STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676136	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huebner Creek Health & Rehabilitation Center	8306 Huebner Rd San Antonio, TX 78240

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observation, interview and record review the facility failed to provide personal privacy for 3 of 6 (Resident #2, Resident #4, and Resident #6) reviewed for dignity. 1. The facility failed to ensure Resident #2 was provided with privacy during wound care. 2. The facility failed to ensure Resident #4 was provided with privacy during wound care. 3. The facility failed to ensure Resident #6 was provided with privacy during ADLs. These failures could affect residents by contributing to poor self-esteem, decreased self-worth, and quality of life. Findings included: 1. Record review of Resident #2's Admission Record, dated 11/13/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: chronic ischemic heart disease (heart's blood supply is reduced over time), muscle wasting, malnutrition, hyperlipidemia (high levels of fat in the blood), depression (low mood), anxiety (feeling of dread, fear, or uneasiness), hypertension (high blood pressure), chronic obstructive pulmonary disease (lung diseases that block airflow and make it difficult to breathe), and GERD (digestive disease in which stomach acid or bile irritates the food pipe lining). Record review of Resident #2's quarterly MDS assessment, dated 9/19/24, revealed the resident had a BIMS score of 9, suggesting moderately impaired cognition. Further review of this document revealed Resident #1 had a pressure ulcer. Record review of Resident #2's Order Summary, dated 11/13/24, revealed an order for wound care as follows: .Cleanse pressure ulcer to left hip with NS, apply calcium alginate to wound bed, and cover with dressing. One time a day every Mon, Wed, Fri . Record review of Resident #2's Care Plan revealed: . [Resident #2] has a pressure ulcer to the Left Trochanter-Stage 4 .Administer treatments as ordered . (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of wound care for Resident #2's pressure ulcer to the left hip, on 11/12/24 beginning at 10:15 am, revealed LVN K entered the resident's room, explained the procedure, performed hand hygiene, and completed wound care without completely closing the door or the privacy curtain. During an interview on 11/12/24 at 11:24 am, LVN K said when providing resident care, she wanted to make sure the resident was always covered, the door was closed, and the privacy curtain was closed. 2. Record review of Resident #4's Admission Record, dated 11/13/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), hypertension (high blood pressure), muscle weakness, type 2 diabetes (condition in which the body has trouble controlling blood sugar and using it for energy), hyperlipidemia (high levels of fat in the blood), acute kidney failure (condition in which kidneys suddenly are unable to filter waste from blood), UTI, and malnutrition. Record review of Resident #4's Care Plan, dated 11/4/24, revealed: The resident has a pressure ulcer . Stage 2 Left Buttock .Administer treatments as ordered . Record review of Resident #4's comprehensive MDS assessment, dated 11/5/24, revealed the resident had a BIMS score of 12, suggesting moderately impaired cognition. Further review of this document revealed Resident #4 had a pressure ulcer. Record review of Resident #4's Order Summary, dated 11/13/24, revealed an order for wound care as follows: .Cleanse wound to buttock with wound cleanser daily; Apply Zinc/collagen; cover with dressing every day shift for wound management . Observation of wound care for Resident #4's pressure ulcer to left buttock, on 11/12/24 beginning at 10:32 am, revealed LVN K entered the resident's room, explained the procedure, performed hand hygiene, and completed wound care without closing the door, privacy curtain, or the blinds. During an interview on 11/12/24 at 11:24 am, LVN K said she had not noticed Resident #4's door was not closed. LVN K further stated it was important the door, privacy curtain, and blinds were closed for resident privacy. LVN K said not providing residents with privacy during care could affect their dignity. LVN K said part of her facility orientation included ensuring the residents' privacy and dignity, which included ensuring the door and privacy curtain was closed during resident care. 3. Record review of Resident #6's Admission Record, dated 11/14/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: dementia, reduced mobility, cognitive communication deficit, need for assistance with personal care, and ostomy status. Record review of Resident #6's Care Plan, dated 4/12/23, revealed: .Incontinent care after each episode . The resident has an ADL Self Care Performance Deficit .Assist with personal hygiene as required .Toilet use: requires staff x1 for assistance . Record review of Resident #6's quarterly MDS assessment, dated 10/3/24, revealed the resident had a BIMS score of 6, suggesting severely impaired cognition. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of perineal care and dressing for Resident #6, on 11/13/24 beginning at 9:57 am, revealed CNA E entered the resident's room, closed the door, explained the procedure, completed perineal care, and placed a new brief and pants on Resident #6 without closing the privacy curtain, or the blinds. Further observation revealed CNA E assisted Resident #6 to sit up on the side of the bed and removed her top without closing the privacy curtain, or the blinds. During an interview on 11/14/24 at 9:15 am, CNA E said when providing resident care, the blinds, curtain, and the door must be closed. CNA E further stated it was important to ensure the resident's decency and privacy. CNA E said it was already embarrassing to have someone else provide the care and to not provide privacy during care could be embarrassing and affect the residents mentally and emotionally. During an interview on 11/13/24 at 10:26 am, RN F said it was important to ensure privacy when care was provided to residents by ensuring the door, blinds, and curtains were closed all the way. RN F further stated this was a lack of trust and if someone walked into the resident's room while care was provided it could be embarrassing for the resident especially if a resident had a wound on their bottom. During an interview on 11/13/24 at 2:10 pm, LVN L said staff were expected to provide resident's privacy during care by pulling the curtain if the resident had a roommate, and ensuring the blinds and the door were closed. LVN L said it was important to provide residents with privacy and not doing so was not honoring the residents' right to privacy. During an interview on 11/13/24 at 3:13 pm, LVN M said her expectation was for staff to ensure when they provided care the privacy curtains were drawn all the way and the door and blinds were closed. LVN M further stated the residents had a right to privacy and it could be embarrassing to them. During an interview on 11/13/24 at 11:22 am, the DON said he expected staff to pull the curtains all the way, especially if the resident had a roommate, and close the blinds when care was provided. The DON further stated not providing privacy to the residents could be embarrassing. The DON said he and the ADONs were responsible for ensuring staff were protecting the residents' privacy and dignity when care was provided. During an interview on 11/14/24 at 2:40 pm, the Administrator said he expected the staff to protect the residents' privacy when care was provided by ensuring privacy curtains were drawn all the way and the doors and blinds were closed as well. The Administrator said this was important for the residents' dignity and could affect them psychologically because it could be embarrassing for them if someone walked in. Record review of the facility's policy titled Perineal Care, effective 5/11/22, revealed: It is essential that residents using various devices, absorbent products .be checked (and changed as needed) on a schedule based on .professional standards of practice .This procedure aims to maintain the resident dignity and self-worth and reduce embarrassment . Record review of the facility's policy titled Resident Rights, revised 11/28/16, revealed: The resident has a right to be treated with respect and dignity .The resident has a right to personal privacy .The resident has a right to a safe .environment, including but not limited to receiving treatment and supports for daily living .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 39251 Based on observations, interviews, and record review, the facility failed to ensure resident medical records are kept in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete and accurately documented for 3 of 4 residents (Residents #1, Resident #3, and Resident#4) reviewed for accuracy of records. 1. The facility failed to ensure Resident #1's treatments were documented per facility policy. 2. The facility failed to ensure Resident #3's treatments were documented per facility policy. 3. The facility failed to ensure Resident #4's treatments were documented per facility policy. These deficient practices could place residents at risk for improper care due to inaccurate records. The findings were: 1. Record review of Resident #1's Admission Record, dated 11/13/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: sepsis (life-threatening complication of an infection), acute kidney injury (sudden decline in kidney function that may be reversible), hypertension (high blood pressure), obstructive sleep apnea (disorder that occurs when the upper airway partially/completely collapses leading to reduced/absent breathing during sleep), and type 2 diabetes (condition in which the body has trouble controlling blood sugar and using it for energy) . Record review of Resident #1's comprehensive MDS assessment, dated 9/10/24, revealed the resident's BIMS score was 15, suggesting intact cognition. Record review of Resident #1's Care Plan, dated 9/20/24, revealed: . [Resident #1] has a pressure ulcer: Stage 3 Right hip .Administer treatments as ordered . Record review of Resident #1's Order Summary, dated 11/13/24, revealed an order for wound care as follows: .Cleanse Right Hip with wound cleanser. Apply Calcium Alginate; Honey; cover with dressing every day shift for wound management . Record review of Resident #1's November WAR revealed the resident did not have wound care to the right hip documented on the following dates: 11/3/24 and 11/8/24. Record review of Resident #1's Progress Notes revealed there was documentation of wound care treatments on the above-mentioned dates. During an interview on 11/9/24 at 2:58 pm, Resident #1 said he received wound care treatments as ordered. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/13/24 at 2:02 pm, LVN H said he was responsible for wound care on occasion, but the facility usually had someone scheduled to cover for the treatment nurse when she was not there. LVN H further stated he did not do any wound care on 11/8/24. Attempted interview on 11/13/24 at 4:54 pm with PCP O was unsuccessful. 2. Record review of Resident #3's Admission Record, dated 11/8/24, revealed the resident was readmitted to the facility on [DATE] with diagnoses that included: dementia, type 2 diabetes, malnutrition, PVD, HTN, Bilateral AKA, need for assistance with personal care, depression, muscle weakness, aphasia, anxiety, OSA, spastic hemiplegia, hearing loss, and spinal stenosis. Record review of Resident #3's Care Plan, dated 9/30/24, revealed: .The resident has a pressure ulcer to the Tight Buttock - stage 4 Sacrum-stag 4 .Administer treatments as ordered Follow facility policies/protocols for the prevention/treatment of skin breakdown . Record review of Resident #3's quarterly MDS assessment, dated 10/4/24, revealed the resident had a BIMS score of 9, suggesting severely impaired cognition. Record review of Resident #3's Order Summary, dated 11/8/24, revealed the following orders: Cleanse Right buttock wound with wound cleanser Apply Santyl, apply calcium Alginate to wound bed; cover with dressing every day shift. Cleanse Right buttock wound with wound cleanser Apply Santyl, apply calcium Alginate to wound bed every day shift. Cleanse Sacrum with wound cleanser; Apply Santyl; Verbal cover with dressing one time a day. Triad to Buttocks every day and evening shift. Santyl External Ointment 250 UNIT/GM (Collagenase) Apply to right buttock topically every day shift every other day for Skin management cleanse right buttock with wound cleanser apply Santyl cover with dressing. Record review of Resident #3's September WAR revealed: Santyl Ointment 250 Unit/GM; apply to right buttock topically every other day for skin management was not documented on 9/21/24. Triad to buttocks every day and evening shift was not documented on: 9/6/24 - day shift, 9/8/24 - day and evening shift, 9/10/24 - day shift, and 9/15/24 - evening shift. Record review of Resident #3's October WAR revealed: Cleanse right buttock wound with wound cleanser; apply Santyl; apply calcium alginate to wound bed every day shift was not documented on: 10/11/24, 10/12/24, 10/13/24, 10/21/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Cleanse right buttock wound with wound cleanser; apply Santyl; apply calcium alginate to wound bed; cover with dressing every day shift was not documented on: 10/26/24 and 10/27/24. Cleanse sacrum with wound cleanser; apply Santyl; cover with dressing one time a day was not documented on:10/11/24, 10/12/24, 10/13/24, 10/21/24, 10/26/24, and 10/27/24. Santyl Ointment 250 Unit/GM; cleanse right buttock with wound cleanser; apply Santyl; cover with dressing every other day was not documented on:10/11/24, 10/13/24, 10/21/24, and 10/27/24. Record review of Resident #3's November WAR revealed: Cleanse right buttock wound with wound cleanser; apply Santyl; apply calcium alginate to wound bed; cover with dressing every day shift was not documented on 11/3/24. Cleanse sacrum with wound cleanser; apply Santyl; cover with dressing one time a day was not documented on 11/3/24. Record review of Resident #3's Progress Notes revealed there was documentation of wound care treatments on the above-mentioned dates. During an interview on 11/13/24 at 1:02 pm, RN F said the treatment nurse was responsible for wound care during the week. RN F further stated she did not work weekends and did not know who was responsible for wound care on the weekends. RN F said if the wound care did not come in, the floor nurse had to do the treatments; however, they did not have the keys to the treatment nurse's office or the treatment cart and so treatments could not be provided. RN F said she had not had to provide wound care in a long time because there was always someone to cover for the treatment nurse when she was not available. RN F further stated the ADONs, and weekend supervisors covered for the treatment nurse when she was not available, and the floor nurses had not provided wound care in September, October, and November. During a telephone interview on 11/13/24 at 4:32 pm, LVN G said when the treatment nurse was not available the floor nurses were responsible for wound care. LVN G said when he was scheduled to provide wound care, he always did but might not have documented it. LVN G said every time Resident #3 had a bowel movement the wound had to be cleaned and the dressing changed. LVN G said sometimes he forgot to document treatments. LVN G said when treatments were not provided, the reason had to be documented in the progress notes and the WAR. LVN G further stated it was important to document treatments so that if a wound worsened, it was known why it was getting worse. During a telephone interview on 11/13/24 at 4:22 pm, the WC MD said she was not notified when there were missed treatments. Attempted telephone interview on 11/13/24 at 4:44 pm with RN I was unsuccessful. During a telephone interview on 11/13/24 at 4:45 pm, the NP said she had not been notified of any missed treatments for Resident #3. During an interview on 11/13/24 at 3:31 pm, LVN K said she provided Resident #3's treatments faithfully, adding he received them every day. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of Resident #4's Admission Record, dated 11/13/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), hypertension (high blood pressure), muscle weakness, type 2 diabetes (condition in which the body has trouble controlling blood sugar and using it for energy), hyperlipidemia (high levels of fat in the blood), acute kidney failure (condition in which kidneys suddenly are unable to filter waste from blood), UTI, and malnutrition. Record review of Resident #4's Care Plan dated 11/4/24, revealed: .The resident has a pressure ulcer or potential for pressure ulcer development: Stage 2 Left Buttock .Administer treatments as ordered . Record review of Resident #4's comprehensive MDS assessment, dated 11/5/24, revealed the resident had a BIMS score of 12, suggesting moderately impaired cognition. Record review of Resident #4's Order Summary, dated 11/13/24, revealed an order for wound care as follows: .Cleanse wound to buttock with wound cleanser daily; Apply Zinc/collagen; cover with dressing every day shift for wound management . Record review of Resident #4's November WAR revealed: Cleanse wound to buttock with wound cleanser daily; Apply Zinc/collagen; cover with dressing every day shift for wound management was not document on 11/2/24 and 11/3/24. During an interview (translated from Spanish) on 11/12/24 at 10:54 am, Resident #4 said he received his treatments as ordered. During an interview on 11/13/24 at 11:22 am, the DON said he was not aware of the missing documentation. The DON further stated he was sure the treatments were completed but were just not documented. The DON said if the treatments were missed, the nurses should have notified the physician. The DON further stated the nurses sometimes provided the treatments but did not document them. The DON said he expected the nurses to document treatments provided in the WAR or progress notes. During an interview on 11/13/24 at 2:10 pm, LVN L said the facility had a treatment nurse Monday - Friday and in the event she was not available she covered for her, but this did not include weekends. LVN L said wound care treatments were documented in the WAR. LVN L further stated the DON or designee were responsible for ensuring treatments were completed. LVN L said she did not provide wound care for Resident #3 on 9/6/ 24, 9/10/24, 9/16/24, 9/21/24, 10/11/24, or 10/21/24. LVN L said she did not provide wound care for Resident #1 on 11/8/24. LVN L further stated if she had provided wound care on the mentioned dates for Resident #1 and Resident #3, she would have documented it. LVN L said either the weekend supervisor or the nurse assigned to the residents were responsible for the wound care. During an interview on 11/13/24 at 3:13 pm, LVN M said the treatment nurse was responsible for wound care and the charge nurses were responsible when she was unavailable. LVN M said she had not provided wound care at the facility. LVN M said wound care should have been documented in the TAR/MAR. LVN M said if the treatments were missed it could affect the resident by delaying the healing process. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/13/24 at 3:31 pm, LVN K said she was responsible for ensuring wound care treatments were completed. LVN K further stated it was her understanding that the ADONs were responsible for wound care during the week and the charge nurses on the weekends when she was not available. LVN K said wound care treatments were documented in the WAR and if treatments were missed, the reason why they were missed should also be documented. LVN K said LVN L completed audits and if there was missing documentation, she would notify her. Attempted telephone interview on 11/13/24 at 4:54 pm with PCP O was unsuccessful. During an interview on 11/14/24 at 2:40 pm, the Administrator said the treatment nurse should document treatments provided and there should be a system in place to monitor that documentation was completed properly. The Administrator further stated one of the ADONs were responsible for ensuring documentation was completed but was not sure how the DON had it arranged. The Administrator said treatments needed to be documented so that the facility staff knew that the treatments were provided and if it they were effective. Record review of the facility's procedure, titled, Pressure Injury: Prevention, Assessment, and Treatment revised 8/12/16, revealed: .6. Nursing Action/Rationale .10 .Sign off on treatment completed (i.e., Stage I through Stage IV) .

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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** 39251 Based on observations, interviews, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 5 of 6 residents (Resident #1, Resident #2, Resident #4, Resident #5, and Resident #6) reviewed for infection control. 1. The facility failed to use proper infection control practices during wound care and perineal care for Resident #1. 2. The facility failed to use proper infection control practices during wound care for Resident #2. 3. The facility failed to use proper infection control practices during wound care for Resident #4. 4. The facility failed to use proper infection control practices during toileting for Resident #5. 5. The facility failed to use proper infection control practices during hygiene, dressing, and linen change for Resident #6. 6. The facility failed to ensure staff complied with Enhanced Barrier Precautions when providing resident care for Resident #1, Resident #2, Resident #4, and Resident #6. These deficient practices could place residents at risk for infection and delayed wound healing. Findings included: 1. Record review of Resident #1's Admission Record, dated 11/13/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: sepsis (life-threatening complication of an infection), acute kidney injury (sudden decline in kidney function that may be reversible), hypertension (high blood pressure), obstructive sleep apnea (disorder that occurs when the upper airway partially/completely collapses leading to reduced/absent breathing during sleep), and type 2 diabetes (condition in which the body has trouble controlling blood sugar and using it for energy) . Record review of Resident #1's comprehensive MDS assessment, dated 9/10/24, revealed the resident's BIMS score was 15, suggesting intact cognition. Further review of this document revealed Resident #1 was occasionally incontinent of the bladder, always incontinent of bowel, was Dependent - Helper does ALL of the effort for toileting hygiene, which included the ability to maintain perineal hygiene, and had a pressure ulcer. Record review of Resident #1's Care Plan, dated 9/20/24, revealed: . [Resident #1] has a pressure ulcer: Stage 3 Right hip .Administer treatments as ordered .The resident has bladder incontinence .The resident has bowel incontinence .Provide pericare after each incontinent episode . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's Order Summary, dated 11/13/24, revealed an order for wound care as follows: .Cleanse Right Hip with wound cleanser. Apply Calcium Alginate; Honey; cover with dressing every day shift for wound management . Observation of wound care and perineal care (washing the genitals and anal area) for Resident #1 on 11/9/24 beginning at 2:39 pm, revealed RN P (assisted by LVN K) prepared to provide wound care for Resident #1's right hip. RN P entered the resident's bathroom and washed her hands for 5 seconds. RN P then returned to the treatment cart, donned gloves, gathered the treatment supplies, and placed them on top of the treatment cart without sanitizing the top of the cart. RN P and LVN K entered Resident #1's room without donning PPE, explained the procedure, and placed the treatment supplies on top of the resident's side table without sanitizing it. RN P removed the dressing to Resident #1's right hip, without removing the gloves, performing hand hygiene, or donning clean gloves. RN P cleaned Resident #1's wound using wound cleanser. The wound was patted dry, and the treatments and clean dressing were applied. RN P entered the resident's bathroom and washed her hands for 6 seconds. RN P returned to provide perineal care for Resident #1. RN P wiped Resident #1's bottom three times using the same surface of the wipe. Resident #1 was positioned on to his back. RN P removed additional wipes from the package and proceeded perineal care. RN P wiped under Resident #1's abdominal folds several times due to the resident having feces under the folds. Resident #1 said the CNA must not have cleaned him properly the prior evening. RN P did not clean Resident #1's penis during perineal care despite the resident having white residue visible on the glans. RN P and LVN K placed a clean brief on Resident #1, RN P did not remove the gloves or perform hand hygiene. RN P then disposed of the trash and replaced Resident #1's blanket still wearing the same gloves used for perineal care. RN P removed her gloves and washed her hands for 4 seconds. During an interview on 11/9/24 at 3:11 pm, Resident #1 said some CNAs provided thorough perineal care and others did not. Resident #1 said he last had a bowel movement on 11/8/24 around 8:00 pm and this was when he last received incontinent care. Resident #1 said when he was not provided with proper incontinent/perineal care it made him feel filthy and very uncomfortable. Resident #1 said he liked to be clean, and he always kept himself clean. Resident #1 said he did not like it at all and did not feel good about it all. Resident #1 said he had not mentioned this to the facility staff because he figured he was getting a shower the next day, so he just waited. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/9/24 at 4:35 pm, RN P said she usually cleaned the top of the treatment cart at the beginning and the end of the shift, so she knew it was clean because only the nurses used that cart. RN P further stated it was important to sanitize the top of the treatment cart so that she knew her area was clean. RN P said the process for hand washing was to run the water, get soap, and wash hands for 20 seconds, rinse, dry, and close the faucet with a clean paper towel. RN P further stated she guessed she washed her hands for 20 seconds during Resident #1's care, adding she counted in her head. RN P said it was important to wash hands for the recommended amount of time to get rid of all the possible microbes on the hands. RN P further stated residents could be affected by improper hand washing because it could be a mode of transmission for infection. RN P said hand hygiene should be done before performing a procedure, after you were done with the procedure, when hands were visibly dirty to prevent cross contamination, between residents, and before donning gloves. RN P said it was important to sanitize the table where the treatment supplies were placed to get rid of the microbes. RN P said not sanitizing the table could affect the residents, but the treatment supplies were in the packages. RN P said she did change her gloves when going from dirty to clean but she did not sanitize her hands. RN P further stated it was important to perform hand hygiene when changing gloves to prevent microbes. RN P said she was not supposed to use the same surface of the wipe more than once so the clean area did not get contaminated. RN P said she did not have to clean the residents' penis during perineal care all the time because the CNAs did it. RN P said she did not want to touch Resident #1's penis all the time, adding the CNAs could do it. RN P said Resident #1 was not on Enhanced Barrier Precautions. RN P said she was required to wear PPE if a resident was on EBP, which included a gown, gloves, mask, and eye protection when necessary. 2. Record review of Resident #2's Admission Record, dated 11/13/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: chronic ischemic heart disease (heart's blood supply is reduced over time), muscle wasting, malnutrition, hyperlipidemia (high levels of fat in the blood), depression (low mood), anxiety (feeling of dread, fear, or uneasiness), hypertension (high blood pressure), chronic obstructive pulmonary disease (lung diseases that block airflow and make it difficult to breathe), and GERD (digestive disease in which stomach acid or bile irritates the food pipe lining). Record review of Resident #2's quarterly MDS assessment, dated 9/19/24, revealed the resident had a BIMS score of 9, suggesting moderately impaired cognition. Further review of this document revealed Resident #1 had a pressure ulcer. Record review of Resident #2's Order Summary, dated 11/13/24, revealed an order for wound care as follows: .Cleanse pressure ulcer to left hip with NS, apply calcium alginate to wound bed, and cover with dressing. One time a day every Mon, Wed, Fri . Record review of Resident #2's Care Plan revealed: .[Resident #2] has a pressure ulcer to the Left Trochanter-Stage 4 .Administer treatments as ordered . Observation of wound care of a pressure ulcer to the left hip for Resident #2 on 11/12/24 beginning at 10:15 am, revealed LVN K gathered treatment supplies, entered Resident #2's room without donning PPE, placed treatment supplies on top of the glove box on the side table, and washed her hands. Further observation revealed LVN K's nails were long. LVN K explained the procedure, removed the old dressing, and placed it in a biohazard bag. LVN K changed her right glove, the glove tore, and LVN K donned another glove without performing hand hygiene. She then cleaned Resident #2's wound, patted it dry, applied the calcium alginate dressing, and outer dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of toileting for Resident #5 on 11/13/24 beginning at 9:47 am revealed CNA D knocked on the door, wheeled Resident #5 into the restroom, sanitized hands, donned gloves, removed brief, assisted Resident #5 onto the commode, removed gloves, and exited the restroom without performing hand hygiene. CNA D stood outside the restroom door until Resident #5 said she was done. CNA D washed her hands for 11 seconds, donned gloves, wiped Resident #5's right and left vaginal area front to back, removed gloves, donned clean gloves without performing hand hygiene, wiped resident's anal area back to front, wiped a 2nd and 3rd time front to back, and wiped again back to front. CNA D placed a clean brief on Resident #5 without changing gloves, replaced the resident's pants, removed gloves, assisted Resident #5 into her wheelchair, and washed hands for 6 seconds. CNA D did not assist Resident #5 with hand hygiene after using the restroom. During a telephone interview on 11/14/24 at 9:38 am, CNA D said when she performed hand hygiene she sang Happy Birthday like twice. CNA D further stated she did not remember how long she should wash her hands for, adding it was like a minute or 2. CNA D said performing hand hygiene properly was important to kill bacteria on the hands and this could affect the residents due to cross contamination. CNA D said when performing perineal care for residents it was important to wash from clean to dirty, so front to back, because the residents could get an infection. CNA D said she was supposed to have hand sanitizer with her and sanitize her hands between glove changes. CNA D further stated this was important to avoid cross contamination, adding the resident could get an infection. CNA D said gloves should be changed when going from dirty to clean, adding this was important to avoid cross contamination. CNA D further stated she was expected to assist residents to wash their hands after using the restroom, adding this was important for infection control purposes. It could affect the residents because of germs and bacteria on the residents' hands and they will then touch things and eat with dirty hands. 5. Record review of Resident #6's Admission Record, dated 11/14/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: dementia (group of thinking and social symptoms that interferes with daily functioning), cognitive communication deficit (difficulty with thinking and language), muscle weakness, receptive-expressive language disorder, need for assistance with personal care, depression (low mood), and a colostomy (surgical procedure creating an opening in the abdomen to redirect stool from the anus). Record review of Resident #6's Care Plan, dated 4/12/23, revealed: .The resident has an ostomy . Record review of Resident #6's quarterly MDS assessment, dated 10/3/24, revealed the resident had a BIMS score of 6, suggesting severely impaired cognition. Further review of this document revealed Resident #6 was Dependent - Helper does ALL of the effort for toileting hygiene, lower body dressing, and putting on footwear, and required Substantial/maximal assistance - Helper does MORE THAN HALF the effort for upper body dressing and personal hygiene, which included combing hair, and bed-to-chair transfer. This document also revealed Resident #6 had an ostomy [surgical procedure creating an opening in the abdomen to allow waste to leave the body] and was always incontinent of the bladder. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of perineal care and dressing for Resident #6 on 11/13/24 beginning at 9:57 am revealed CNA E explained procedure, donned gloves without performing hand hygiene and did not wear a gown, uncovered the resident, placed the blanket in a plastic bag, changed gloves without performing hand hygiene, opened clean brief and package of wipes, removed several wipes from package, wipe the left, right side, and middle of Resident #6's vaginal area using the same wipe, removed more wipes from the package, wiped right buttock four times using the same surface, wiped the left buttock three times using the same surface, changed gloves without performing hand hygiene, the right glove tore, and CNA E did not replace it. CNA E placed the new brief on Resident #6, removed gloves, did not perform hand hygiene, went to the linen cart in the hallway to get trash bag and more gloves, returned to Resident #6's room and donned gloves without performing hand hygiene, removed clothes from closet, placed pants on Resident #6, placed pillows and the rest of the dirty linen in a plastic bag, removed the resident's sweater and top and placed them in the plastic bag, removed gloves and donned new gloves without performing hand hygiene, put shoes on the resident and brushed her hair, removed gloves, did not perform hand hygiene, left room the resident's room to get a gait belt, returned to Resident #6's room, did not perform hand hygiene, placed gait belt on Resident #6 and assisted her into her wheelchair, CNA E said her hands were clean. Further observation revealed CNA E had long fingernails. CNA E said Resident #6 was on EBP as a precaution because she had a rash, but it was resolved. CNA E further stated the EBP was precaution for like peri-care and stuff because Resident #6 had a colostomy, so it was there in case staff wanted to wear PPE. CNA E said she did not wear PPE because she did not access the colostomy. During an interview on 11/14/24 at 9:15 am, CNA E said hand hygiene should be performed as soon as she walked into the resident's room. CNA E further stated once she completed perineal care, she should either sanitize or wash her hands, then put on new gloves, and apply the clean brief and clothing. CNA E said this was important to avoid cross contamination, especially when performing perineal care. CNA E said if she wiped the wrong way during perineal care (back to front) the resident could get a yeast infection or bacterial vaginitis. CNA E said hand hygiene should be performed between glove changes. CNA E said the facility had a policy regarding nails and said she knew hers were too long. CNA E further stated dirty bacteria can stay in the nail beds and fake nails tend to hide bacteria underneath. The resident could also be hurt with long nails, so they were supposed to be short, just by the nail bed. CNA E said she should never use the same surface more than once when wiping a resident. CNA E said this was important because she could have transferred bacteria from one surface to another and this could cause an infection. CNA E said when a glove tore, she was supposed to take it off, and replace it because she could get bacteria on her hands. CNA E said EBP was a precaution in case fecal matter got on her or if the resident had an infection in the feces in the colostomy bag. CNA E further stated not following EBP could affect the residents because a lot of bacteria can get into an open area and cause infection. 6. Signs for EBP and PPE were observed outside the rooms of Resident #1 on 11/9/24 at 2:39 pm, Resident #2 on 11/12/24 at 10:15 am, Resident #4 on 11/12/24 at 10:32 am, Resident #5 on 11/13/24 at 9:47 am, and Resident #6 on 11/13/24 at 9:57 am. Further observations revealed CNA E did not wear PPE when care was provided to Resident #6, LVN K did not wear PPE when care was provided to Resident #1, Resident #2, Resident #4, and RN P did not wear PPE when care was provided to Resident #1. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 11/12/24 at 11:24 am, LVN K said she should not have placed the treatment supplies on the bed because she did not know what had been on Resident #2's bed. LVN K said she should have cleaned Resident #4's table for infection control because she did not know what had been on the table and to avoid cross contamination. LVN K said she did not realize she had placed the cleanser bottle on the brief when preforming wound care for Resident #4 which could cause to cross contamination. LVN K said it was important treatment supplies were not placed on a dirty surface because it may be used for more than one resident, and it was placed back in the treatment cart without sanitizing the cleanser bottle and contaminated the treatment cart. LVN K said when she touched the pad on the dressing for Resident #4, she contaminated the dressing that she applied to Resident #4's wound. LVN K said Resident #4 could be affected by this because whatever was on her hands went onto the pad and then onto the wound, which can lead to infection to the wound. LVN K said it was important for nails to be trimmed to prevent infection and for resident safety, so that they were not accidentally scratched, and gloves were not punctured. LVN K further stated residents could be affected due to germs that she may carry from having long nails, possible injuries, or torn gloves. LVN K said she should perform hand hygiene when changing gloves to avoid infection due to cross contamination. LVN K further stated the residents could be affected by this because it could make the bacteria on her hands could contaminate the wound which could lead to infection. LVN K said Resident #2 was on EBP because of his wound. LVN K further stated EBP was to let the staff know that a resident had a wound, indwelling catheter, or feeding tube, in case it was very soiled so that it did not get on your hands or gloves and so that bodily fluids did not get on her. LVN K said PPE was only required if a resident was on droplet or airborne precautions, with MRSA for example, but not for EBP. LVN K said she was just told that a sign had to be outside the door for residents that had a feeding tube, indwelling catheter, or wounds. During an interview on 11/13/24 at 11:22 am, the DON said he was the facility's Infection Preventionist. The DON said he expected staff to complete wound care properly, without cross contamination. The DON further stated staff were expected to perform hand hygiene when they enter the resident's room, dressings were removed, and gloves were changed. The DON said every time staff changed their gloves, they should sanitize their hands with ABG for 15-20 seconds or wash hands for approximately 30 seconds to remove most of the bacteria from their hands. The DON said when a glove tore staff were expected change it because they can get sick themselves from infection. The DON said he could not remember the length of fingernails allowed but said they should be trimmed and well-kept because they could contribute to cross contamination. The DON said standard practice was that staff pull out all the wipes needed when providing care to resident and should not reach into the package of wipes because they may be contaminating the package of wipes even if they were used for one resident. The DON said he expected staff to perform perineal care according to the facility policies/procedures. The DON further stated he expected staff to clean the penis every time they provide perineal care on male residents because there could be build up that may cause infections. The DON said he expected staff to wipe front to back for female residents to avoid cross contamination with feces. The DON said he and the ADONs were responsible for ensuring perineal care was completed according to procedures. The DON said EBP was used when care was provided for residents with wounds. The DON further staff were expected to wear PPE (gloves, gown and mask when needed) when care was provided to avoid contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/13/24 at 2:10 pm, LVN L said she and the DON made observations to ensure staff were following infection control practices. LVN L said following infection control practices were important to minimize the risk for infections. LVN L said staff were required to clean the penis of male residents during perineal care every time care was provided for incontinent residents. LVN L said this was important because it was standard practice and not cleaning the resident properly could lead to infections and skin breakdown. LVN L said when perineal care was provided for a female resident, staff should wipe from front to back because the vagina could potentially become contaminated with feces causing infection. LVN L further stated staff were expected to clean residents thoroughly, including under skin folds, when providing incontinent care for residents. LVN L said EBP were used when a resident had wounds, colostomy, catheters, urostomy, enteral feedings, or tracheostomy, for example. LVN L further stated staff were required to wear a gown and gloves when providing wound care and incontinent care for residents on EBP every time they were providing care, and this was not a choice. LVN L said it was important to wear the PPE to decrease the risk of infection to themselves, the community, and the resident. During an interview on 11/13/24 at 3:13 pm, LVN M said when staff provided perineal care and wound care, they were expected to change gloves when they were soiled. LVN M further stated staff were expected to perform hand hygiene for 20 seconds after removing gloves and before putting on new gloves to prevent the spread of infections. LVN M said staff were expected to clean the penis every time perineal care was provided for male residents. LVN M said when staff provided perineal care for female residents, they were expected to wipe front to back. LVN M said staff were expected to wipe under skin folds when providing incontinent care because bacteria grew were there was warmth and this area needed to be cleaned to prevent infection from starting. LVN M said staff were expected to wear PPE, gown, and gloves, when they provided direct care for residents that had a feeding tube, indwelling catheter, colostomy, urostomy, or wounds to prevent further spread of infections. During an interview on 11/14/24 at 2:40 pm, the Administrator said the DON was the Infection Preventionist. The Administrator further stated it was important for staff to adhere to policies/procedures to prevent the spread of infections. The Administrator said staff were expected to donn PPE (gown, gloves, hand hygiene) when they provided direct care for residents on EBP to ensure the residents were protected from potential infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled, Infection Control Plan: Overview, updated 03/2024, revealed: .The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection . The facility will require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene . Before and after entering isolation precaution settings . Before and after assisting a resident with personal care .Before and after changing a dressing; Upon and after coming in contact with a resident's intact skin . Before and after assisting a resident with toileting (hand washing with soap and water) After handling soiled or used linens, dressings, bedpans, catheters, and urinals; After handling soiled equipment . After removing gloves . Recommended techniques for washing hands with soap and water include . rubbing hands together vigorously for at least 20 seconds . Except for situations where hand washing is specifically required, antimicrobial agents such as ABHR are also appropriate for cleaning hands and can be used for direct resident care . Wearing gloves does not replace the need for hand washing because gloves may have small inapparent defects or be torn during use, and hands can become contaminated during removal of gloves .It is important that all staff involved in direct resident contact maintain fingernails that are clean, neat, and trimmed. Staff will wear intact disposable gloves in good condition and change after each use, which helps reduce the spread of microorganisms . Record review of the facility's policy titled, Enhanced Barrier Precautions, dated 4/1/24, revealed: .EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing . Further review of this policy revealed PPE was necessary when staff performed wound care, transferred a resident, changed briefs, or assisted with toileting, dressed a resident, provided hygiene, and changed linens.