664 Based on interview and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate administering of all drugs to meet the needs of each resident for 2 of 9 residents reviewed for medication administration. (Residents #31 and #72) 1. The facility failed to ensure LVN C checked g-tube placement (Gastrostomy tube-tube surgically inserted through the skin into the stomach) prior to administering medications to Resident #31. 2. The facility failed to ensure LVN K administered insulin according to physician orders for Resident #72. These failures could place residents at risk of not receiving the desired therapeutic effects of their medications and residents with g-tubes at risk of tube clogging/obstruction, tube replacement, medical complications, or a decline in health due to inappropriate G-tube care, management, and not following appropriate procedures. Findings included: 1. Record review of physician orders for April 2024 indicated Resident #31 was a [AGE] year-old male readmitted on [DATE] with diagnoses including gastrostomy tube. During an observation on 04/09/24 at 07:35 a.m., LVN C administered medications to Resident #31 through his g-tube. LVN C did not check placement of the g-tube prior to administering his medication through the g-tube. During an interview on 04/09/24 at 01:20 p.m., LVN C said she had checked placement of the g-tube when she administered other medications around 06:30 a.m. to Resident #31. Record review of a Gastrostomy Tube Care policy and procedure revised 02/13/07 indicated 7 .1. unplug or unclamp the tube and check the placement by aspiration or injecting air and listening to the stomach for sounds. 2. Aspirate gastric contents with a 60 ml syringe and if the residual is less than 50% of the last feeding or within guidelines of specific physician's order reinject aspirate and continue with the gavage procedure 2. Record review of physician orders for April 2024 indicated Resident #72 was a [AGE] year-old female admitted on [DATE] with diagnoses including type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar). Record review of physician orders for April 2024 indicated Resident #72 had an order dated 12/13/23 for insulin regular (human). During an observation on 04/09/24 at 11:30 a.m., LVN K administered medications to Resident #72. LVN K administered Humulin N 10 units subcutaneously to the right upper thigh. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/09/24 at 01:40 p.m. LVN K said the Humulin N was what was sent by the pharmacy as interchange for the regular insulin for Resident #72. During an interview on 04/09/24 at 01:45 p.m., the DON said Resident #72 should have received the regular insulin since that was what was ordered by the physician. The DON said she did not know why the pharmacy sent the Humulin N on 04/05/24. During an interview on 04/09/24 at 03:10 p.m., the DON said after she spoke with the surveyor, she contacted and spoke with the pharmacy consultant and was told the pharmacist changed the insulin and sent the Humulin N instead. She said they were contacting the physician to clarify which insulin Resident #72 was to be administered. Record review of the Medication Administration Procedures policy and procedure revised 10/25/17 indicated 20. The 10 rights of medication should always be adhered to: Right medication According to Insulin Options: Humulin R U-100, Humulin N & Humulin 70/30 accessed at https://www.humulin.com/insulin-options#:~:text=Humulin%20N%20is%20an%20intermediate,injected%20into%20muscle%20or%20veins, Humulin N is an intermediate acting insulin that is slower to act and lasts longer than regular human insulin

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 30664 Based on observation, interview, and record, the facility failed to ensure drugs and biologicals used in the facility were stored and secured properly for 2 of 3 medication carts (Hall 6 Nurse Cart and the MA Cart) and 1 of 2 medication rooms reviewed for drug storage. The facility failed to provide a separately locked, permanently affixed compartment for storage of controlled drugs in the refrigerator of the medication room. The facility failed to ensure expired medications including narcotics were not available for use on the Hall 6 Nurse Cart and the MA Cart. The facility failed to ensure open dates were on inhalers and nasal sprays on the Hall 6 Nurse Cart. These failures could place residents at risk for drug diversion or receiving expired medication which could lead to exacerbation of their disease process and deterioration in general health. Findings included: During an observation on 04/10/24 at 02:40 p.m. of the Hall 6 Nurse Cart indicated the following: * An opened Insulin Glargine kwik pen (used to treat elevated blood sugars) with open date of 03/08/24; * Two (2) cards of Acetaminophen 300mg with codeine 60mg (narcotic pain medication) with 30 tablets each card expired on 02/28/24; * Two opened inhalers of Trelegy (used to treat respiratory diseases) with no open date and printed on inhaler to discard after 6 weeks; and * An opened bottle of fluticasone nasal spray (used to treat allergies) with no open date. During an interview on 04/10/24 at 02:50 p.m., LVN L said the insulin was only to be used for 28 days after opening. She said the inhalers should have open dates on them to ensure they are discarded after 6 weeks. She said the nasal spray should have an open date on it because it was only good for a month. She said the nasal spray was discontinued a couple of days after it was ordered. She said expired medications were to be removed from the cart. She said expired medications left on the cart left them available to be administered to the residents and could cause adverse effects from expired. She said expired medications left on the cart could also lead to a drug diversion. During an observation on 04/10/24 at 02:55 p.m., the MA cart had a card of escitalopram (antidepressant) with 25 tablets expired on 01/27/24. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/10/24 at 03:00 p.m., MA H said expired medications were to be placed in the locked cabinet in the medication room for the ADON to remove and dispose of them. During an interview on 04/10/24 at 03:20 p.m., the DON said expired medications should be removed from the medication carts as they could be administered to residents, or a drug diversion could occur. Record review of a Recommended Medication Storage policy and procedure revised 07/12 indicated: Medications that require and open date as directed by the manufacturer should be dated when opened in a manner that it is clear when the medication was opened. Below is a list of medications that require a date when opening and the recommended time frame the medication should be used. This is not an all-inclusive list and the manufacturer recommendations will supersede this list (fluticasone)-expires 6 weeks (50 mcg strength) or 2 months (100 and 250 mcg strengths) Insulins (Vials, Cartridges, Pens) Insulin Glargine Expires 28 days after initial use regardless of product storage (refrigerated or room temperature) Record review of a Storage of Controlled Substance policy and procedure dated 2003 indicated 6. All drugs in the Nursing Station shall be stored under the following conditions: Drugs shall not be kept on hand after the expiration date on the label, and no contaminated or deteriorated drugs shall be available. Discontinued drugs containers shall be marked to indicate that the drug has be discontinued and shall be disposed of within thirty (30) days of the date of the drug was discontinued, unless the drug is reordered within that time During an observation and interview on 4/10/24 at 3:55 p.m., the refrigerator in the medication room contained a locked metal box that could be removed from the refrigerator. LVN F said the lock box was to store controlled medications that had to be refrigerated. He said the box was affixed inside the previous refrigerator in the medication room, but a new refrigerator was put in place a few months ago and the lock box had just been sitting in the refrigerator since that time. He said a possible negative outcome of the box not being affixed inside the refrigerator could be drug diversion. During an interview on 4/10/24 at 4:01 p.m., the DON said the lock box inside the refrigerator should be affixed to prevent drug diversion. She said expired medications should be removed from the medication carts as they could be administered to residents, or a drug diversion could occur. During an interview on 04/10/24 at 4:20 p.m., the Administrator said the new refrigerator had been in the medication room for 3 months and the lock box had never been permanently affixed. Record review of a Storage of Controlled Substance policy and procedure dated 2003 indicated 6 The controlled drugs (Schedule II) as listed in the Comprehensive Drug Abuse Prevention Act of 1970 as well as other drugs subject to abuse will be kept locked in a separate, permanently affixed compartment for the storage of controlled drugs

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 33460 Based on interview and record review, the facility failed to employ sufficient staff with appropriate competencies and skill sets to carry out the functions of the food and nutrition service for 1 of 1 facility kitchen reviewed for food and nutrition services. The facility failed to designate a person to serve as the dietary manager who met the required qualifications. The facility designated Dietary Supervisor did not have a dietary manager's certification or any other qualifying credentials from 06/14/23 to 04/10/24. This failure could place residents at risk for the spread of foodborne illness and residents not having their nutritional needs met. The findings included: Record review of the personnel file for the Dietary Supervisor indicated no documentation that she had completed the certified Dietary Manager course. She was in school however completion date would be September 2024. She had a date of hire of 03/19/20. She was appointed Dietary Supervisor on 06/14/23. During an interview on 4/8/24 at 8:30 a.m., the Dietary Supervisor said she had not completed the dietary manager classes. She said she was working as dietary supervisor until she completed the certified dietary manager classes. During an interview on 04/10/24 at 2:00 p.m., the Administrator said her expectation was for the DM to be certified to oversee the dietary services. She said the DM would monitor staff's dietary certifications and ensure diets were followed. The Administrator said the Dietary Supervisor was going to school to become certified Dietary Manager. During an interview on 04/10/24 at 3:00 p.m., the Regional HR said the Dietary Supervisor was not a certified dietary manager and had assumed the position on 06/14/23. Reference obtained from the Texas Food Establishment Rules dated 2015 indicated .Certified Food Protection Manager and Food Handler Requirements. (a) At least one employee that has supervisory and management responsibility and the authority to direct and control food preparation and service shall be a certified food protection manager who has shown proficiency of required information through passing a test that is part of an accredited program. The policy for the Dietary Manager was requested and the policy was not provided prior to exit.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 33460 Based on interview and record review, the facility failed to employ staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service for 1 of 10 dietary staff (Dietary Staff G) reviewed for food and nutrition services. The facility failed to ensure Dietary Aide G had a current Food Handler's Certificate while working in the facility's kitchen on 04/8/24 to 04/10/24. This failure could place residents who consumed food prepared in the facility kitchen at risk of foodborne illness due to being served by improperly trained staff. Findings included: Record review of 10 Dietary Staff food handlers' certificates indicated Dietary Staff G did not have a food handler's certificate. During an interview on 04/10/24 at 2:00 p.m. the Administrator said Dietary Staff G's food handler's certificate was not found and the certificate should have been here at the facility. During an interview on 4/10/24 at 3:00 p.m., the Regional HR said Dietary Staff G did not have food handler certificate. She said the facility was responsibility to ensure all dietary staff had food handlers' certificates, to prevent food born illness and it was a requirement. Review of reference obtained from the Texas Food Establishment Rules' dated 2015 indicated .Certified Food Protection Manager and Food Handler Requirements. (e) The food establishment shall maintain on premises a certificate of completion of the food handler training course for each food employee. The requirement to complete a food handler training course shall be effective September 1, 2016. The policy was requested for food handler's certificate and was not provided prior to exit.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30664 Based on observation, interview, and record review, the facility failed to ensure an infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections were maintained for the facility for 4 of 6 residents reviewed for infection control. (Residents #31, #72, #7, and #82) The facility failed to ensure LVN C washed/sanitized her hands when entering Resident #31's room and between glove changes during medication administration via g-tube. The facility failed to ensure LVN J and LVN K cleaned the glucometer device according to the contact time of the disinfectant before and after use on Residents #72, #7, and #82. These failures could place residents at risk for exposure to infections and blood borne pathogens. Findings included: 1. Record review of physician orders for April 2024 indicated Resident #31 was a [AGE] year-old male readmitted on [DATE] with diagnoses including gastrostomy tube. During an observation on 04/09/24 at 07:35 a.m., LVN C entered Resident #31 to administer his g-tube medication. LVN C did not wash her hands when she entered the room. When she changed gloves after administering the medication, she changed gloves and did not sanitize her hands between. During an interview on 04/09/24 at 07:45 a.m., LVN C said she should have washed her hands when she entered the resident room and sanitized her hands between the glove change. 2. Record review of physician orders for April 2024 indicated Resident #72 was a [AGE] year-old female admitted on [DATE] with diagnoses including type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar) and viral hepatitis C (a virus that causes chronic liver inflammation and long-term damage). During an observation on 04/09/24 at 11:30 a.m., LVN K was to obtain a finger stick blood sugar level on Resident #72. LVN K wiped the glucometer device with a disinfectant wipe for about 15 seconds. Surveyor noted wipe container had 1 minute contact time on it. LVN K entered the resident room and obtained the fingerstick blood sugar. LVN K exited the room. LVN C wiped glucometer with wipe but did not allow 1 minute contact time. During an interview on 04/09/24 at 11:35 a.m., LVN K acknowledged the wipes had a 1-minute contact time and said she should either wipe the glucometer for 1 minute or wrap the glucometer with the wipe and let it sit for 1 minute. She said she did not realize she did not wipe the glucometer for the minute required by the disinfectant wipe. Record review of physician orders for April 2024 indicated Resident #7 was a [AGE] year-old male admitted on [DATE] with diagnoses including type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 04/09/24 at 04:40 p.m., LVN J was to obtain a finger stick blood sugar level on Resident #7. LVN J wiped glucometer with wipe for 2 swipes and threw the wipe away. LVN J entered Resident #7's room and obtained the finger stick blood sugar. LVN J then exited the room and wiped the glucometer device with a wipe for 2 swipes and did not allow for the 1-minute contact time. 3. Record review of physician orders for April 2024 indicated Resident #82 was a [AGE] year-old male admitted on [DATE] with diagnoses including type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar). During an observation on 04/09/24 at 04:45 p.m., LVN J was to obtain a fingerstick blood sugar level on Resident #82. LVN J entered Resident #82 ' s room and obtained the fingerstick blood. LVN J then exited the room and wiped the glucometer device with a wipe for 2 swipes and did not allow for the 1-minute contact time. During an interview on 04/09/24 at 04:47 p.m., LVN J acknowledged the disinfectant wipes had a 1-minute contact time. She said she was looking to see if there was a second glucometer so she could allow the glucometer to have the 1-minute contact time. She said she could either wipe the glucometer for 1 minute or wrap the glucometer with the wipe and let it sit for 1 minute. Record review of a Glucometer policy and procedure revised 02/13/07 indicated 4. Maintenance: 1. Clean and inspect meter exterior with each use. 2. Meter will be cleaned with a germicidal and allowed to air dry between patient testings

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. 33460 Based on observation, interview, and record review, the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system, which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside and toilet and bathing facilities, for 1 of 1 facility's reviewed for a functioning call light system and for 5 of the facility's 5 halls (Halls 100, 200, 300, 500, and 600) reviewed for resident call system, The facility failed to have a functioning call light system for residents who resided in the facility on Halls 100, 200, 300, 500, and 600 from 04/05/24 to 04/10/24. This could place the residents at risk of not receiving the care and services to maintain their highest level of well-being. Findings included: During an observation on 04/08/24 at 8:45 a.m., the call lights on Hall 200 were not working and the residents were using whistles and maracas (musical instruments). The staff was answering alternative call tools. During observations on 04/8/24 at 9:39 a.m., the call lights on Hall 100 were not working and the residents had whistles and bells. The staff was responding to the bells and whistles. During observations on 04/08/24 at 9:45 a.m., the Hall 500 had residents with bells and whistles to call for assistance and were making frequent rounds to monitor residents with cognitive impairments every 15-minute rounds. Hall 500 had 2 CNAs, a nurse and activity person on the hall. During observation on 4/8/24 at 10:00 a.m., the call lights on Hall 300 were not working and the residents were using whistles and maracas (shaking it and hitting it on the over bed table). The staff was answering alternative call tools. During an interview on 04/8/24 at 11:00 a.m., the Administrator said call lights went out on Friday and the facility was obtaining bids on the new call light system or just repairing this one. She said they had put in place extra staff and monitoring every 15- or 30-minute and round sheets were placed on each resident door for the staff to document. They had informed the staff on the process while call lights were not functioning properly. During an observation on 04/08/24 at 2:39 p.m., the call lights on Hall 600 were not working due to the call system not working properly on 04/05/24. The facility had the residents with bells and whistles to call for assistance and are making frequent rounds to monitor residents with cognitive impairments. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observations from 04/8/24 to 04/10/24 during the survey, the staff were answering the needs of the residents, but the system remained not in use. There were round sheets on the resident's door indicating staff were making extra rounds on the residents who were unable to use call light tools every 15-minute rounds. All other residents were every 30 minutes. During an interview on 4/10/24 at 3:30 p.m., the Administrator said the regional office decided to repair the old call light system and the call light system would be next Tuesday (04/16/24). Requested a policy on call lights from the Administrator. During an interview on 04/10/24 at 3:35 p.m., the Administrator said there was no policy on call light and the call light system will be repaired on Friday (04/12/24).