

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676125	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2025
NAME OF PROVIDER OR SUPPLIER Windsor Atrium		STREET ADDRESS, CITY, STATE, ZIP CODE 1814 Atrium Place Harlingen, TX 78550	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered- care plan, and the resident's choices for 1 (Resident #9) of 5 residents reviewed for quality of care. CNA N and CNA E on 08/04/25 identified a loose, abnormal arm while providing R#9 care and continued to provide care without communicating with the nurse. R#9 was not assessed for the abnormality several hours later after the CNA N remembered she had not reported the abnormality to the charge nurse. R#9 x-ray results: acute oblique displaced fracture of the distal humerus (upper arm bone) An Immediate Jeopardy was identified on 08/27/2025. The Immediate Jeopardy template was provided to the facility on [DATE] at 05:23 p.m. While the Immediate Jeopardy was removed on 08/28/2025 at 4:24 p.m. The facility remained out of compliance at a scope of isolation and a severity of harm with potential for more than minimal harm that was not an immediate jeopardy because of the facility's need for continued monitoring of implemented procedures. This failure could place residents at risk of delay in care, worsening of health conditions, adverse reactions, hospitalization, and death. Findings included: Record review of Resident #9's order summary report dated 08/05/2025 reflected a [AGE] year-old female with an admission date of 01/19/2025 with pertinent diagnoses that included dementia (a group of symptoms affecting memory, thinking, and social abilities, which interfere with daily life), hemiplegia and hemiparesis following cerebral infarction (stroke) affecting left dominant side. Record review of Resident #9's quarterly MDS assessment dated [DATE] reflected a Brief Interview for Mental Status was not performed. Resident #9 had functional limitations in range of motion on upper and lower extremities. Resident#9 was totally dependent for all activities of daily living. Record review of Resident #9's comprehensive care plan dated 02/14/2025 revealed she required total assistance for all functional performance: transfer, eating, dressing, lying to sitting, oral, personal hygiene, and bed mobility. Record review of Resident #9's change in condition progress notes on her electronic medical record dated 08/04/2025 at 2:46 p.m., authored by LVN A reflected: left arm noted flaccid, started 08/04/2025. Record review of Resident#9's progress notes on her electronic medical record dated 08/04/2025 at 1:40 p.m., revealed LVN I was the nurse for Resident #9, patient received her morning meds, during this time patient noted on bed semi-Fowlers, medication and feedings administered via peg. During administration of medications patient noted comfortable no apparent distress noted, no nonverbal signs of pain noted during administration, respirations even and unlabored, no nonverbal signs of pain or facial grimacing noted at that time. Nystatin powder applied to affected area, during administration Resident #9's arm was not moved due to hx of contracture applied powder on the sides, then in the afternoon CNA N brought to LVN I's attention a concern regarding Resident #9's left arm that it seemed loose. LVN I then ask the CNA N to go with her to show her the concern regarding Resident #9's left arm. CNA N explained Resident #9's arm was contracted but seem loose. LVN I then assessed Resident#9's arm and noted flaccid effect to arm with sensitivity to touch. LVN I notified the Nurse Practitioner, new orders for x-ray to Resident #9's left arm. PRN pain management was in place. Record review of Resident#9's progress notes on her electronic medical record dated 08/04/2025 at 7:07 p.m., revealed Resident #9's x-ray (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	684 quality of CareCNAs on 8/4/25 identified a loose, abnormal arm while providing R #9 care and continued to provide care without communicating with the nurse. R#9 was not assessed for the abnormality several hours later after the CNA remembered she had not reported the abnormality to the charge nurse. R#9 x-ray results: acute oblique displaced fracture of the distal humerus (upper arm bone)Actions for Resident InvolvedOn 8/4/25, Licensed Nurse performed a head-to-toe assessment on Resident #9 and identified change of condition on Resident #9's left arm. Licensed Nurse administered pain medicine after pain evaluation was conducted and notified physician of change in condition and orders for X-ray was carried out.Resident #9 was sent to emergency room on 8/4/25 for evaluation and management. On 8/12/25, Resident #9 was re-admitted to facility.Identification of Others:On 8/27/25, head-to-toe assessments were completed by DON/Designee on all residents to identify for any changes in condition. Should any change in condition is identified, evaluation will be documented, and the physician and responsible party will be notified. Findings revealed there were no changes in conditions identified. Systemic Changes/ EducationOn 8/4/25 and 8/27/25, the Director of Nursing/Designee initiated and completed education with 100% of Direct Care Staff. Comprehension of training was verified by having nurses voice understanding of the training and repeat back training contents.Direct Care Staff were educated on the following: Immediate Notification of Changes of Condition to include stopping care to promote safety and timely reporting to licensed nurse/supervisor when a change in resident condition is identified. Safe Resident handling Abuse and Neglect License nurses will document in the record of assessment/evaluation completed with any change in resident condition to include MD and Responsible Party notifications. Re-educated Licensed nurses on keeping continuous rounding and communication with direct care staff to identifyThose that are PRN and/ or out of town -FMLA-will be taken off schedule and have the education completed prior to accepting assignment for their next scheduled shift.Beginning 8/27/25 and ongoing, newly hired licensed nurses will receive this training during orientation prior to providing care to the residents. The training will include the above-stated educational componentsBeginning 8/27/25, and going forward, the Director of Nursing/ designee will review the Stop and Watch and 24- hour report.in the morning clinical meeting to ensure that changes of condition are. documentedin the clinical record, communicated with the physician and the resident representative and actions aretaken timely to address the change in condition.MonitoringBeginning 8/27/25, and on-going, the Director of Nursing or designee will monitor the following:Changes in condition are promptly reported, documented and addressed by reviewing the 24- hour report and clinical record during morning clinical meetings and on weekends.Beginning 8/27/25, and on-going, the Administrator will attend the morning clinical meeting to ensure compliance with review of the Stop and Watch, 24-hour report and medical record in the morning clinical meeting to identify changes in condition and actions carried out and documented. On 8/27/25, An Ad Hoc QAPI meeting was held with the Medical Director, Facility Administrator, Director of Nursing, and Regional Clinical Specialist to review the plan of removal.On 8/27/25, The following monitoring system will be in place for the two C.N.A's involved in this event:1. Suspend deficient C.N.A's for Thursday 8/28/25 and Friday 8/29/25.2. C.N.A will be brought in Monday and Tuesday for a classroom Inservice training for the prevention of re occurrence.3. Assistant director of nurses will be assigned to monitor deficient C.N.A's x 30 days4. DON or assigned designee will then monitor this progress weekly and present to QAPI We respectfully submit this action plan for the removal of Immediate Jeopardy. Verification of IJ: Started on 08/28/2025 at 08:04 a.m. and included: Record review of an In-Service with subject of Stop and watch, dated 08/04/2025, indicated that working staff signed the in-service record. Record review of an In-Service with subject of Turning and reposition, dated 08/05/2025, indicated that working staff signed the in-service record. Record review of an In-Service with subject of Safe Resident Handling/Transfers, dated 08/07/2025, indicated that working staff signed the in-service record. Record review of an In-Service with subject of Abuse, Neglect, and Exploitation, dated 08/09/2025 and 08/27/25, indicated that working staff signed the in-service record. Record review of an In-Service with subject of Patient safety and (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to maintain effective pest control for 1 of 1 facility in that: The facility failed to have pest control effectively treat the facility for roaches and ants. This deficient practice could place residents at risk of exposure to pests, diseases, infections, and diminished quality of life. The findings include: During an observation on 08/03/2025 at 11:15 a.m., revealed a live roach on the wall in the hallway of the 100 hall. This observation was pointed out to LVN Q and walked away to notify staff. Maintenance staff captured the roach. LVN Q was in the hallway where the live roach was with her medication nurse cart. During an observation on 08/03/2025 at 11:38 a.m., revealed a large black live ant on the wall by the light fixture near the main dining area. During an interview on 08/03/2025 at 11:16 a.m., LVN Q stated that he had not seen roaches in the facility until now. He stated that he does not know how often pest control comes. He stated that they have a pest control sighting logbook in place at the nurse's station where they were to document if they see any ants or roaches. Maintenance staff will take care of contacting pest control. He stated the roaches can create infections to the residents. During an interview on 08/03/25 at 11:25 a.m., the Maintenance Director stated that pest control comes every month per contract. He stated that pest control came out about a week and a half ago. They fumigated the whole facility and the exterior. He stated that have not had issues with roaches. Occasionally they might come inf from the drains but they spray around them. The facility has two pest control sighting logbooks at each nurse station for the staff to document whenever they have a sighting of any bugs. He stated that he checks the logbook monthly but they do report it to him. He stated that he captures, collects and disposes of the bug. Pest control would then be provided with a list of all sightings. The Maintenance Director stated the negative outcome was that they can bring in infection. During an interview on 08/05/2025 at 2:57 p.m., the Administrator stated they have a pest control vendor was scheduled once a month and as needed. He stated there were two sighting logbooks and the maintenance director reviews them. This information gets entered into TELS (building management digital platform). If they find a roach, they immediately get rid of it. Then they call pest control to come in right away. Maintaining a pest and rodent free environment keeps the residents safe from bites and food gets spoiled if roaches were nearby. He stated they do not have a pest control policy. Record review of Pest Control sighting logbooks revealed two entries for the month of June 2025- dated 06/9/2025 noted room [ROOM NUMBER] lots of ants and 06/09/2025 noted room [ROOM NUMBER] roaches in room and restroom. No sightings for the month of July 2025. Record review of Pest Control Invoice, dated 06/21/2025, revealed the following services, Regular Pest Service and Flying Insect Program. Under General Comments/Instructions: Talked to contact looked over sighting logs and treated rooms [ROOM NUMBERS]. Interior. Inspected and treated all common areas, hallways, bathroom, kitchen, dining, offices and. changed glue boards as well. Exterior .Inspected and treated perimeter of building and replaced baits in rodent bait stations. Record review of Pest Control Invoice, dated 07/21/2025, revealed the following services, Regular Pest Service and Flying Insect Program. Under General Comments/Instructions: Talked to contact looked over sighting logs nothing noted. Interior. Inspected and treated all common areas, hallways, bathroom, kitchen, dining, offices and. changed glue boards as well. Exterior .Inspected and treated perimeter of building and replaced baits in rodent bait stations. Record review of Pest Control Agreement, dated 04/01/2017, revealed the following, Service Program Specifications: Interior crawling Insect & Rodent Programs. Frequency: Every Month. Interior Flying Insect Program (if applicable). Frequency: Every Month Exterior Crawling Insect & Rodent Programs: Frequency: Every Month Service Log Sightings:		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews the facility failed to ensure the residents right to be informed of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers, for 1 of 5 residents (Resident #16) reviewed for consent for antipsychotic medications in that: Resident #16 was prescribed and administered Lorazepam (a psychotropic) without prior consent based on information of the benefits, risks, and options available. This failure could affect the right to self-determination of all facility residents who receive medication by allowing them to receive medication without their prior knowledge or consent, or that of their responsible party or emergency contacts. The findings included: Record review of Resident #16's admission record dated 08/04/2025, revealed a [AGE] year-old female with an admission date of 03/20/2023. Resident #16's diagnoses included amnesia (the loss of memories, including facts, information and experiences), anxiety disorder, history of falling, and chronic obstructive pulmonary disease (a lung disease characterized by persistent airflow limitation and chronic inflammation of the airways and lungs). Record review of Resident #16's Annual MDS, dated [DATE], revealed a BIMS score of 01, indicating severe cognitive impairment. There were no psychiatric/mood/anxiety disorder noted. Record review of Resident #16's Physician's orders dated 06/17/2025 revealed Lorazepam Oral Concentrate 2mg/mL (Lorazepam) *Controlled Drug* Give 0.5 mL by mouth every four hours as needed for anxiety or agitation for 14 days. Record review of Resident #16's care plan, dated 06/20/2025, revealed no mention of the psychotropic (Lorazepam) Resident #16 was receiving. Record review of Resident #16's medical record did not reveal a consent for the psychotropic Lorazepam until 07/08/2025. Record review of Resident #16's June 2025 MAR revealed Resident #16 was administered Lorazepam 2 mg/mL on 06/17/2025 at 09:08 PM and 06/22/2025 at 02:27 PM by mouth. During an interview on 08/07/2025 at 4:35 PM, the Administrator stated he did not know why there was not a consent in PCC (electronic health record) for the Lorazepam before the administration of the medication for Resident #16. He said it was the nurse who took the order who was responsible for getting the consents for psychotropics and antipsychotics and the consent needed to be signed before the medication was administered. He said if the consent was not signed and the resident received the psychotropic or antipsychotic, it would violate the resident's right to be informed. During an interview on 08/07/2025 at 04:07 PM, LVN I stated for antipsychotics and psychotropics a consent was completed with signatures for those medications (before giving the medication). During an interview on 08/07/2025 at 04:54 PM, the ADON stated a consent needed to be signed before the antipsychotic or psychotropic was given. During an interview on 08/07/2025 at 5:07 PM, RN J stated psychotropics and antipsychotics needed a consent form. RN J stated a consent must be signed before medication was given. RN J stated verbal consent was allowed. During an interview on 08/07/2025 at 5:34 PM the DON stated a consent was needed immediately on receipt of an antipsychotic or psychotropic before giving the medication. The DON stated if they did not get a consent from the resident or their RP, their right to know (about the medication) was being violated. A record review of the facility's policy Use of Psychotropic Medication(s), dated 03/05/25, revealed, Policy Explanation and Compliance Guidelines: 9.Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase. 10. The resident has the right to accept or decline the initiation or increase of a psychotropic medication. 11.The facility will document that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and the preferred option to accept or decline in a format the facility deems to use (e.g., written consent form, narrative note, etc.).		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights and 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 1 (Resident #10) of 5 residents reviewed for comprehensive care plans. 1. The facility failed to update Resident #10's oxygen order in his care plan. These failures could lead to residents not receiving needed care and/or consideration from staff as care is provided and/or receiving improper care/treatment. Findings Included: 1. Record review of Resident #10's admission record dated 08/3/2025 reflected a [AGE] year-old male with an admission date of 6/18/2025. Pertinent diagnoses included Tracheostomy status (the presence of a tracheostomy, a surgical procedure that creates an opening in the trachea to allow breathing), acute respiratory failure with hypoxia (is a serious medical condition where the lungs are unable to adequately oxygenate the blood and/or remove carbon dioxide). Record review of Resident #10's Quarterly MDS assessment, dated 07/8/2025 revealed he received oxygen therapy while a resident. Record review of Resident #10's person-centered care plan, initiated date 7/22/2025 reflected Resident #10 used oxygen therapy related to acute respiratory failure status post tracheostomy status. Intervention included oxygen settings: oxygen settings via tracheostomy collar at 6 liters per minute continuous. Record review of Resident #10's physician order dated 08/3/2025, revealed oxygen at 2 LPM via trach tube every shift for hypoxia. During an observation of Resident #10 on 08/3/2025 at 9:50 a.m., the oxygen level on the oxygen concentration machine was at 1.5Liters Per Minute via tracheostomy. Resident #10 was in bed with head of the bed slightly elevated. No signs of respiratory distress noted. In an interview on 08/3/2025 at 9:55 a.m., LVN A, stated she was the nurse for Resident #10. LVN A said the Oxygen was set at 1.5 Liters Per Minute. She stated the oxygen setting was supposed to be at 2 Liters Per Minute per physician orders. She stated that she checked the settings at the beginning of her shift. She was not sure who might have moved it. LVN A stated that she checked Resident #10's oxygen tubing and saturation this morning. She stated that she usually checks the oxygen once a day and as needed. LVN A stated that the negative outcome to keeping Resident# 10's oxygen setting at 1.5 Liters Per Minute was that resident could go into respiratory distress or oxygen level might drop. During an interview on 08/6/25 at 08:26 AM the ADON stated the care plan should have been updated by whomever received the order for the oxygen when they received it. ADON stated if the care plan was not updated could affect the Resident #10 by not receiving the oxygen that he required. During an interview on 08/7/25 at 09:50 AM DON stated that she was responsible to update the care plan for Resident #10, but she missed it. DON stated the care plan had to be updated to give the resident the best care and to verify if the interventions were effective. The DON stated care plans were created upon admission within 48 hours, updated 14 days after admission, quarterly, and upon change of condition. The DON stated Resident #10 was at risk of not receiving the proper oxygen that he required. Record review of facility's policy titled Comprehensive Care Plans with a date implemented 10/24/25 revealed the following: it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with 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 resident's comprehensive assessment.		

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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** Based on observation, interviews and record reviews, the facility failed to review and revise comprehensive care plans after each assessment for 2 (Resident #10, Resident #4) of 8 residents reviewed for comprehensive care plan revisions. 1.The facility failed to review and revise Resident #10's comprehensive person-centered care plan for catheter use. 2.The facility failed to review and revise Resident #4's comprehensive person-centered care plan for insulin use. This failure could affect residents and place them at risk of not receiving appropriate interventions to meet their current needs. The findings included: 1.Record review of Resident #10's admission record dated 08/05/2025, revealed a [AGE] year-old male with an original admission date of 04/10/2025 and a readmission date of 06/12/2025. Resident #10's diagnoses included cerebral infarction (stroke) affecting his left side, seizures, hypertension (high blood pressure), chronic kidney disease, and pain, unspecified. Record review of Resident #10's admission MDS, dated [DATE], revealed a BIMS score of 10, indicating moderate cognitive impairment. Resident #10 was always incontinent of bladder (Resident #10 returned to the facility with and order for a catheter on 06/12/2025). Resident #10's weight at the time of the assessment was 220 pounds with weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. Record review of Resident #10's Weight and Vitals dated 04/10/2025 revealed Resident #10's weight was 233 pounds. Record review of Resident #10's Physician's order dated 06/12/2025 revealed a catheter was ordered. Record review of Resident #10's care plan dated 06/19/2025 revealed no mention of weight loss or a catheter. Record review of Resident #10's Progress Notes dated 06/12/2025 at 09:54 PM revealed Bladder Function: Bladder function unchanged Cath: Foley Catheter with care provided. Record review of Progress Notes dated 06/12/2025 at 10:59 PM, written by LVN I revealed, Patient admitted with indwelling foley catheter. Observation on 08/03/2025 at 12:04 PM revealed Resident #10's Foley catheter hanging on the left side of the bed, below the bladder, in a privacy cover. During an interview on 08/07/2025 at 05:07 PM, RN J stated Foley catheters were care planned. If the resident was a new admission, the admitting nurse would care plan a Foley, but if the resident was returning from the hospital, MDS staff would update the care plan. During an interview on 08/07/2025 at 05:23 PM, MDS RN stated he was the MDS coordinator. MDS RN stated MDS was responsible for updating the care plans. He stated ADONs put the acute changes for a resident in the care plan (changes that occurred after the resident's baseline care plan had been completed). MDS RN said when a MDS assessment was completed, the resident's care plan was (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	updated. During an interview on 08/07/2025 at 05:34 PM, the DON stated the DON, ADONs, and MDS coordinators were responsible for updating the care plan. The DON stated the care plan was to be revised immediately. The DON stated the negative outcome would be they were not communicating the plan of care. During an interview on 08/07/2025 at 05:47 PM the Administrator stated meetings were every morning which covered the prior admissions making sure everything was in order, every department was gone over, medical records request, care plans updated, etc. 2. Record review of Resident #4's electronic admission record dated 08/07/2025, revealed an [AGE] year-old female with an original admission date of 04/15/2021 and a readmission date of 07/06/2025. Resident #4's pertinent diagnoses included Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out simple tasks), Type 2 Diabetes Mellitus (high blood sugar levels), Congestive Heart Failure, Metabolic Encephalopathy (any disease or disorder of the brain, characterized by changes in brain function or structure), Dysphagia (difficulty swallowing). Record review of Resident #4's Comprehensive MDS, dated [DATE], revealed a BIMS score of 10, indicating moderate cognitive impairment. Resident #4 was noted for taking a high risk medication of insulin. Record review of the Physician's Order Summary dated 08/07/2025 revealed Resident #4 was prescribed Tresiba Insulin with a start date 07/07/2025. Record review of Resident #4's care plan dated 07/14/2025 revealed no mention of insulin. During an interview on 08/06/2025 at 5:05 p.m., the MDS RN K stated that he was responsible for updating Resident #4's care plan. He stated that he had seven days to complete the comprehensive care plan. MDS RN K stated he did not care plan the insulin because it was not flagged as black box (a serious warning given by the Food and Drug Administration for medications that may cause serious harm or death) that may but he would add it to the care plan. He stated that it was important for the insulin to be care planned because it was a way of good communication for the nurses and so that Resident #4 received the best quality of care. During an interview on 08/06/2025 at 5:19 p.m., the DON stated the ADON, MDS coordinator, and she were responsible for updating the care plan. She stated the care plan was to be revised within 48 hours but immediately was best practice. The DON stated insulin should be care planned even if it was not flagged as a black box medication. The DON stated the negative outcome would be they were not communicating how they cared for the resident.^^^ Record review of facility's policy Care Plan Revisions Upon Status Change dated 10/24/2022 revealed: Policy: The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Explanation and Compliance Guidelines: 1.The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. 2.Procedure for reviewing and revising the care plan when a resident experiences a status change: a.Upon identification of a change in status, the nurse will notify the MDS Coordinator, the physician, and the resident representative, if applicable. d.The care plan will be updated with the new or modified interventions. f.Care plans will be modified as needed by the MDS Coordinator or other designated staff member.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident received assistance devices to prevent accidents for one (Resident #110) of three residents reviewed for transfers. CNA E failed to use a footrest to transfer Resident #110 from resident's room to shower room. The failure placed the residents, who required one or two people to assist with transferring, at risk for injury. Findings included: Record review of Resident #110's face sheet dated 8/5/25 revealed a [AGE] year-old male admitted originally on 6/20/25. His diagnoses included, cerebral infarction due to unspecified occlusion or stenosis of left posterior cerebral artery (a stroke where part of the brain is damaged due to a blockage or narrowing of a blood vessel, but the specific cause of the blockage is not identified), unsteadiness on feet, other abnormalities of gait and mobility. Review of Resident #110's Comprehensive Plan of Care, dated 6/20/25, revealed Resident #110 was totally dependent on staff to wheel at least 150 feet in a corridor or similar space. Review of Resident #110's MDS assessment, dated 6/25/25, revealed the resident was totally dependent for assistance with transfers. Observation on 8/05/25 at 10:35 a.m. revealed CNA E was wheeling Resident #110 to the shower room. The resident was dragging his feet, and the resident's foot was between the wheelchair and the door frame. The surveyor intervened to prevent injury to the right foot by telling CNA E that the resident's foot was between the wheelchair and door frame. During an interview on 8/05/25 at 10:35 a.m. CNA E said that the resident had footrests, but she forgot to put them in the wheelchair. CNA E said that she was only transferring the resident from the room to the shower room, and it was a short distance. CNA E said that Resident #110 could have been hurt because his foot was stuck between the wheelchair and the door frame. During an interview on 8/07/25 on 9:57 a.m. the DON revealed the facility expected staff to always use footrests on residents that needed them. The DON said that the negative outcome of transferring the resident without the footrest was that Resident #110 had a high potential risk for injury. Record review of the facility's Incidents and Accidents Policy date implemented 08/15/2022 revealed: it is the policy of this facility for staff to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and restore continence to the extent possible for 1 of 5 resident (Resident#91) reviewed for indwelling catheters. The facility failed to prevent Resident#91's urinary catheter tubing (bag) from touching the floor. This failure could place residents at risk for cross contamination and urinary tract infections. Findings included: Record review of Resident#91's face sheet revealed a [AGE] year-old male originally admitted on [DATE]. Resident#91 had primary/admitting diagnoses of metabolic encephalopathy (a condition where the brain's function is impaired due to metabolic or systemic illness affecting other body systems, rather than a direct brain injury), obstructive and reflux uropathy (when flow of urine is blocked in the bladder, ureter, or urethra). Record review of Resident #91's MDS dated [DATE], Section C-Cognitive patterns revealed Resident #91 had a BIMS score of 8 which indicated Resident #91 had moderately impaired cognition. Section H-Bladder and bowel revealed Resident #91 had an indwelling catheter. Record review of Resident #91's care plan dated 5/10/2025 revealed Resident #91 had a foley catheter Obstructive and reflux uropathy Date initiated 07/30/25 and revised on 07/30/25, Intervention/tasks listed Resident #91 had a 16 french 10 milliliters balloon (the size of the catheter) indwelling position catheter bag and tubing below the level of the bladder and away from entrance room door. Record review of Resident #91's Order Summary printed 08/3/25 revealed an order to Change the Foley Catheter 16 # French with a 10 milliliters balloon every 30 days and if plugged out or dislodged as needed. The orders included Foley catheter care every shift and as needed with a start date of 04/29/25. During an observation conducted on 08/3/25 at 09:50 AM, Resident #91's foley catheter bag was noted laying on the floor on the right side of Resident #91's bed. During interview with CNA B on 08/3/25 at 10:35 AM, CNA B was informed and shown the catheter bag laying on the floor. She stated the foley bag should not be touching the floor. CNA B stated by the foley bag touching the floor, Resident #91 could be at risk for infection. During interview with LVN A on 08/3/25 at 10:45 AM, LVN A was informed and shown the catheter bag laying on the floor. She stated it should not be touching the floor. LVN A put on gloves after sanitizing hands with hand sanitizer and hung the foley bag on Resident#91's bedframe. She replied that a negative outcome of the foley catheter bag being on the floor was the catheter wouldn't drain well and pick up bacteria from floor. LVN A stated that she received infection control training very often, about once a month, which included hand washing, enhanced barrier precautions, foley catheter care, and equipment sanitation and avoiding cross contamination. During interview with the ADON on 08/6/25 at 1:12 PM, she stated that once a foley change was completed, she ensured she got yellow drainage, and that the catheter was placed properly. The ADON said that she ensured the bag was not touching the floor and ensured it had a privacy cover. The ADON stated that if the catheter bag did touch the floor, the resident would be at risk of infection. She stated that the inservices for Infection Control were done about once a week. She stated that in-services were done about once a month on catheter changes. During interview with the DON on 08/7/25 at 9:53 AM, she stated that catheters should be on the side of the bed, not on the part that went up and down, so it did not fall, but on the frame. The DON stated, no, it should not be touching the floor, if on the floor not necessary a problem because if open something going could go in but it was a closed system. She stated they would be thinking of ways to prevent bags from touching the floor on residents with low lying beds, perhaps putting another bag to serve as a barrier. As per the DON there was no policy on Foley Catheters. Record Review of Policy Titled Infection Prevention and Control Program with implemented date May 13, 2023, revealed: 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 and transmission of communicable diseases and infections as per accepted national standards and guidelines.		

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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** Based on observation, interview and record review, the facility failed to ensure that residents who needed respiratory care were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 2 of 5 (Resident #10 and Resident #13) residents reviewed for respiratory care. 1. The facility failed to ensure Resident #10's oxygen was administered at the correct setting of 2 liters per minute on 08/3/2025 as ordered by the physician. 2. The facility failed to ensure Resident #13's oxygen was administered as ordered by the physician. These deficient practices could place residents who receive respiratory care at an increased risk of developing respiratory complications and a decreased quality of care. The findings included: 1. Record review of Resident #10's admission record dated 08/3/2025 reflected a [AGE] year-old male with an admission date of 6/18/2025. Pertinent diagnoses included Tracheostomy status (the presence or absence of a tracheostomy, a surgical procedure that creates an opening in the trachea to allow breathing), acute respiratory failure with hypoxia (is a serious medical condition where the lungs are unable to adequately oxygenate the blood and/or remove carbon dioxide). Record review of Resident #10's Quarterly MDS assessment, dated 07/8/2025 revealed oxygen therapy while a resident. Record review of Resident #10's person-centered care plan, initiated date 7/22/2025 reflected Resident #10 used oxygen therapy related to acute respiratory failure status post tracheostomy status. Intervention included oxygen settings: oxygen settings via trach collar at 6 liters per minute continuous. Record review of Resident #10's physician order dated 08/3/2025, revealed oxygen at 2 LPM via trach tube every shift for hypoxia. During an observation of Resident #10 on 08/3/2025 at 9:50 a.m., the oxygen level on the oxygen concentration machine was at 1.5Liters Per Minute via tracheostomy. Resident #10 was in bed with head of the bed slightly elevated. No signs of respiratory distress noted. In an interview on 08/3/2025 at 9:55 a.m., LVN A, stated she was the nurse for Resident #10. LVN A said the Oxygen was set at 1.5 Liters Per Minute. She stated the oxygen setting was supposed to be at 2 Liters Per Minute per physician orders. She stated that she checked the settings at the beginning of her shift. She was not sure who might have moved it. LVN A stated that she checked Resident #10's oxygen tubing and saturation this morning. She stated that she usually checks the oxygen once a day and as needed. LVN A stated that the negative outcome to keeping Resident# 10's oxygen setting at 1.5 Liters Per Minute was that resident could go into respiratory distress or oxygen level might drop. In an interview on 08/7/2025 at 09:45 a.m., the DON stated the nurses assigned to that hall was responsible for checking the Oxygen settings. She stated that the nurses was to check the setting once per shift. The DON stated they are to follow oxygen settings on physician orders. The DON stated that the negative outcome could be the resident could have a respiratory distress and hypoxia (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(low oxygen levels). 2. Record review of Resident #13's electronic face sheet dated 08/03/2025 reflected the resident was a 90 -year-old female admitted to the facility on [DATE] with an original admission date of 05/24/2021. Resident #13 pertinent diagnoses which included the following: Congestive Heart Failure, Dysphagia (difficulty swallowing), Dementia, Hypertension (high blood pressure), Muscle Wasting and Atrophy (thinning or loss of muscle mass, usually from a lack of muscle use). Record review of Resident #13's Quarterly MDS assessment, dated 07/17/2025 reflected a BIMS score of 2, which indicated Resident #13 had severe cognitive impairment. Record review of Resident #13's physician order dated 07/31/2025, reflected oxygen at 2 LPM via nasal cannula every shift for hypoxia. During an observation of Resident #13 on 08/03/2025 at 10:50 a.m. the resident was in bed with head of the bed slightly elevated and had no oxygen via NC. No signs of respiratory distress noted. In an interview on 08/03/2025 at 10:58 a.m., LVN O, stated she was the nurse for Resident #13. She stated Resident #13 was not on oxygen. She stated that she had checked her SpO2 this morning and it was 98. She then verified that Resident#13 had a physician order for oxygen and she was to follow through with orders. LVN O stated that Resident #13 oxygen levels had been reading above 95. She was not aware that Resident #13 had an active oxygen order for continuous but will call doctor to get an prn order. LVN O stated the negative outcome was that Resident #13 can decline and go into hypoxia (low oxygen levels). In an interview on 08/03/2025 at 04:21 p.m., the DON, stated that the nurse assigned to that hall was responsible for checking the oxygen orders. She stated that the nurse was to check the oxygen orders per shift. The DON stated the nurse was to follow through with the active oxygen physician orders. She stated that the nurses were checking Resident #13's oxygen levels every shift. The DON stated that the negative outcome would be that the resident was not getting the required oxygen as required and could have a respiratory distress. Record review of the Lippincott Nursing Procedures 8th edition published on November 1, 2018 Oxygen Administration implementation section revealed: verify the practitioner's order for the oxygen therapy, because oxygen is considered a medication or therapy and should be prescribed. Record review of the facility's Medication Administration policy dated 10/01/2019, revealed Policy, Explanation and Compliance Guidelines: 14. Administer medications as ordered in accordance with manufacturer specifications.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation and interview, the facility failed to ensure that diabetic equipment were stored in a locked compartment for 1 of 4 medication carts. The facility failed to ensure a (diabetic) lancet, sitting on top the unattended medication cart, was secured. This failure could place residents at risk of access or injury from a lancet. Findings were: During an observation on 08/06/2025, at 12:05 PM, revealed on top of the 600 hall medication cart sitting in the 600 hallway unattended, there was a diabetic lancet. During an interview on 08/06/2025 at 12:07 PM, RN J walked up to cart. RN J stated the (diabetic) lancet was supposed to be secured in the medication cart. RN J stated the negative outcome could be someone could come by and grab it off the cart. RN J secured the lancet in the medication cart. During an interview on 08/07/2025 at 5:34 PM, the DON stated the lancet should be kept in the medication cart until use. She said it would be a safety issue if it were left on top the medication cart unattended. During an interview on 08/07/2025 at 06:30 PM, LVN H stated the lancet was supposed to be locked inside the medication cart and not left unattended. LVN H said if the lancet were left unattended in top of the cart a resident could grab it and get hurt. She said the last in-service on sharps was last month During an interview on 08/07/2025 at 06:40 PM, the ADON said that was not ok to leave the lancet unattended in top of the cart. The ADON said the lancets needed to be locked inside the cart. The negative outcome could be that any resident could grab it and get hurt. The ADON said the in-services on how to handle sharps are done every month and as needed. Record review of the facility's Medication Administration policy dated 10/01/2019, revealed: Procedure: 3. Do not leave the medication cart unlocked or unattended in the resident care area.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for kitchen sanitation. 1. The facility failed to ensure foods were properly stored, labeled, and dated. 2. The facility failed to ensure the DM's hands were washed and gloves were worn during the assistance of food preparation. These failures placed all residents who ate food served by the kitchen at risk of cross contamination and food-borne illness. Findings Include: Observation of the kitchen counter on 08/03/25 at 9:20 AM revealed the following: 1. 1 container of Thick-It (a brand of food and beverage thickener designed to help people with swallowing difficulties) covered with foil. Observation of the walk-in refrigerator on 08/03/25 at 9:26 AM revealed the following: 1. 1 bag of sliced melons - date was not legible 2. 1 crate of onion which had loose onions out of the bag - not labeled or dated 3. 1 bell pepper in a cardboard box - not labeled or dated In an interview on 08/03/25 at 9:47 AM, the DA stated the cook that last used the thick-it, should have placed a plastic lid on the container and not foil. The DA stated if the container was not closed properly, the container was at risk of contamination or spoilage. The DA stated whoever received and put away the food items was responsible for items to be labeled and dated. The DA stated the dates needed to be easy to read. The DA stated if food items was not labeled, the cooks or kitchen staff would not know when food arrived or was opened. The DA stated improper labeling put residents at risk for illness. During an observation on 08/04/25 at 10:45 AM, the DM did not wash her hands nor put on gloves to assist the cook with preparing pureed meals. With bare hands, the DM picked up a dirty blender off the meal prep counter and took it to get washed. The DM returned with a washed blender and placed it on the food prep counter for the cook to use. The DM then took a clean disposable bag and lined a clean metal food container with the bag. The metal food container was placed next to the cook for the cook to pour out the pureed meal he was going to finish pureeing. When the cook finished pureeing the meal, he removed the plastic bag from the metal container and discarded it. The cook then washed his hands, put on gloves, and placed a new disposable bag into the metal container. The cook then proceeded to pour the pureed meal into the metal container. The DM took the dirty food blender that had just been used to get washed. The DM returned to the meal prep counter and started collecting the trash around the counter. In the entire meal preparation time, the DM did not wash her hands nor apply gloves when assisting the cook. In an interview on 08/04/25 at 11:05 AM, the DM stated that all staff was responsible for ensuring items were stored, labeled and dated. The DM stated every item opened, should have an open date in the refrigerator, freezer, and dry storage. The DM stated if food items was not properly labeled and dated, staff may be unaware of when the items was opened, increasing the risk of food spoilage and potential illness for residents. The DM stated dates should have been legible to read to make it easy for staff to discard when needed. The DM stated if food items was not properly labeled or stored, it would have increased the risk of food getting spoiled or it would cause potential illness for the residents. The DM stated when she was helping the cook with meal preparation, she simply forgot to wash her hands and put gloves on. The DM stated the consequences for not having washed her hands or wearing gloves would be food borne illnesses and could make residents sick. In an interview on 08/04/25 at 11: 14 AM, the cook stated he had worked at the facility for about nine months. The cook stated he would generally prepare the pureed meals on his own but appreciated the DM helped him today. The cook stated he was nervous and concentrated on his task that he did not notice the DM did not have gloves on, nor that she did not wash her hands. The cook stated it was important to wash one's hands and use gloves when preparing food because food could have been cross contaminated, and residents could have become ill. Record review of the Food Storage Policy dated 06/01/19 revealed the following: Policy: 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, (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	federal and US Food Codes and HACCP guidelines.1. Dry storage room d. To ensure freshness, store opened and bulk items in tightly covered containers.2. Refrigeratorsd. Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage. Record review of the Employee Sanitation Policy dated 10/01/18 revealed the following: Policy: The Nutrition & Food service employees of the facility will practice good sanitation practices in accordance with the state and US Food Codes in order to maximize the risk of infection and food borne illnesses. 5. Hand Washinga. Employees must wash their hands and exposed portions of their arms at designated hand washing facilities at the following times: iv. Immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles v. During food preparation, as often as necessary to remove soil and contamination and prevent cross contamination when changing tasks vii. After engaging in other activities that contaminate the hands.6. Use of Gloves c. Use single use gloves for one task ci. Change gloves: i. Between each food preparation task.ii. After touching items, utensils or equipment not related to task.iv. When leaving food preparation area for any reason.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 (Resident #16) of 4 residents reviewed for medical records accuracy, in that: The facility failed to provide any documentation in the Progress Notes for Resident #16's from 01/31/2025 through 06/04/2025. This deficient practice could affect residents whose records are maintained by the facility and could place them at risk for errors in care, and treatment. The findings included: Record review of Resident #16's admission record dated 08/04/2025, revealed a [AGE] year-old female with an admission date of 03/20/2023. Resident #16's diagnoses included amnesia (the loss of memories, including facts, information and experiences), anxiety disorder, history of falling, and chronic obstructive pulmonary disease (a lung disease characterized by persistent airflow limitation and chronic inflammation of the airways and lungs). Record review of Resident #16's Annual MDS, dated [DATE], revealed a BIMS of 01, indicating severe cognitive impairment. Record review of Resident #16's Progress Notes revealed there was no documentation written from 01/31/2025 through 06/04/2025. During an interview on 08/07/2025 at 04:07 PM, LVN I stated LVNs were responsible for documentation. LVN I stated if the nurses had not documented, it was not done. She said that was what was taught in nursing school. During an interview on 08/07/2025 at 04:54 PM, the ADON stated anything and everything was documented on PCC (change of meds, change of condition, etc.) In an interview on 08/07/2025 at 05:34 PM, the DON stated the nurses' notes are to be thorough and complete. She said if the notes were not written, it does not show the care or progress of the resident. In an interview on 08/07/2025 at 05:47 PM, the Administrator stated when the nurses wrote their risk management or nursing assessments, there was a button to click that would transfer the notes to the resident's progress notes. He stated the nurses must not be doing that although they knew they should do it. The administrator stated he was aware of the missing progress notes for Resident #16 and nurses were being in-serviced.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program which ensured standard and transmission-based precautions were followed to prevent the spread of infection, for 2 (Resident#39 and Resident #47) of 5 residents reviewed for infection control issues. 1. The facility failed to prevent family members from entering R#39's isolation room without donning PPE. 2. The facility failed to ensure the dressing on Resident #39's peripheral intravenous line (a short flexible tube inserted into a vein to administer fluids and medications) was dated and initialed. 3.CNA C failed to remove contaminated gloves after catheter care prior placing clean brief on Resident #47. These failures could place residents at risk of cross contamination and infection. Record review of Resident #39's Face Sheet revealed Resident #39 was a [AGE] year-old male admitted to facility on 07/11/25 for diagnoses of sepsis (a life-threatening medical emergency caused by the body's extreme and overactive response to an infection) due to methicillin resistant staphylococcus aureus (a group of gram-positive bacteria that were genetically distinct from other strains of staphylococcus aureus that was resistant to many antibiotics) and bloodstream infection due to central venous catheter. Record review of Resident #39's 5-day Medicare Part A MDS assessment revealed Resident #39 was understood by others, was able to understand others, and had a BIMS score of 11 which indicated he had moderate cognitive impairment. Section O - Special Treatments, Procedures, and Programs revealed Resident #39 had an IV peripheral access. Record review of Resident #39's comprehensive care plan dated 07/14/25 revealed Resident #39 had infection of the blood stream (MRSA) and revision on 08/03/25 revealed the family refused to follow isolation precautions regarding proper use of PPE with interventions to administer antibiotics, contact isolation precautions, and education on contact isolation precautions and proper use of PPE provided to family, however non-compliance continues. Further documentation revealed Resident #39 had infection of the blood stream (MRSA) and revision on 08/03/25 revealed administer antibiotic as ordered by physician, Record review of Resident #39's Order Summary Report dated August 2025 revealed Resident #39 had order for contact isolation DX: MSSA Bacteremia every shift until 08/15/25 start date of 08/02/25 and orders for vancomycin HCl intravenous Solution 750 mg/150 ml use 750 mg intravenously at bedtime every Tue, Thurs, Sat for MSSA Bacteremia for two weeks, start date 07/29/25. Observation on 08/03/2025 at 11:57 a.m., revealed a sign on the door instructing visitors to check with the nurse before entering the room. There was PPE (gowns, gloves, masks) available outside the doorway. In an interview Resident #39 said he was admitted to the facility because he had an infection to his A/V shunt. Resident #39 said he was supposed to be discharged Saturday but his labs indicated he still had organisms in his blood so he would continue with antibiotics via IV. On 08/03/25 at 12:22 p.m., Surveyor observed a family member, and a child go into Resident #39's room. Resident #39 was on contact isolation for MRSA to the blood and the family members did not use PPE. In an interview on 08/03/2025 at 12:23 p.m., CNA G said Resident #39 was on contact isolation. CNA (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	G said the family had been educated several times on the importance of putting on PPE, but they had refused to wear the PPE. CNA G said anyone that went into a room of a resident on contact isolation needed to use PPE to prevent the spread of infection. CNA G said visitors going into a resident's room that was on contact isolation had to use a gown, and gloves. In an interview on 08/03/2025 at 12:39 p.m., the FM said the nurse did educate them about the importance of wearing PPE. The FM said her sister was an NP and she told them that as long as they do not have contact with blood or other body fluids, they should be ok. The FM said they do not provide any care to Resident #39, so she was not worried about being infected. The FM said she washed her hands when she comes into the room and washed her hands before leaving. She knows how important it was to wash her hands. In an interview on 08/03/25 at 3:15 p.m. LVN H said they had educated the family several times and they were still refusing to don PPE. LVN H said Resident #39 had MRSA to the blood and if the family had contact with any body fluids there could be transmission of the infection. LVN H said the chance of them getting infected was very small, but it was still a probability. LVN H said they could not prevent the family from seeing Resident #39 because he had a right to have visitors. Observation on 08/04/2025 at 9:45 a.m. revealed Resident #39 was in his room lying in bed. He had a peripheral intravenous lock covered with a transparent dressing with no date and no initials on his right hand. There were no signs or symptoms of infection or infiltration noted at the IV site. In an interview on 08/04/2025 at 9:49 a.m. LVN P stated she was the nurse for Resident #39. She stated that the nurse who initiated the IV was responsible for labeling the dressing with the date and initials. LVN P stated that it was important to label the IV site to know when the last time it was changed. She stated that if it was not changed within three days then it can cause infection. She stated that she has not checked his IV site yet. LVN P stated that the IV site should be checked every shift. The site was to be checked for any signs of infection, the date and signature on the dressing, check that the saline lock cap was in place. She stated she had training on IV administration once a month as well as skill check offs. LVN P confirmed the resident had a peripheral IV lock in his right hand covered with a transparent dressing that was not labeled. In an interview on 08/04/2025 at 11:00 a.m., the DON stated that the charge nurse was responsible for labeling the IV dressing. The IV dressing was to be labeled with the date and initials of the nurse who inserted the IV. She stated that the negative outcome of not labeling dressing was that it go over the recommended standard time of every 72 hours and could cause infection. She stated that IV administration class was done annually and as needed. In an interview on 08/05/2025 at 4:38 PM the DON said Resident #39 was on contact isolation and anyone entering into his room had to wear PPE. The DON said if someone was not wearing PPE, they could potentially be infected with the same organism that Resident #39 had or they could carry some of the bacteria and spread it to other areas of the facility if they touched the doorknobs, handrails or other areas of the facility. The DON said she had never had a situation where visitors refused to wear PPE. The DON said she had instructed the nurses to educate the families that came to visit a resident on transmission-based precautions on the importance of wearing PPE. The DON said even though the family did not don the PPE, they could not prevent the family from visiting the resident. The DON said she told the family to stay in the room and before leaving the room to wash their hands. 3. Record review of Resident #47's face sheet dated 8/4/25 revealed a [AGE] year old female (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admitted originally on 7/8/25. Her diagnoses included, neurogenic bladder (a condition where nerve damage affects bladder control, leading to problems with either storing or releasing urine), needs for assistance with personal care. Record review of Resident #47's Comprehensive Care Plan initiated: 07/12/2025 documented, Problem: Resident #47 is dependent on staff for meeting emotional, intellectual, physical and social needs related to physical limitations. Interventions: Resident #47 needs assistance with ADLs as required during the activity. Record review of Resident #47's MDS dated [DATE] documented a Brief Interview of Mental Status score of 11/moderate impaired cognition, as well as dependent of staff to assist in activities of daily living. Indwelling catheter used. During an observation on 08/4/2025 at 9:29 AM, CNA C entered Resident #47's room after knocking. CNA C began with washing hands for 30seconds, gloved up, and prepared table of needed supplies. CNA C continued by raising bed and then discarded gloves. After discarding the gloves, CNA C continued with applying hand sanitizer and she did apply new gloves. CAN C proceeded with catheter care and proceeded placed a new brief on resident, using same pair of gloves, catheter care, and applied new brief. During an interview on 08/4/2025 at 9:58 AM with CNA C stated that they should have changed those gloves after cleaning the foley catheter, for the reason to minimize contraction of infection. CNA C stated they should have washed hands/use hand sanitizer and changed gloves, before, during, and after care to minimize chance of infection. CNA C stated that resident could get an infection because she did not changed gloves when changing from one area to another area. During an interview on 08/7/25 at 10:05 AM with the DON, The DON stated that after perineum care, hand hygiene should have been performed prior to moving to the second part of applying the new brief. The DON stressed the importance of infection prevention and stated that personnel were educated and observed by her performing specific care during checkoffs, before being allowed to work on floor independently. DON stated this practice could put Resident #47 at risk for infection. Record review of the facility's Infection Control policy dated 05/13/23 revealed: This facility has established and maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. 2.All staff are responsible for following all policies and procedures related to the program. 5. Isolation Protocol (Transmission Based Precautions) a. A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current CDC guidelines. b. Resident will be placed on the least restrictive transmission-based precaution for the shortest duration possible under the circumstances. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.13. Resident/Family/Visitor Education and Screening a. Residents, family members, and visitors are provided information relative to the rationale for the isolation, behaviors required of them in observing these precautions, and conditions, for which to notify the nursing staff. b. Information on various infectious diseases is available from our Infection Preventionist. c. Isolation signs are used to alert staff, family members, and visitors of transmission-based precautions.		