

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2025
NAME OF PROVIDER OR SUPPLIER Town East Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3617 O'Hare Dr Mesquite, TX 75150	
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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 residents received adequate supervision and assistance devices to prevent accidents for one of thirteen (Resident #97) residents reviewed for accidents and supervision. The facility failed to prevent Resident #97's elopement from the facility on 6/12/25 without staff being aware that she had eloped. An Immediate Jeopardy (IJ) situation was identified on 8/13/25. While the IJ was removed on 09/05/25, the facility remained out of compliance at a scope of isolated with the potential for more than minimal harm, due to the facility's need of corrective systems. This failure could place residents at risk for serious injuries, serious harm and death. Record review of Resident #97's face sheet, dated 8/12/25, reflected an [AGE] year-old female who was admitted on [DATE]. Resident #97 had diagnoses which included dementia (brain disorders that cause a decline in cognitive functions), atrial fibrillation (an irregular heart rate), chronic kidney disease, obstructive and reflux uropathy (urine flow is blocked or flows backward), atherosclerotic heart disease (damage/disease in the heart's major blood vessels), and asthma (a chronic lung condition). Record review of Resident #97's nursing progress notes, dated 6/30/25, reflected Resident #97 was discharged from the facility on 6/30/25. Record review of Resident #97's quarterly Minimum Data Set assessment, dated 12/30/24, reflected Resident #97's BIMS score was 7, which indicated moderate cognitive impairment. Section GG0170 (Mobile Devices) reflected Resident #97 used a wheelchair for mobilizing. Section E (Behavior) reflected behavior was not exhibited for wandering. Record review of Resident #97's quarterly elopement evaluations, dated 2/11/25 and 5/13/25, reflected a score of 2, categorized as low risk for elopement. Record review of Resident #97's care plan, dated 8/12/25, reflected elopement interventions were not documented in the plan of care. Record review of the Provider Investigation Report, dated 6/19/25, reflected on 6/12/25, CNA E went to lunch and was driving down the road the facility was located on, which consisted of one lane each way, at approximately 7:15pm. CNA E noticed an elderly woman walking down the street, when the woman looked up, CNA E realized it was a resident, parked his truck and assisted her back to the facility. The physician and responsible party were notified regarding the incident. Resident was placed on 15-minute checks 6/13/25 until discharge 6/30/25. Resident #97 was discharged on 6/30/25 from the facility. Record review of a google search of the city the facility is located, Monthly Weather/AccuWeather, reflected the temperature was 80 degrees Fahrenheit on 6/12/2025, the date of Resident #97's elopement. During an interview on 8/12/25 at 9:28am, the DON stated she heard a staff member, unsure of the name, talking about the elopement incident on 6/13/25. The DON stated the charge nurse, RN AK, present during the incident, stated she was busy and forgot to report the incident. The DON stated she was unsure when the resident was last seen. The DON stated the exit doors didn't automatically open. The DON stated someone must be let out or the bar on the door was pushed and held for 15 seconds and the door lock released after the alarm sounded. The DON stated she was unsure how the resident left and stated when the alarm sounded, staff should have gone to the door and checked. The DON stated there was a receptionist from 10:00am to 10:30am, Monday-Friday, and left at 6:00pm. The DON stated once the receptionist left, (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the staff were responsible for watching who entered and exited the facility. An interview and observation on 08/12/2025 at 9:57am with the Maintenance Director revealed exit doors on each hall (100, 200, 200, 400), in both therapy rooms, the dining room, and the front door sounded the alarm when pushed for 15 seconds and the door lock released. Each door, except for the front door, contained signage, Push until alarm sounds, door will release in 15 seconds. Each door required a code to disarm the alarm and exit as an option . It was observed the front door followed the same process but staff at the nursing station accessed a key fob for exit/entry. During an interview on 8/12/25 at 12:20pm, CNA E revealed while sitting in his truck in the facility parking lot during his lunch break at 7:15pm, he observed Resident #97 walking out of the front entrance behind a group of family members. CNA E stated the family members walked to their cars parked in parking spaces in the front of the building while Resident #97 walked past them. CNA E stated Resident #97 was at the edge of the parking lot near the street the facility was located on. CNA E stated he got out of his truck and walked Resident #97 back into the building. During an interview on 8/12/25 at 2:30pm, RN AK revealed she checked Resident #97's vitals upon her return. RN AK stated Resident #97 appeared exhausted and short of breath, so she gave Resident #97 a breathing treatment. RN AK stated she informed the DON of the elopement the next morning because she was busy the day of the incident. RN AK stated the elopement protocol was to notify the DON within 2 hours. RN AK stated she could not remember hearing any door alarms 6/12/25. RN AK stated the last time she saw the resident was around dinner time. RN AK stated she was unaware the resident left. During an interview on 8/12/25 at 3:00pm, CNA AM stated he didn't hear the alarms on the doors the day of the incident. CNA AM stated Resident #97 normally ate in her room and he thought he gave her a dinner tray around 5:00pm. CNA AM stated he was unaware the resident was an elopement risk . During an interview on 8/12/25 at 3:40pm, the Receptionist stated her work schedule was 10:00am-6:30pm, Monday-Friday. The Receptionist stated the key fob to the front door was placed in the 100-hall binder located at the nurse's station after her shift. The receptionist stated there was another Receptionist who worked the same work hours on weekends. During an interview on 8/13/2025 at 10:16am, the Administrator stated the DON informed her the next morning after the elopement (6/12/25) the investigation began. The Administrator stated she was unsure how the resident eloped from the building. The Administrator stated the nurse, unsure of the name, heard the door alarm the day of the incident, but was busy on the hall and by the time she went to the door, there was no one there. The Administrator stated when the receptionist left, there was a key fob located at the nurse's station, which allowed visitors to enter/exit through the front door or a code was entered . The Administrator stated the risk to a resident who eloped could be weather related injuries, traffic challenges, getting hit by a car, being taken by someone or death. The Administrator stated Resident #97 did not exhibit elopement or exit seeking tendencies prior to the incident. The Administrator stated there should have been elopement interventions in the care plan according to policy since the elopement evaluation indicated elopement risk. The Administrator stated since they didn't realize the resident was missing, the emergency elopement process, according to policy, could not be implemented . Record review of the facility's provided policy on Wandering and Elopements, dated 2021, reflected If a resident is missing, initiate the elopement/missing resident emergency procedure.If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.This was determined to be an Immediate Jeopardy (IJ) on 08/13/25 at 5:26 PM. The Administrator was notified. The Administrator was provided with the IJ template on 08/13/25 at 5:26 PM. The following Plan of Removal submitted by the facility was accepted on 08/14/25 at 10:23 AM:Plan: 1. Inservice staff responding to the access code in re-entering to ensure the door is locked and secured. The DON and ADON in-service staff and Paycom electronic educational platform in-service were pushed out to all staff August 13, 2025. 2. Compliance of Inservice completion is available by electronic review of what staff have completed listed by department and name.3. No employee will be allowed to work without completion of Inservice.4. The (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	desk. An observation on 9/5/25 at 12:30pm with the Maintenance Director revealed all entry and exit doors (the front door, the entry door on halls 100, 200, 300, 400, therapy room doors (on hall 200 and 300 and dining room doors) remained audible until staff members entered the code to relock and reset the door. An observation on 9/5/25 at 3:00pm reflected a sign on the front entry door, the entry door on halls 100, 200, 300, 400, the therapy room doors (on hall 200 and 300) and dining room doors reflected a reminder to visitors not to allow residents to follow them out. During an interview 9/4/25 at 9:30am, the Administrator and DON were advised the administrative review process revealed the plan of removal did not address how the facility will monitor the doors and front desk after hours, residents' piggybacking behind exiting visitors, monitoring staff after the door alarm sounds, and how staff will account for all residents in the facility. The Administrator stated there were weekly elopement drills for 4 weeks after the incident and once monthly thereafter. The key fob was no longer in use at the facility. The receptionist and nurses were required to go to the front door and enter the door code to allow individuals in/out of the front entry door. There is a sign on the front door for visitors to ensure residents don't follow behind them when exiting. Therapy doors are locked after the last therapists leaves for the day. Interviews on 9/4/25 with CNA T, LVN AA, LVN AC, Housekeeper AR, Housekeeper AP from the 6:00am-2:00pm shift, CNA O, CNA H, and LVN AS from the 2:00PM-10:00PM shift, CNA F, CNA AT, and LVN Z from the 10PM-6AM shift, the Dietary Manager, ADON, Business Office Manager, Receptionist, Director of Rehabilitation and Occupational Therapy Assistant revealed the binder containing residents at risk for elopement is checked at the beginning of every shift. When the door alarm sounds, respond immediately, check outside the facility for possible elopement, notify the charge nurse immediately, key in the code to stop the alarm, check the head count of each resident to ensure all residents were at the facility. The LVNs would notify the DON and Administrator immediately. During an interview 9/4/25 at 12:43pm, the Director of Rehabilitation stated the therapy doors are locked when the last therapist leaves due to patient safety. The Director of Rehabilitation stated the locked therapy doors prevented access to exit therapy doors. During an interview 9/5/25 at 2:00pm, the DON stated she randomly interviewed 2 staff members for compliance for staff competency of elopement binder and checking the binder before the start of their shift. During an interview 9/5/25 at 2:20pm, the Administrator stated part of the agenda at IDT daily morning meetings were discussing residents with behaviors and changes in behavior. The Administrator stated residents with behaviors were discussed in the IDT morning meeting by clinical staff. Record review reflected in services on 6/13/25 for staff on elopement, immediate notification of an elopement, an elopement drill and how to respond to door alarms conducted by ADON. Record review reflected the ADON was previously educated on elopement procedures upon hire and during elopement drills. Record review of the Town East Village Egress Inspections dated 6/3/25, 6/10/25, 6/13/25, 6/17/25, 6/24/25, 7/1/25, 7/8/25, 7/14/25, 7/22/25, 7/24/25, 8/5/25, 8/12/25, 8/19/25, 8/26/25, 9/2/25 reflected door inspections of the front entrance door, the entry door on halls 100, 200, 300, 400, the therapy rooms (on hall 200 and 300) and dining area right and left entrance doors. Record review on 9/5/25 reflected one-on-one in-services conducted by the DON on 6/13/25 with CNA E on immediate notification of elopement to the charge nurse. Record review on 9/5/25 reflected one-on-one in-services conducted by the DON on 6/13/25 with RN AK on reporting elopement immediately to the DON, ADON, or Administrator. Record review reflected in-services on Wandering/Elopement conducted by the Administrator on 6/16/25. Record review reflected in-services conducted by the Quality Improvement Nurse 8/1/25 on elopement policies and procedures. Record review reflected a Wandering and Elopement video in Paycom was assigned to all staff 8/13/25. A required posttest for all staff, listed by staff name and department, was completed 8/13/25 and 8/14/25. Record review of the New Team Member Orientation Agenda for new employees reflected education for new employees on elopement procedures. Record review reflected in-services on 8/13/25 for all staff on elopement/wandering. An Immediate Jeopardy (IJ) situation was identified on 8/13/25. While the IJ was removed on 09/05/25, the facility remained out of (continued on next page)		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	compliance at a scope of isolated with the potential for more than minimal harm, due to the facility's need of corrective systems.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 4 (Resident #24, Resident #5 and Resident # 75 and Resident #88) of 18 residents reviewed for ADLs. The facility failed on 08/12/2025 to ensure the following:1. Resident #24 had her fingernails trimmed.2. Resident #5 had her fingernails trimmed.3. Resident #75 had her fingernails cleaned and trimmed.4. Resident #88 had his fingernails cleaned and trimmed. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections, and a decreased quality of life.Findings included: 1-Resident #24Record review of Resident #24's MDS assessment dated [DATE] reflected Resident #24 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included MS (multiple sclerosis [a potentially debilitating disease in which the immune system attacks the protective covering of nerve cells (myelin) in the brain and spinal cord]), quadriplegia (paralysis of all four limbs), and heart failure. Resident #24 had a BIMS score of 14, which indicated intact cognition. The MDS functional assessment indicated Resident #24 was dependent on staff for personal hygiene. Record review of Resident #24's Care Plan dated 06/06/25, reflected the following: Focus: [Resident#24] has an ADL self-care performance deficit r/t Activity Intolerance, Confusion, Impaired balance. Goal: the Resident will maintain current level of function in through the review date. Interventions: Personal hygiene.the Resident is totally dependent on 1-2 staff for personal hygiene and oral care. In an observation and interview on 08/12/25 at 11:23 AM Resident #24 was lying in her bed. Resident #24's nails on both hands were approximately 0.6 cm in length extending from the tip of her fingers, and jagged. The nails were discolored tan with black matter underneath. Resident #24 stated she would like her fingernails trimmed and cleaned. In an interview on 08/12/25 at 3:11 PM CNA M looked at Resident #24's fingernails and stated they were dirty and needed to be trimmed. CNA M stated residents' fingernails were supposed to be cleaned on Residents ?shower days and as needed. CNA stated that both CNAs and Nurses were responsible for nailcare. She said that if Resident has diabetes, then nurses trimmed their fingernails. She stated that if nails were long and dirty, residents may be at risk of infection. 2- Resident #5 Record review of Resident #5's Quarterly assessment dated [DATE] reflected Resident #5 was a [AGE] year-old female initially admitted to the facility on [DATE]. Her relevant diagnoses included: Diabetes Mellitus (high blood glucose levels), Dementia (a general term for a decline in mental ability severe enough to interfere with daily life, affecting memory, thinking, and behavior), Muscle weakness, Cerebrovascular accident (occurs when blood flow to the brain is interrupted, causing brain damage), Alzheimer's disease (progressive neurodegenerative disorder that is the most common form of dementia) and legal blindness. Resident #5 had a BIMS score of 9/15 which indicated Resident #5 had moderate cognitive impairment. The MDS functional assessment indicated Resident #5 needed moderate assistance from staff for personal hygiene. Review of Resident #5's comprehensive care plan revised 10/03/2024 reflected, Focus:[Resident #5] has an ADL self-care performance deficit related to Activity Intolerance, Dementia, Impaired balance. Goal: [Resident #5] will maintain current level of function in through the review date. Intervention: Encourage the [Resident #5] to discuss feelings about self-care deficit. In an observation and interview on 08/12/2025 at 11:09 AM with Resident #5 revealed she was in her room, lying on her bed. Resident 5's nails on left hands were approximately 0.7 cm in length extending from the tip of her fingers, and jagged. The nails were discolored tan with black matter underneath. Resident #5 stated she would like her fingernails trimmed. In an interview on 08/12/2025 at 12:23 PM with Agency LVN D stated that both CNAs and nurses were responsible for ADL care including nailcare. She stated that if resident was diabetic, nurses would trim resident fingernails. She added risk of long and dirty fingernails was increased risk of infection and possible loss of skin integrity. She stated since she was an Agency (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nurse, she was not very familiar with all of Resident #5's care needs, adding Resident #5 had visually impairment and needed care with her personal hygiene. In an interview on 08/12/2025 at 3:26 PM with CNA C stated nail care was offered to all residents on shower days and as needed. She stated that CNAs were allowed to cut the residents' nails if they were not diabetic. She also added that not trimming or cleaning fingernails could lead to infections. 3-Resident #75Record review of Resident #75's Face Sheet dated 08/14/2025 reflected she was a [AGE] year old female with an initial admission date of 05/31/2024, diagnoses included Hemiplegia and Hemiparesis following Cerebral Infraction affecting left dominant side (paralysis or weakness on one side of the body resulting from a stroke), Vascular Dementia (reduced blood flow to the brain, leading to problems with thinking, memory, and behavior), Acute Respiratory Failure with Hypoxia (a serious medical condition where the lungs are unable to adequately oxygenate the blood (hypoxia) and maintain normal carbon dioxide levels), Acquired absence of eye (loss of an eye after birth). Record review of Resident #75's MDS assessment dated [DATE] reflected she had a BIMS score of 05 indicated her cognition was severely impaired. Resident #75 needed moderate assistance with tub/shower transfers. Resident #75 required supervision or touching assistance with personal hygiene. Record review of Resident #75's care plan with a revision date of 02/17/2025 reflected she required assistance with her ADLs (eating, toileting, showers, transfer, mobility). Goal; Resident #75 will be clean. Intervention: provide grooming and personal hygiene. Observation on 08/12/2025 at 11:08 AM revealed Resident #75 was lying in her bed; resident was nonverbal due to her declining health. Resident #75 was observed to have long and dirty fingernails up to two inches long on both hands. 4- Resident #88Record review of Resident #88's face sheet dated 08/14/2025 reflected he had an initial admission date of 05/17/2024, diagnoses included Unspecified Dementia (memory loss), Parkinson's disease with dyskinesia with fluctuations (a neurological disorder primarily affects movement, involuntary uncontrollable movements). Record review of Resident #88's MDS assessment dated [DATE] reflected he had a BIMS score of 9, which indicated moderate cognitive impairment. Resident #88 needed substantial/maximal assistance with personal hygiene. Record review of Resident #88's care plan with a revision date of 04/10/2025 reflected he had an ADLS self-care performance deficit related to Dementia, impaired balance. Interventions: Bathing/showering: Check nail length and trim and clean on bath days and as necessary. Observation and interview on 08/12/2025 at 10:34 AM revealed Resident #88 was lying in his bed and he was observed to have long and dirty finger nails up to two inches long on both hands. Resident #88 stated he would like his fingernails to be cleaned and trimmed but the staff had not offered to do it. Interview with LVN AA on 08/14/2025 at 1:45 PM revealed she was the nurse for Resident #75 and #88, she was not aware they had long and dirty fingernails. She stated it was all the nursing staff's responsibility to make sure resident fingernails were clean and trimmed. She stated long unclean fingernails increased the risk of infections and skin tear among residents and she expected all the residents to have their fingernails cleaned and trimmed. She stated she received in service on fingernail care within a month. Interview with CNA M on 08/14/2025 at 01:52 PM revealed she expected all the residents to have their fingernails cleaned and trimmed and it was the nursing staff who were responsible to clean and trim resident fingernails. She stated long dirty fingernails increased the risk of skin tear and infections among residents. She stated she received in service on fingernail care within a month. Interview with CNA N on 08/14/2025 at 02:17 PM revealed all the nurses and aides were responsible to make sure the resident's fingernails were cleaned and trimmed, not doing so would increase the risk of infections and diseases. She stated she received in service on fingernail care within the past month. Interview with RN AK on 08/14/25 at 02:30 PM revealed she expected all the residents to have their fingernails cleaned and (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	trimmed, unless the resident refused it. She stated the nurses were responsible to make sure the resident had clean and trimmed fingernails, not doing so increased the risk among residents to develop infections and skin tear. She stated she received in service on fingernail care within the past month. In an interview on 08/15/25 at 10:58 AM, the DON stated nail care should be completed as needed and every time aides washed the residents' hands. The DON stated nails should be observed daily. The DON stated nurses were responsible for trimming the nails of residents who were diabetic, and CNAs could trim other residents' nails. The DON stated she expected CNAs to offer to cut and clean nails if they were long and dirty. The DON stated the ADON, and the DON would do the routine rounds to monitor. The DON stated residents having long and dirty fingernails could be an infection control issue. In an Interview on 08/15/25 at 1:02 PM, the Administrator stated nail care should be completed every day before meal, and after meal, and check the fingernail every day to make sure they are not jagged and trim as needed. She stated the activities staff participated in nails care for the residents. She stated nail care was the responsibility of the clinical care staffs, CNAs and nurses. She stated the risk to residents, they may scratch themselves or someone else or hurt themselves, and development of an infection. Record Review of the facility policy titled Care of Fingernails/Toenails revised October 2010 reflected, Purpose: The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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 for the facility's only kitchen reviewed for food and nutrition services. The facility failed to ensure food items were properly stored in the facility freezer on 08/12/25. These failures could affect residents who received their meals from the facility's kitchen, by placing them at risk for food-borne illness, and food contamination. Findings included: Observation on 8/12/25 at 9:45 AM in the facility freezer revealed 2 big plastic bags of frozen beef patties and 1 big plastic bag of chicken steak fries were left uncovered in opened brown boxes exposing them to frigid air. In an interview on 8/13/25 at 2:00 PM with Dietary Aide B who revealed all food items in the kitchen should be covered appropriately and it was usually the responsibility of the cooks to seal food in the freezer. She added that the risk to residents of not appropriately covering food items was residents could get sick. In an interview 8/14/25 at 3:10 PM with the Dietary Manager who stated that everyone in the kitchen was responsible for food storage, however cooks were ultimately responsible for covering food items in the freezer appropriately. She stated her expectation was all foods should be appropriately covered and sealed. She added the risk to residents of improper food storage that included dating, labeling, and covering food items was possibility of food borne illness in residents and cross contamination of food. She stated as the Dietary Manager she conducted daily rounds and routine checks to ensure proper food storage. In an interview on 08/15/2025 at 9:29 AM with [NAME] A stated everyone in the kitchen including dietary aides, cooks, and managers were responsible for appropriate food storage. She added cooks usually were responsible for food storage in the freezers. She stated all food items in the kitchen especially in the freezer should be appropriately sealed and covered to decrease the risk of food borne illness in residents and prevent cross contamination of foods. Review of the facility's policy titled Food Receiving and Storage revised July 2014, reflected, . Policy Statement: Foods shall be received and stored in a manner that complies with safe food handling practices. 7. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). Review of the Food and Drug Administration Food Code, dated 2022, reflected, . Food Storage.(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure each resident bedside, toilet, and bathing facilities were adequately equipped to allow all residents to call for staff assistance through a communication system that would relays the call directly to a staff member or a centralized staff work area for 13 of 24 residents (Resident #56, Resident #6, Resident #57, Resident #5, Resident #8, Resident #79, Resident #36, Resident #78, Resident #65, Resident #50, Resident #38, Resident #53, and Resident #27) reviewed for residents' call system.1-The facility failed on 08/12/2025 to ensure the call light system was accessible to a resident lying on the floor in the shared residents' toilets located inside the residents' rooms . Resident#6. Resident#57. Resident #5. Resident #8. Resident #79. Resident #36. Resident #78. Resident #65. Resident #50. Resident #38. Resident #53. Resident #272-The facility failed to provide a working communication system that was easily at reach and would allow Resident #56 the ability to safely call for staff assistance.This failure could place residents at risk of not having a means of directly contacting caregivers in an emergency or when they needed support for daily living. 1-Observation on 08/12/25 at 10:42 AM revealed resident's shared toilet call light pull string was missing for Resident #50 and Resident #38.Observation on 08/12/25 at 11:19 AM revealed resident's shared toilet call light pull string was missing for Resident #79 and Resident #36.Observation on 08/12/25 at 11:35 AM revealed resident's shared toilet call light pull string was missing for Resident #65Observation on 08/12/25 2:24 PM revealed resident's shared toilet call light pull string was missing for Resident #6 and Resident #57. Observation on 08/12/25 at 02:53 PM revealed resident's shared toilet call light pull string was missing for Resident #78Observation on 08/12/25 3:15 PM revealed resident's shared toilet call light pull string was missing for Resident #5 and Resident #8. Observation on 08/12/25 at 03:29 PM revealed resident's shared toilet call light pull string was missing for Resident #53 and Resident #27.Interview and observation on 08/12/25 at 4:00 PM, the Maintenance Director looked at the call light outlets in the shared residents' toilets located inside the residents' rooms, and stated the call light strings were missing, and the strings needed to be within the reach of a resident who was on the floor. The Maintenance Director stated he would fix them right away. The Maintenance Director stated the risk to residents was the residents could fall and not get help. 2- Record review of Resident #56's quarterly MDS assessment, dated 08/12/25, reflected Resident #56 was an [AGE] year-old female admitted on [DATE]. Her diagnoses included dementia (a general term for a decline in mental ability severe enough to interfere with daily life, affecting memory, thinking, and behavior), weakness, and adult failure to thrive. No BIMS score or functional status was recorded for the Resident.Review of Resident #56's Comprehensive Care Plan date 07/26/25, reflected the following: Focus: [Resident #56] Risk for Falls r/t Dementia, Confusion. Goal: Resident Will Be Free of Falls thru the next review period. Intervention. Assist Resident with ambulation and transfers, utilizing therapy recommendations.An observation on 08/12/25 at 11:07 AM revealed Resident #56 was lying in bed, cleaned, groomed, and covered with a blanket her bed was in the highest position, and the call light button was on the floor behind the bed at the left side. Resident #56 was not able to answer interview questions. Observation/Interview on 08/12/25 at 2:58 PM, CNA X entered Resident# 56's room and located the call light cord and button in the floor. CNA X picked up the call light button and put it within Resident #56's reach. He stated the call light was on the floor, and not next to Resident #56. He stated the problem was she would not be able to call for help, anything could happen to her. CNA X stated if she was incontinent or having an emergency she could not call.Interview with the DON on 8/15/25 at 10:58 AM, revealed the expectation for call light placement was residents should always have the call light within reach, and the call light should be placed on the resident's dominant side. She said the risk to residents of not having their call lights within reach was delayed care. The DON stated call light string missing in the bathroom, anybody, such as the aide and nurses, were supposed (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to report it to the Maintenance Director to get fixed. The DON stated call light string in the bathrooms supposed to be within the reach of the resident lying in the floor. Interview on 08/15/25 at 1:02 PM, the Administrator stated her expectation was the call light button should always be within residents' reach, clipped to residents' clothes or linen, where they could reach it. She stated the risk the Resident could not calling for help if he/she sustained a fall, and not having their needs meet. She stated the missing call light string in the bathroom should be logged in in the Maintenance log binder and reported to the Maintenance Director and replaced. She stated the risk to resident may not have a way to call if they sustained a full in the bathroom. Review of the facility policy titled Resident Call light System, dated June 2020, revealed, Purpose: The purpose of this procedure is to respond to the resident's requests and needs. Policy Implementation: A call light system (audible and visual) is in place and operative in the facility. This system allows individual residents to access a system that notifies nursing that the resident has a need. Residents can communicate with the Nurse's Station from their room and/or bathing and toileting facilities. General Guidelines: .4. Ensure that the call light is easily reachable by the resident.		

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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 interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for three (Resident #34, Resident #96, Resident #97) of thirteen residents reviewed for care plans. The facility failed to develop a care plan for elopement for Resident #97 after the resident eloped on 06/12/25 and remained in the facility until discharge on [DATE]. This failure could place residents at risk for not receiving care and services to meet their needs, diminished function of health, and regressions in their overall health. Record review of Resident #97's face sheet, dated 8/12/25, reflected an [AGE] year-old female who was admitted on [DATE]. Resident #97 had diagnoses which included dementia (brain disorders that cause a decline in cognitive functions), atrial fibrillation (an irregular heart rate), chronic kidney disease, obstructive and reflux uropathy (urine flow is blocked or flows backward), atherosclerotic heart disease (damage/disease in the heart's major blood vessels), and asthma (a chronic lung condition). Record review of Resident #97's quarterly Minimum Data Set assessment dated [DATE] reflected the resident's Brief Interview for Mental Status (BIMS) score was 7 which indicated moderate cognitive impairment. Section GG0170 (Mobile Devices) reflected the resident used a wheelchair for mobilizing. Section E (Behavior) reflected behavior not exhibited for wandering. Record review of Resident #97's quarterly elopement evaluations dated 2/11/25 and 5/13/25 reflected a score of 2, categorized as low risk of elopement. Record review of the Provider Investigation Report, dated 6/19/25, reflected on 6/12/25, CNA E went to lunch and was driving down the road the facility was located on, which consisted of one lane each way, at approximately 7:15pm. CNA E noticed an elderly woman walking down the street, when the woman looked up, CNA E realized it was a resident, parked his truck and assisted her back to the facility. The physician and responsible party were notified regarding the incident. Resident was placed on 15-minute checks 6/13/25 until discharge 6/30/25. Resident #97 was discharged on 6/30/25 from the facility. Record review of Resident #97's nursing progress notes, dated 6/30/25, reflected Resident #97 was discharged from the facility on 6/30/25. Record review of Resident #97's care plan reviewed 8/12/25 revealed elopement interventions were not addressed in the plan of care. During an interview on 8/15/25 at 1:06pm, the MDS Coordinator stated she reviewed the elopement assessments completed upon admission and quarterly. The MDS Coordinator stated she was unsure why there were not elopement interventions in the care plans of residents at risk for elopement. The MDS Coordinator stated there should have been elopement interventions in the care plan since resident safety was the main concern. During an interview on 8/14/25 at 10:19am, the ADON stated it was her and the DON's responsibility to input elopement interventions in the care plan if the resident was identified at risk for elopement. The ADON stated she does not know why the elopement evaluations were overlooked and interventions were not placed in the care plan. During an interview on 8/15/25 at 11:05am, the DON stated she and the ADON were responsible for ensuring elopement interventions were implemented in the care plan. The DON stated there was not a process in place for reviewing elopement evaluations to determine interventions. The DON stated staff observed resident behaviors and determined elopement risk. The DON stated floor nurses completed elopement evaluations upon admissions and quarterly. The DON stated floor nurses were unaware the results of the elopement evaluation should have been relayed. The DON stated she and the ADON were responsible for relaying residents at risk of elopement to staff. The DON stated it was important to have interventions to reflect the accurate needs of the resident. During an interview on 8/12/25 at 10:16am, the Administrator stated there should have been elopement interventions for residents identified at risk according to policy. The Administrator stated the expectation was that every resident had a care plan with appropriate goals and interventions. Record review of the facility provided policy on Wandering and Elopements dated 2021 reflected If identified as at risk for (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure a resident who was fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 of 2 residents (Resident #44) reviewed for feeding tubes. The facility failed to ensure Resident #44's hydration bag for the tube feeding pump was labeled and dated. This failure could result in complications of enteral feedings such as receiving incorrect hydration or elevated risk of infection with using the same hydration bag over multiple days. Findings included: Review of Resident #44's Quarterly MDS assessment, dated 7/20/2025, revealed that Resident #44 was a [AGE] year-old male re-admitted to the facility on [DATE]. Relevant diagnoses included Unspecified Dementia (a general term for a decline in mental ability severe enough to interfere with daily life, affecting memory, thinking, and behavior), Dysphagia (difficulty swallowing solids, liquids, or both), Gastrostomy status (which is a surgically created opening in the stomach, typically for feeding purposes when a person cannot eat or drink normally), Diabetes mellitus (high blood glucose levels), Hypernatremia (elevated blood sodium levels). Resident #44 had a G-tube (G-tube or feeding tube - a tube inserted through the stomach that brings nutrition directly to the stomach). Resident #44 had a BIMS score of 1 suggesting severe cognitive impairment. Review of Resident #44's comprehensive care plan, dated 07/18/2025, revealed, Focus: [Resident #44] requires tube feeding: Glucerna 1.5 (G-tube formula) at 70 Milliliters per hour, with 45 Milliliters per hour water flush x 22 hours every shift per order, at risk for aspiration. Goal: [Resident#44] will maintain adequate nutritional and hydration status as evidenced by weight stable, no signs or symptoms of malnutrition or dehydration through review. Intervention: [Resident #44] Provide local care to G-tube site as ordered and monitor for signs and symptoms of infection. Review of Resident #44's Physician order dated 4/2/2025 revealed , Glucerna 1.5 at 70 Milliliters per hour with 45 Milliliters per hour water flush x 22 hours every shift. Review of Resident #44's Physician order dated 02/06/2025 revealed, Resident #44 had NPO (nothing by mouth) diet, NPO texture, NPO consistency, for Resident is NPO for everything. In an observation on 08/12/2025 at 10:40 AM, Resident #44 was lying in his bed. Resident #44 had a feeding pump at her bedside that was switched off. The feeding pump had 2 bags hanging. One bag was marked and dated as tube feeding formula and time hung. The second bag had colorless liquid, without a label noting content, date it was hung, or resident's name. In another observation and interview on 08/12/2025 at 10:43 AM, Agency LVN D walked into Resident #44's room. She donned gloves and gown. She checked Resident #44's G-tube residuals (the amount of stomach contents that remain after tube feeding.) She then started Resident #44's feeding pump. She stated she identified the bag with colorless liquid was the hydration bag and stated the bag did not have a label or date on it. She stated G-tube feeds were stopped in the morning to provide rest to the resident and she restarted it now. She stated all G-tube feeding bags should be dated and labeled each time before administering the feeds. She stated the risk of not dating the tube feed bag was an increased risk of infection related to an unknown hung date. In an interview with the ADON on 08/12/2025 at 10:57 AM, revealed her expectation was that nurses should date and label all G-tube feeding supplies including hydration bag on the pump. She stated that risk of not labeling was possibility of infection since it was unknown how long the hydration bag was hanging. In an interview on 08/14/2025 at 9:26 AM, the DON revealed that it was a standard nursing protocol to date and label tube feed formula and hydration bag with its contents, date feedings started, and resident identifier. Her expectation was that all nursing staff follow standard protocols. She stated the charge nurse who initiated the tube feeding for the resident for the day should be dating the hydration bag. She stated that risk of not dating and labeling tube feeding hydration bag was a possibility of the same bag being used for the resident for multiple days and a source of potential infection. She added as the DON, the ADON and (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	herself rounded on all residents on daily basis to ensure quality of care was maintained. In another interview on 08/15/2025 at 2:33 PM, with the DON stated there was no specific policy for dating hydration bag for tube feeding, however, it was clinical expectation per nursing standards that all G-tube feeding supplies including hydration bag should be labeled and dated. Recommendation from American Society for Parenteral and Enteral Nutrition (ASPEN) Safe Practices for Enteral Nutrition Therapy, dated January 2017, Practice Recommendations .Standardize the labels for all Enteral formula containers, bags, or syringes to include who prepared the formula, date/time it was prepared, and date and time it was started.		

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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 observations, interviews, and record review the facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 2 of 6 Residents (Resident #56, Resident #61) reviewed for respiratory care. 1-The facility failed to ensure Oxygen (O2) in use signage was on Resident #56's, and Resident#61 doorway. This failure could place residents at risk of not receiving appropriate respiratory care. 1-Record review of Resident #56's MDS assessment, dated 08/12/25, reflected Resident #56 was an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included dementia (a general term for a decline in mental ability severe enough to interfere with daily life, affecting memory, thinking, and behavior), weakness, coronary artery disease (a condition where the arteries supplying blood to the heart become narrowed or blocked, usually due to plaque buildup [atherosclerosis]), and adult failure to thrive. No BIMS score was recorded for the Resident. Review of Resident #56's Comprehensive Care Plan, date 07/26/25, reflected the following: Focus: [Resident #56] has oxygen therapy r/t Ineffective gas exchange. Goal: [Resident#61] will have no signs/symptoms of poor oxygen absorption through the review date. Intervention: Monitor for signs and symptoms of respiratory distress and report to [physician] as needed. Record review of Resident #56's physician orders, dated 07/26/25, reflected, Oxygen at 3 liter per minute per nasal canula every shift and as needed to maintain oxygen saturation above 98%. Change Oxygen Tubing, and humidifier bottle every night shift every Sunday, every 7 days. Observation on 08/12/25 at 11:07 AM revealed Resident #56 was lying in her bed awake. Observation revealed the oxygen concentrator was running at 3L/min. 2-Record review of Resident #61's quarterly MDS assessment dated [DATE] reflected Resident #61 was an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included acute (a sudden, life-threatening condition where the lungs cannot provide enough oxygen to the body or remove enough carbon dioxide, leading to organ dysfunction) and chronic (a gradual, long-term condition where the lungs can't effectively exchange oxygen and carbon dioxide, leading to symptoms like shortness of breath, fatigue, confusion, and a blue tint to the skin) respiratory failure, asthma (a chronic lung condition that causes inflamed and narrowed airways, leading to symptoms like coughing, wheezing, shortness of breath, and chest tightness), and coronary artery disease (a condition where the arteries supplying blood to the heart become narrowed or blocked, usually due to plaque buildup [atherosclerosis]). Resident #61 had BIMS of 13, which indicated intact cognition. MDS also reflected Resident #61 was on Oxygen therapy. Review of Resident #61's Comprehensive Care Plan, dated 07/23/25, reflected the following: Focus: [Resident #61] has oxygen therapy r/t Ineffective gas exchange. Goal: [Resident#61] will have no signs/symptoms of poor oxygen absorption through the review date. Intervention: Monitor for signs and symptoms of respiratory distress and report to [physician] as needed. Record review of Resident #61's physician orders dated 07/27/25 reflected, Oxygen at 3 liter per minute per nasal canula every shift and as needed to maintain oxygen saturation above 98%. Change Oxygen Tubing and humidifier bottle every night shift every Sunday, every 7 days. Observation on 08/12/25 at 11:11 AM, revealed Resident #61 was sleeping in her bed. Observation revealed the oxygen concentrator was running at 3L/min. In an observation on 08/12/25 at 11:13 AM, both Resident #56 and Resident#61 in bed with oxygen at 3L min nasal canula. Observed that the residents' room doorway did not have signage for No Smoking/Oxygen in use outside the door. In an interview and observation on 08/12/25 at 3:00 PM, RN AK checked both residents (Resident#56, and Resident#61) and stated both Resident were on Oxygen therapy. She stated she did not see the Oxygen in use sign on Resident #56's and Resident #61's room door. She stated every resident on oxygen therapy should have the sign to ensure safety if flammable objects were brought to the room. RN AK stated nurses were responsible for changing nasal cannula tubing on a weekly basis and as needed. In an interview on 08/12/25 10:58 (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	AM, the DON she stated the expectation was for the tubing to be changed on Sundays, and the nurses should check the tubing daily. She stated that the risk of not changing it in a timely manner could lead to infection control lapses and decreased quality of care. For the missing Oxygen signage in front of the room while the oxygen was in use, she stated did not see any risk, because the signage indicates No Smoking/Oxygen in Use, and the facility was designated as a none smoking place. Record review of facility policy titled Oxygen Administration revised 02/2025 reflected, Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration, and infection prevention associated with respiratory therapy tasks.4. No Smoking/Oxygen in Use signs.5. Oxygen cannula and tubing will be changed within 7-10 days or if visibly soiled. Store in a covered device (i.e. plastic bag, kangaroo pouch) between uses .		

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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 designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 8 residents (Resident#11, and Resident#70) reviewed for infection control. 1-The facility failed to ensure LVN AE did not carry and use gloves in his uniform pocket while starting the G-tube feeding (gastrostomy tube is a tube that is surgically inserted through the abdominal wall and into the stomach to provide an alternative way to deliver nutrition, fluids, and medications directly to the stomach) for Resident#11 on 08/14/25.2-The facility failed to ensure LVN AA used the required PPE for Resident#70, who was on enhanced barrier precautions due to his Feeding tube while administering him his medication per G-tube feeding on 08/14/25. These failures could place the residents at risk of cross-contamination and development of infection. 1-Record review of Resident #11's quarterly MDS assessment, dated 08/03/25, reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included dementia (a general term for a decline in mental ability severe enough to interfere with daily life, affecting memory, thinking, and behavior), Cerebrovascular accident (a medical emergency that occurs when blood flow to the brain is disrupted, causing brain cells to die), urinary tract infection and aphagia (a medical condition characterized by the inability or refusal to swallow, preventing a person from consuming food or fluids) She had a BIMS score of 10/15 which indicated moderate cognitive impairment. Further review revealed Resident #11 had a feeding tube (A feeding tube is a medical device used to provide nutrition to people who cannot obtain nutrition by mouth, are unable to swallow safely, or need nutritional supplementation).Record review of the Resident #11's care plan, dated 05/19/25, reflected, Focus: [Resident#11] requires tube feeding r/t Dysphagia (is the medical term for difficulty swallowing food or liquids). Goal. The resident will remain free of side effects or complications related to tube feeding through review date. Approach. Provide local care to G-Tube site as ordered and monitor for signs/symptom of infection.In an observation on 08/14/25 at 10:11 AM, Resident#11 lying in bed. LVN AE entered Resident #11's room to change her feeding tube dressing. LVN AE put on own, washed hands, put on clean gloves. LVN AE sanitized bed side table, removed gloves, washed hands, and put on clean gloves from his uniform pocket. LVN AE got the dressing supplies and put them on the bedside table. LVN AE removed the old dressing, cleaned the exit site with a gauze soaked with normal saline. LVN AE removed gloves, washed hands, and put clean gloves from his uniform pocket. LVN AE applied a clean split 4x4 gauze on Resident #11's feeding tube site and taped it with paper tape dated 08/14/2025. LVN AE removed the gown, gloves, washed hands, and exited the room.In interview on 08/14/2025 at 10:25 AM, LVN AE stated he had a hand full of gloves in his pocket, and he used them will taking care of the residents. When asked if he was supposed to have gloves in his pocket he replied, yes, he had them for emergency and if a resident had a cut and he needed to intervene quickly. LVN AE stated there was no difference between gloves in his pocket and the open gloves box. 2-Record review of Resident #70's quarterly MDS assessment dated , 07/07/25, reflected a [AGE] year-old male admitted on [DATE] and readmitted on [DATE]. His diagnoses included hypertension (elevated blood pressure), type 2 diabetic (elevated blood sugar), Cerebrovascular accident (a medical emergency that occurs when blood flow to the brain is disrupted, causing brain cells to die), and aphagia. He had a BIMS score of 14/15 which indicted intact cognition. Further review revealed Resident #70 had a feeding tube (A feeding tube is a medical device used to provide nutrition to people who cannot obtain nutrition by mouth, are unable to swallow safely, or need nutritional supplementation).Record review of the Resident #70's care plan, dated 07/17/25, reflected, Focus: [Resident#70] requires tube feeding r/t Dysphagia. Goal. Resident#70 will be free of aspiration through the review date. Approach. Monitor/document/report any signs/symptoms of: Aspiration fever.Infection at tube site .In an (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observation on 08/15/25 at 08:02 AM, there was an EBP signage on Resident #70's room door with the reading ENHANCED BARRIER PRECAUTION with the instruction of the PPE (gown, and gloves) use in high contact with the Resident and no PPE supplies outside the Room. LVN AA prepared Resident #70's morning medications using proper hand hygiene and gloves use. LVN AA took the medications to Resident #70's bed side table, washed hands and donned clean gloves, and did not put on a gown. LVN AA gave Resident #70 his medication per feeding tube, no concerns noticed. LVN AA removed gloves, washed hands, and exited the room. In an interview with LVN AA on 08/15/25 at 08:12 AM, she stated residents who had a feeding tube were under enhanced barrier precautions. LVN AA stated she received training on EBP, and she knew she had to wear gown for any high contact care with the residents in EBP. She stated the risk would be spreading germs between residents and staff. In an interview with the DON on 08/15/25 at 10:58 AM, she stated the facility did not have a policy that said not to have gloves in the pocket, but they have the policy that stated to use clean gloves from the box. She further stated the gloves in the staff uniform pocket could not be clean like the one in the box because the staff may have other things (pens, scissors, .etc.) in their pocket with the gloves, and the gloves could become contaminated. The DON stated, per the facility policy, resident's medications administration per G-tube feeding was a form of high contact with the resident in EBP. She further stated staff were trained and required to wear a gown for the resident in EBP for any contact care. She stated the risk was potential spread of infection. Record review of the facility's policy, Enhanced Barrier Precautions Cheat sheet dated May 2024, reflected, Enhanced barrier precautions EBPs - Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Enhanced-Based Precautions are indicated during Device care or use: central line, urinary catheter, feeding tube.		