STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676147	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stallings Court Nursing and Rehabilitation	4616 NE Stallings Dr Nacogdoches, TX 75965

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46436 Based on observation, interview, and record review the facility failed to ensure each resident was treated with respect, dignity, and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or quality of life, recognizing each resident's individuality for 1 of 6 residents (Resident # 11) observed for resident rights. CNA C and the ADON failed to provide Resident #11 with full privacy while receiving care on 11/18/2024. This failure could place residents at risk of not being treated with dignity and respect. Findings include: Record review of Resident #11's facility face sheet, dated 11/19/2024, reflected Resident #11 was a [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis which included Atrial Fibrillation (an irregular heartbeat). Record review of Resident #11's comprehensive care plan, dated 9/19/2024, reflected Resident #11 had bowel and bladder incontinence and required incontinent care from staff. Record review of Resident #11's quarterly MDS assessment, dated 9/21/2024, reflected Resident #11 had a BIMS of 11, which indicated moderately impaired cognition and was dependent on staff for toileting. During an observation on 11/18/24 at 2:34 PM revealed CNA C and the ADON entered Resident #11's room to provide incontinent care. The privacy curtain on the door side of the room was not pulled during care and left Resident #11 exposed. A visitor opened the door and entered the room during care and Resident #11 was exposed. During an interview on 11/18/24 at 2:42 PM, Resident # 11 said the staff usually pulled both privacy curtains but not always. She said she would be embarrassed if someone walked in and saw her naked. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/18/24 at 2:44 PM, CNA C said she had been a CNA for 2 years and at the facility 1 year . She said she was recently checked off resident rights . She said she pulled her curtain on her side and did not recognize the curtain on the door side was not pulled. She said by not pulling the curtain it could cause the resident to be exposed and embarrassed. During an interview on 11/18/24 at 2:50 PM, the ADON said she had been at the facility for 3 years . She said she was responsible for competency checks for all staff and she and the CNA had recently had annual competency training. She said she should have pulled the curtain to provide privacy during care and by not doing so residents could be exposed and embarrassed . During an interview on 11/20/24 at 1:50 PM, the DON said every person employed at the facility was responsible for ensuring resident rights and dignity. He said the privacy curtain should always be pulled to provide the resident with full privacy and expected that to occur with each resident encounter during personal hygiene and care. He said by not respecting resident rights and dignity it could cause embarrassment if they were exposed during care. During an interview on 11/20/24 at 2:16 PM, the Administrator said resident rights and dignity were the responsibility of every employee. She said during resident personal care like incontinent care the privacy curtain should always be pulled to avoid exposing the resident. She said she expected all staff to maintain dignity for every resident and by not doing so it could cause embarrassment. Record review of the facility policy titled Quality of Life - Dignity, dated October 2009, reflected, .Residents shall be treated with dignity and respect at all times, Staff shall promote maintain and protect resident privacy including bodily privacy during assistance with personal care

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49017 Based on interview and record review the facility failed to make sure a comprehensive care plan was prepared by an interdisciplinary team, that included but not limited to a nurse aide with responsibility for the resident and a member of food and nutrition services staff for 4 of 4 residents (Residents #6, #27, #54 and #58) reviewed for care plans. The facility failed to ensure the dietary manager and nurse aides with responsibility for the residents were invited and attended the resident care plan conferences. This failure could place residents at risk for not receiving the care and services to meet their needs. Findings include: 1. Record review of Resident #6's facility face sheet reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis which included senile degeneration of the brain (disease that affect memory, thinking, and the ability to perform daily activities). Record review of Resident #6's comprehensive quarterly assessment, dated 10/9/2024, reflected the resident had a BIMS of 02, which indicated severe cognitive impairment. Record review of Resident #6's care plan conference reflected no evidence of attendance by the dietary manager and nurse aide with responsibility for the resident on 10/28/2024. 2. Record review of Resident #27 facility face sheet reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis which included cerebral infarction . Record review of Resident #27 comprehensive quarterly assessment, dated 10/2/2024, reflected the resident had a BIMS of 11, which indicated moderate cognitive impairment. Record review of Resident #27 care plan conference reflected no evidence of attendance by the dietary manager and nurse aide with responsibility for the resident on 10/22/2024. 3. Record review of Resident #54's facility face sheet reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE] with a diagnosis which included cerebral infarction. Record review of Resident #54's comprehensive quarterly assessment, dated 8/19/2024, reflected the resident had a BIMS of 15, which indicated no cognitive impairment. Record review of Resident #54's care plan conference reflected no evidence of attendance by the dietary manager and nurse aide with responsibility for the resident on 11/05/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Record review of Resident #58 facility face sheet reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included cerebral infarction (the pathologic process that results in an area of necrotic tissue in the brain) and epilepsy (brain disorder that causes recurring, unprovoked seizures). Record review of Resident #58 comprehensive quarterly assessment, dated 8/29/2024, reflected the resident had a BIMS of 12, which indicated moderate cognitive impairment. Record review of Resident #58 care plan conference reflected no evidence of attendance by the dietary manager and nurse aide with responsibility for the resident on 10/22/2024. During an interview on 11/20/2024 at 10:00 AM with the Dietary Manager, he said he had been in his position for 2 years . He stated he did not attend care plan meetings, he said he would attend the IDT meeting when he was not working in the kitchen related to staffing challenges. He said he attended half of the meetings. He said he usually was working in the kitchen when care plan meeting occurred. He said he communicated any dietary changes during the morning stand up meeting and he communicated with the unit managers. He said he did not initiate or update care plans and the nursing staff did the care plans for the residents. He said he did an assessment on all residents who were admitted to the facility and any residents who were readmitted to the facility. He said the registered dietician came to the facility every other week and she also performed assessments on residents that were new admissions, readmissions, or had weight loss or weight gains. He said dietary recommendations were given to the nursing staff to implement. In an interview with the MDS Coordinator on 11/20/2024 at 10:15 AM, she said she was responsible for completing the MDS for residents and she was also responsible for updating the care plans. She stated she and the Social Worker coordinated the care conference meetings. She said IDT meetings, or care conferences, were done weekly and the members present were herself, social services, unit manager, therapy, and family representatives at times and residents at times. She said the Dietary Manager did attend some of the meetings, but he was usually working in the kitchen and was unable to come to the meetings. She stated certified nurse assistants did not participate in the meetings. In an interview with the Director of Nursing on 11/20/2024 at 10:25 AM, he said he participated in the care plan meetings. He said he was responsible for updating the care plans along with the MDS Coordinator. He said the IDT team consisted of himself, social services, MDS coordinator, therapy, activities, and dietary. He said dietary did not always participate in care plan meetings due to staffing. He said dietary was hit and miss . He said he communicated with dietary before and after care plan meetings. He said he did all the dietary care plans and updated them as needed. He stated he electronically signed the dietary section of the care conference summary. He said the Dietary Manager attended about 50% of care plan meetings. He stated certified nurse aides did not attend care conference meetings. He stated that the dietary manager and a certified nurse assistant should attend care conferences to communicate any changes in the residents condition and it would allow for a team approach to the residents care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Social Worker on 11/20/2024 at 10:35 AM, she said she participated in the care conference meetings weekly. She said she participated in the IDT meetings. She said the MDS Coordinator, therapy, the Director of Nurses, activities, and dietary participated in the weekly meetings. She said dietary did not attend the IDT regularly due to staffing issues. She said the DON usually signed and completed the dietary responsibilities for the care conferences. She said the certified nurse aides did not participate in the care conferences . In an interview on 11/20/2024 at 2:35 PM with the Administrator, she stated she and the DON were responsible for making sure all members of the IDT team were present for the care plan conferences. She was able to name all members who were required to be present at the care plan conference. She said a risk for a member of the IDT team not being present and participating was not being able to communicate changes in the residents and everyone contributing to goal setting to help maintain the residents' highest level of functioning. Record review of the facility's policy titled Care Planning- Interdisciplinary Team revised September 2013, reflected the care plan is based on the resident's comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team which include . the dietary manager/Dietician .nursing assistants responsible for the residents care

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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** 43994 46273 46436 Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good, nutrition, grooming and personal and oral hygiene for 4 of 12 residents (Residents #34, #37, #48, #69) reviewed for activities of daily living . 1.The facility failed to ensure Resident #37's had clean linens on 11/19/2024. 2. The facility failed to provide nail and mouth care to Resident #34 on 11/18/24 and 11/19/2024. 3. The facility failed to provide nail care to Resident #48 on 11/18/24 and 11/19/24. 4. The facility failed to ensure Resident #69 did not have oily hair and body odor on 11/18/24. These failures could place residents at risk of not having their needs met which could result in poor care, risk for skin breakdown, feelings of poor self-esteem, lack of dignity and health. Findings include: 1. Record review of Resident #37's Admission Record, dated 11/20/2024, reflected she admitted to the facility on [DATE] and was a [AGE] year old female. Resident #37 had diagnoses which included Parkinsonism (brain condition that causes slowed movements and tremors), Major depressive disorder (persistent feeling of sadness or loss of interest) and hypertension and retention of urine (condition where the bladder does not empty completely). Record review of Resident #37's Quarterly MDS Assessment, dated 8/20/2024, reflected she had moderate impairment in thinking with a BIMS score of 9. She required substantial/maximal assistance with toileting and personal hygiene. She was always incontinent of urine and bowel. Record review of Resident #27's care plan, revised on 4/12/2022, reflected she was incontinent of bowel/bladder and had the potential for impaired skin and UTI's. Interventions included to check the resident during rounds and as required for incontinence. Change clothing PRN after incontinence episodes. During an observation on 11/19/2024 at 3:32 PM, revealed Resident #37 was in bed awake, the ADON and the Treatment Nurse were in the room to perform a skin assessment. They pulled back her linens and a strong ammonia odor permeated (filled) the room. Her brief was dry and the draw sheet was soaked and yellow stained. The ADON and Treatment Nurse removed the draw sheet and the resident said she was scheduled to get a shower that day on 11/19/2024. There were no skin issues noted during the assessment. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/19/2024 at 3:40 PM, the ADON said the staff assigned to Resident #37 earlier that day was CNA D. She said there was a strong urine odor in Resident #37's room and the draw sheet was wet and yellow stained. She said the staff should have changed Resident #37's draw sheet when they changed her if it was wet. She said residents could be at risk for skin breakdown if staff did not remove wet linens. Attempted a phone interview on 11/19/2024 at 4:09 PM with CNA D, there was no answer and a message for a return phone call was left. During a phone interview on 11/20/2024 at 7:45 AM, CNA D said she worked at the facility PRN and had only worked at the facility for 4 days and started on 11/9/2024. She said she worked on 11/19/2024 on the 6 am - 2 PM shift and was assigned the hall with Resident #37. She said she made rounds after breakfast, before lunch and after lunch. She said she changed Resident #37 about 4 times on 11/19/2024. She said she did not change the sheets but changed the draw sheet once during the shift. She said the draw sheet was changed about 1-1:15 PM on 11/19/2024 during her last round before her shift ended at 2 PM. She said there was a risk for skin breakdown if a resident was left on wet sheets. She said on her first day of work on 11/9/2024, she was told her hall she was assigned and given report and then allowed to work by herself. During an observation and interview on 11/20/2024 at 8:14 AM, in the room of Resident #37, Resident #37 said she received a shower yesterday 11/19/2024 after the skin assessment that was conducted by the ADON and Treatment Nurse. She said yesterday, 11/19/2024, she was changed 3 times during the day shift. She said her draw sheet was changed once, but it was wet yesterday afternoon (11/19/2024) and it did not get changed until the ADON and Treatment Nurse came in the room. She said being left on a wet draw sheet happened often because the urine would run out of her brief on the left side. She said she could feel when the draw sheet or linens were wet underneath her. She said she usually had to tell the staff her linens were wet because if not, they would not get changed. She said some of the older staff knew what to do and would place a thicker layer underneath her. During an interview on 11/20/2024 at 8:24 AM, CNA E said she had been employed at the facility since June 2024 and worked full time. She said she usually made rounds every 2 hours and more often as needed. She said if the entire bed was wet, she would change them along with the draw sheet. She said if the draw sheet was wet, she would not leave it under the resident. She said residents could be at risk for skin breakdown, discomfort or residents could start to smell if they were left on wet linens. She said she had training when she was hired by other nurse aides and had skills check off. During an interview on 11/20/2024 at 2:27 PM, the DON said staff should be changing linens anytime they were dirty. He said he was not aware of the incident with Resident #37 yesterday 11/19/2024. He said there could be a risk for nonhygienic and skin issues if residents were left on wet or dirty linens. He said he in-serviced staff that day 11/20/2024 on pericare. He said the facility did not have a policy on changing linens with incontinent care. During an interview on 11/20/2024 at 3:10 PM, the Administrator said she was made aware of Resident #37 who had wet linens on yesterday, 11/19/2024. She said linens should be changed when soiled by the nurse aides. She said residents could have skin breakdown and expected for linens to be changed when they were soiled. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a CNA Proficiency Evaluation for CNA D met expectations on 11/11/2024 with perineal care conducted by the ADON. 2. Record review of Resident #34's facility face sheet, dated 11/19/2024, reflected Resident #34 was a [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis which included Alzheimer's (loss of memory). Record review of Resident #34's comprehensive care plan, dated 8/23/2024, reflected Resident #34 had history of skin tears and nails should be kept short to reduce risk of scratching or injury from picking at skin. Record review of Resident #34's quarterly MDS assessment, dated 10/11/2024, reflected Resident #34 had a BIMS of 4, which indicated severe cognition. Resident #34 was maximum assistance with personal hygiene. During an observation and interview on 11/18/24 at 9:38 AM revealed Resident #34's fingernails were long and had a dark thick substance under them. Resident #34 said no one cleaned them but would like them cleaned. She said she had a shower that morning. She said her teeth were never brushed and her teeth were observed with food particles and white buildup around teeth . During an observation and interview on 11/19/24 at 8:05 AM revealed Resident #34's fingernails had a thick dark substance under them, and teeth had food particles. She said she needed her toenails trimmed as well. During an observation and interview on 11/19/24 at 9:43 AM revealed Resident #34's feet were inspected with the Treatment nurse. The toenails on both feet were thick and overgrown. The Treatment Nurse said toenail care was to be completed on bath days unless the resident was diabetic. She said untrimmed nails cold cause skin issues and discomfort . 3. Record review of Resident #48's facility face sheet reflected Resident #48 was a [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis which included Dementia (loss of memory). Record review of Resident #48's comprehensive care plan, dated 5/21/24, reflected Resident #48 had potential impairment to skin integrity and avoid scratching and required assistance with ADL's and staff to assist with personal hygiene and oral care. Record review of Resident #48's quarterly MDS assessment, dated 8/16/24, reflected Resident #48 had a BIMS of 13, which indicated intact cognition. Resident #48 was dependent on staff for personal hygiene. During an observation and interview on 11/18/24 at 10:17 AM revealed Resident #48's fingernails were long and had a dark thick substance under them. She said the staff cleaned them maybe once a week but would like them done more often . During an observation on 11/18/24 at 3:00 PM revealed Resident #48's fingernails had a dark thick substance under them. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 11/19/24 at 8:10 AM revealed Resident #48's fingernails were long and dark substance under them. She said she had a bath, but the staff did not clean or trim her fingernails . During an interview on 11/19/24 at 1:23 PM, CNA A said she had been a CNA for [AGE] years and the CNAs were responsible for ensuring residents nails were cleaned and trimmed at least on shower days and as needed if they were dirty. She said mouthcare should be done daily. She said if nails were left dirty and untrimmed it could cause skin breakdown and infections and if mouth care was not provided it could affect their eating and cause mouth sores. During an interview on 11/19/24 at 2:00 PM, LVN B said she had been a LVN for 3 1/2 years and at the facility 6 months . She said the CNA's were responsible for all ADL care and should be cleaning nails and performing mouth care daily. She said the charge nurse should be checking that ADL care was performed with rounds and she missed that ADL care had been missed for Resident #34 and Resident #48. She said ADL care should be completed to prevent infections, injuries or skin changes. During an interview on 11/20/24 at 1:50 PM, the DON said the CNAs were responsible for performing ADL care and the charge nurses and management nursing were to oversee that care was provided. He said all staff were trained on hire, annually and as needed on ADL care, and expected nail care and mouth care to be provided to each resident daily. He said if ADL care was not provided it caused infections or injuries. During an interview on 11/20/24 at 2:16 PM, the Administrator said the charge nurses and management nurses were responsible for oversight of ADL care. She said nails should be cleaned when soiled, trimmed as needed and mouth care should be performed daily. She said she expected every resident to receive all required ADL care daily to prevent infections and injuries. Record review of the facility's policy, titled Mouthcare, dated April 2007 reflected, .cleanse and freshen the resident's mouth to prevent infections of the mouth . Record review of the facility's policy, titled Care of Fingernails/Toenails, dated April 2007, reflected, .nail care includes daily cleaning and regular trimming . 4. Record review of Resident #69's facility face sheet, dated 11/19/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and subsequently readmitted on [DATE]. Resident #66 had diagnoses which included cerebral infarction (stroke), hypertension (high blood pressure) and dementia (a group of symptoms affecting memory, thinking, and social abilities). Record review of Resident #69's comprehensive MDS assessment, dated 8/19/24, reflected he had a BIMS score of 10, which indicated he had moderately impaired cognition. He exhibited rejection of care 1 to 3 days during previous 7-day period. He required partial to moderate assistance with showers. He was occasionally incontinent of bowel and bladder. Record review of Resident #69's comprehensive care plan, dated 9/23/24, reflected he was resistive to treatment/care by refusing bathing. He had the following intervention: .document care being resisted .monitor behaviors and document number of episodes (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's, undated, shower schedule located inside linen closet, reflected Resident #69 was scheduled for showers on Tuesdays, Thursdays and Saturdays on the 2-10PM shift. Record review of Resident #69's bathing care record, dated 11/19/24, reflected he did not get a shower on 10/22/24, 10/31/24 or 11/7/24 with no resident refusal documented. Record review of nursing progress notes for Resident #69 reflected there was no nursing progress note which indicated the resident was offered and refused his shower on 10/22/24, 10/31/24 or 11/7/24. During an observation and interview on 11/18/24 at 10:20 AM revealed Resident #69 was observed in his room sitting up in his wheelchair. There was an odor in his room indicative of body odor. The resident said he did not get his showers and staff had not washed his hair. The resident's hair was observed to appear oily and had white flakes on the top of his hair. He said staff did not offer to give him a shower or wash his hair, he said they did shave him occasionally. He said it made him feel not good when he had dirty hair and had not been showered. During an interview on 11/20/24 at 11:20 AM, LVN B said Resident #69 was on the 2-10 schedule for showers, so she was not familiar if he refused often or not. She said the nurse was responsible for ensuring residents received their showers. During an interview on 11/20/24 at 11:30 AM, CNA J said she did not work with Resident #69 very often, but if a resident refused their shower, then the CNA was responsible to notify the charge nurse and document in the kiosk that the resident had refused. During an interview on 11/20/24 at 2:30 PM, CNA K said she did care for Resident #69. She said he refused his shower most of the time. She said when he refused, she would notify the charge nurse and sometimes the nurse could convince him to take it. She said if a resident continued to refuse and she was not able to shower him, she would then document the resident's refusal in the kiosk. During an interview on 11/20/24 at 2:55 PM, the DON said Resident #69 refused showers all the time and the nurses were responsible for documenting his refusals, but they had not been documenting this. He said going forward he would educate the staff and make sure the nurses were properly documenting when a resident refused showers. During an interview on 11/20/24 at 3:00 PM, LVN M said if a resident refused showers, then she would notify the nurse practitioner and document in a progress note the resident refused, if she was made aware of the refusal by the CNA. She said Resident #69 did sometimes refuse his showers. During an interview on 11/20/24 at 3:10 PM, the Administrator said she expected her staff to properly document resident refusals. She said going forward, she would educate the nurses to document when a resident refused care. She said residents could be at risk for skin breakdown if they did not receive proper ADL care. Record review of the facility policy titled Shower/Tub Bath, dated 2001 and revised in October 2009, reflected .Documentation: The following information should be recorded on the resident's ADL record and/or in the resident's medical record: 4. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken .Reporting: 1. Notify the supervisor if the resident refuses the shower/tub bath

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46436 Based on observation, interview, and record review the facility failed to ensure a resident with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility was demonstrably unavoidable for 1 of 6 residents (Resident #14) reviewed for quality of care. The facility failed to ensure Resident #14 had her splints for contractures in her hands on 11/18/24. This failure could place residents at risk of increased contractures, not receiving care and services to maintain their highest level of well-being and decline. Findings include: Record review of Resident #14's facility face sheet, dated 11/19/2024, reflected Resident #14 was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #14 had a diagnosis which included Parkinson's (a movement disorder of the nervous system that worsens over time). Record review of Resident #14's comprehensive care plan, dated 8/19/2024, reflected Resident #14 had limited physical mobility related to contractures and to apply hand splint to the right hand and left-hand palm protector. Record review of Resident #14's quarterly MDS, dated [DATE], reflected Resident #14 had a BIMS of 09, which indicated moderately impaired cognition. Resident #14 did not receive restorative nursing services for splint assistance. During an observation on 11/18/24 at 9:22 AM revealed Resident # 14's hands were contracted and there was no splint or device in her hands. There was a carrot device on her bedside table. During an phone interview on 11/18/24 at 2:22 PM, Resident #14's family member said Resident #14 should have a carrot in her hands because of contractures and had a history of getting skin breakdown from her fingernails . During an observation and interview on 11/18/24 at 3:23 PM revealed Resident #14 shook her head no when asked if she had her hand splints in place today. She was observed with no device in her hands and the carrot device remained on the bedside table. During an interview on 11/19/24 at 1:23 PM, CNA A said she had been a CNA for [AGE] years and at the facility 3 1/2 years . She said residents who had splints were usually on therapy or restorative and they applied the devices, but the CNAs were also trained to apply them. She said the devices should be applied daily as the resident allowed to prevent further contractures or skin breakdown. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/19/24 at 1:33 PM, the Restorative Aide said she had been the restorative aide care for 1 1/2 years . She said Resident #14 was on restorative but no longer and the CNA's and nurses were responsible for applying her splints. She said the nurses were given a list of residents who required splints and should be checking them and ensuring they were in place every day. She said if splints were not placed, contractures could worsen or there could be skin breakdown. During an interview on 11/19/24 at 1:35 PM, the PTA said residents who required special devices like splints the restorative aide or therapist applied the device, but all CNA's and nurses were trained so they could apply the devices on the weekends. She said Resident #14 was off therapy, but the DON was given a list of all residents who required devices and the nurses or CNAs should have been applying Resident #14's splints daily . She said by not applying them resident contractures could worsen or they could have pain. During an interview on 11/19/24 at 1:45 PM, LVN B said she had been an LVN for 3 1/2 years and at the facility 6 months . She said she was aware Resident #14 required splints on her hands and she had them on today. She said she was not sure why she did not have them on yesterday. She said there was a list at the nurse's station, and she checked devices on her rounds. She said if devices were not in place contractures could increase, or skin breakdown and pain could occur. During an interview on 11/20/24 at 1:50 PM, the DON said the CNA's and restorative aide were responsible for ensuring devices like splints were put in place as outlined in the resident's care plan. He said they did not do orders for devices and only placed a list at the nurse's station for the nurses to know who required what devices. He said there was no system in place to oversee and ensure the devices were in place but would start a new system. He said he expected all needed devices, such as hand splints, were in place as the resident required, and by not doing so contractures could worsen. During an interview on 11/20/24 at 2:16 PM, the Administrator said devices like hand splints should be in place as the care plan stated and the CNA's or nurses should be applying them. She said the DON was responsible for oversight and would make sure there was a system in place to check devices daily. She said she expected all residents with hand splints got them to prevent an increase in contractures. Record review of the facility's policy titled Contracture Management, dated March 2012, reflected .treatments and techniques employed by nursing home staff helps prevent or slow down contractures. Splinting devices are often utilized to prevent further contractures

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273 Based on observation, interview and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and service to prevent urinary tract infections and to restore continence to the extent possible for 1 of 3 residents (Resident #76) reviewed for indwelling catheter. The facility failed to ensure Resident #76's indwelling catheter securement device was in place. This failure could place residents at risk for urethral tears, discomfort, infection and hospitalization . Findings include: Record review of Resident #76's facility face sheet, dated 11/19/24, reflected an [AGE] year-old male who was admitted to the facility on [DATE] and subsequently readmitted on [DATE]. Resident #76 had diagnoses which included pulmonary mycobacterial infection (lung infections are caused by a common type of bacteria called mycobacteria), hyperlipidemia (high cholesterol), and hypertension (high blood pressure). Record review of Resident #76's Nursing Home PPS MDS assessment, dated 10/23/24, reflected Resident #76 had a BIMS score of 10, which indicated that he had moderately impaired cognition. Resident had an indwelling catheter and was always incontinent of bowel. Record review of Resident #76's comprehensive care plan, dated 11/12/24, reflected he had an indwelling catheter and had the following intervention: .check tubing for kinks each shift The care plan did not address securing the catheter with an anchor. Record review of Resident #76's physician's order summary report, dated 11/19/24, reflected he had the following order, dated 11/12/24: .Foley catheter 16FR 10cc bulb to bedside drainage, Diagnosis: Urinary retention During an observation on 11/19/24 at 1:20 PM revealed Resident #76 in bed with no securement device on his foley catheter. During an interview on 11/19/24 at 1:30 PM, the Restorative Aide said Resident #76 should have an anchor on his catheter to prevent it from pulling. She said he had just returned from the hospital with the catheter. During an interview on 11/19/24 at 1:48 PM, the DON said anchors were not normally used unless the residents requested them. During an interview on 11/20/24 at 2:42 PM, LVN L said the nurses are responsible to use anchors on the catheters to prevent them from pulling and causing pain. She said Resident #76 had recently returned from the hospital and it must have gotten missed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/24 at 2:55 PM, the DON said Resident #76 had only been back from the hospital for a few days. He said the anchor helped to prevent the catheter from becoming dislodged and getting yanked out. He said going forward he would educate the nurses and ensure securement devices were used. During an interview on 11/20/24 at 3:10 PM, the Administrator said she expected her staff to use anchors to secure foley catheters. She said she would educate the staff and ensure the policy was followed going forward. She said residents needing indwelling catheters could be at risk for pain if tubing was not anchored to prevent it from pulling. Record review of the facility's policy titled Catheter Care, Urinary, dated 2001 and revised in April 2010, reflected .17. Secure catheter utilizing a leg band

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on observation, interview and record review the facility failed to ensure drugs and biologicals were store in locked compartments under proper temperature controls for 2 of 3 medication carts (medication aide cart and nurse cart for halls 300 and 400), 1 of 1 medication rooms and 1 of 16 residents (Resident #18) reviewed for pharmacy services. The facility failed to ensure Fluticasone nasal spray was properly stored and locked in accordance with currently accepted professional standards for Resident #18 from 11/18/2024-11/19/2024 that was at her bedside. 1. The facility failed to dispose of expired medications from the medication aide and nurse medication carts on 11/19/2024 which included: (3) packages of Juven nutrition powder with use by date of November 1, 2024. (2) bottles of Glucerna 1.2 cal dated November 1, 2024. 2. The facility failed to dispose of expired medications in the medication room on 11/19/2024 which included: (1) box of phenylephrine hcl expired 9/2024 (1) box of I-caps expired 6/2023 (3) boxes of gas relief expired 8/2024 (1) bottle of Geri Lanta expired 11/2023. These failures could place residents at risk for adverse effects and reduced therapeutic effects of medication and supplies. Findings include: 1. Record review of Resident #18's Admission Record, dated 11/20/2024, reflected the resident admitted to the facility on [DATE] and was [AGE] years old female. Resident #18 had diagnoses which included Alzheimer's Disease, atherosclerotic heart disease (buildup of plaque in the arteries), major depressive disorder (persistent sadness or loss of interest), and hypertension. Record review of active physician orders for Resident #18, dated 11/20/2024, reflected an order for Flonase allergy relief suspension 50 mcg/act 1 spray in both nostrils one time a day for allergic rhinitis with a start date of 9/22/2021. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #18's Quarterly MDS Assessment, dated 11/7/2024, reflected she had moderate impairment in thinking with a BIMS score of 8. She required supervision or touching assistance with ADLs except for showering/bathing with partial/moderate assistance. Record review of Resident #18's care plan, last review dated 9/6/2024, did not indicate she was care planned to self-administer her nasal spray. During an observation and interview on 11/18/24 at 9:24 AM, in the room of Resident #18 was sitting up in a recliner dressed. She said she had been at the facility for a while. There was a bottle of fluticasone spray on a table by her recliner that was not in a box and Resident #18 said the nurse brought it into the room for her to use and she used it once a day. During an observation on 11/18/2024 at 2:27 PM, in the room of Resident #18 revealed the resident was not in the room, the bottle of nasal spray was still on the table. During an observation on 11/19/2024 at 7:44 AM, MA N was assigned the medication cart for hall 300 and 400. The State Surveyor checked the cart and it had (3) packages of Juven nutrition powder (supplement that supports wound healing) indicated a use by date of [DATE]. During an observation and interview during medication administration on 11/19/2024 at 8:26 AM, MA G was in the room of Resident #18 to give her morning medications. Resident #18 still had the bottle of nasal spray on the table by her recliner. MA G said Resident #18 did not get her nasal spray yesterday, 11/18/2024, because she did not have a box to it inside of the medication cart. She said she was not aware Resident #18 had her nasal spray in her room. She said medications should not be left at the bedside. She said Resident #18 had not been deemed to take medications on her own and the medication aides and nurses gave her medications. She said she observed the nasal spray at the bedside of Resident #18 before and removed it and placed it back inside of the medication cart. She said the facility had a lot of PRN staff on the weekends and was not sure if that was who left it in the room or not. She said if medications were left in the rooms of residents, they could get confused and someone could come along and take them. During an observation on 11/19/2024 at 9:29 AM, in the medication room with RN F revealed: (1) box of phenylephrine hcl expired 9/24, (1) box of I-caps expired 6/2023, (3) boxes of gas relief expired 8/24, and (1) bottle gerilanta expired 11/23. During an interview on 11/19/2024 at 9:49 AM, RN F said the ADON, and unit managers were responsible for the medication rooms and storing of medications. She said anytime they placed an order for medications or when medications were pulled, they checked the medication room. She said they checked the medication room at least monthly. She said there could be a risk of sickness if residents were taking medications that were expired. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/19/2024 at 1:43 PM, the ADON said she and the unit managers were responsible for checking the medication carts and the medication room for expired medications. She said she checked the medication cart for hall 100 last week and the Pharmacist visited the facility last week and checked the medication room as well. She said she was not sure how the expired medications were missed. She said there could be a risk of sickness if residents received medications that were expired. She said medications should not be stored at the bedside, she Resident #18 had not been deemed to administer medications to herself. She said there was a risk for other residents to get the medications if they were left at the bedside or the resident could take too much. During an observation on 11/19/2024 at 3:42 PM, the nurse cart for halls 300 and 400 was assigned to the NP and revealed: (2) bottles of Glucerna 1.2 cal dated [DATE]. During an interview on 11/20/2024 at 2:27 PM, the DON said whoever was responsible for the carts that day was responsible for ensuring the carts did not have expired medications and the Unit Managers were responsible for checking them weekly along with the medication rooms. He said medications should always be stored in the carts or in the medication room. He said there were not any residents in the facility that were deemed safe to self-administer any medications in the facility. He said the Pharmacist visited the facility monthly and checked the carts and medication rooms during visits. He said there was a risk for adverse effects to the residents if residents took expired medications or the residents could take too much if medications were left at the bedside. He said he started an in-service with staff yesterday (11/19/2024) about medication storage. During an interview on 11/20/2024 at 3:10 PM, the Administrator said the nurse and nurse aides were responsible for checking the carts daily. She said the medication room was the responsibility of Nursing for checking it daily to make sure there were not any expired medications. She said medications should not be stored at the bedside and should be kept in the medication carts. She said there were not any residents in the facility that could self-administer medications. She said she planned to have nursing supervise and monitor the medication carts and the room. She said there could be negative effects for the residents if they were given medications that were expired or left at the bedside. Record review of an in-service, dated 11/19/2024, titled Nurse & Med Carts by the DON reflected, no medications that are expired can be on the medication cart. It is your responsibility to check daily. Record review of an in-service, dated 11/19/2024, titled Meds at Bedside by the DON indicated, no medication at all are allowed to be kept by residents or at bedside. Pull the medication and give to charge nurse if found. Record review of the facility's policy titled Storage of Medication, revised April 2007, reflected, .The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. 1. Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received. 2. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49017 Based on observation, interview and record review the facility failed to ensure each resident was provided food prepared in a form designed to meet individual needs for 3 of 3 residents (Residents #27, Resident #12 and Resident # 24) reviewed for pureed diets. The facility failed to prepare the pureed diet to the consistency required for Resident #27, Resident #12 and Resident #24. This failure could place residents at risk of not having nutritional needs met by consuming foods that could cause choking and decreased meal intakes. Findings include: 1. Record review of Resident #27's facility face sheet, dated 11/20/2024, for reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #27 had diagnoses which included aphasia following cerebral infarction (a disorder resulting from damage or injury to the language area in the brain), dysphagia (A condition with difficulty in swallowing food or liquid. This may interfere in a person's ability to eat and drink), and protein calorie malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets). Record review of Resident #27's quarterly MDS assessment, dated 10/2/2024, reflected she had a BIMS score of 11, which indicated she had moderate cognitive impairment. Section GG indicated she required supervision assistance for eating. Record review of Resident #27's comprehensive care plan, dated 7/20/2022 and revised on 10/22/2024, reflected Resident #27 was on a low salt pureed diet. Record review of Resident #27's physician's order summery report, dated 11/20/2024, reflected she was ordered a low sodium, dysphagia pureed level 1 regular diet with a start date of 9/5/2024. 2. Record review of Resident #12's facility face sheet, dated 11/20/2024, for reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #12 had diagnoses which included dysphagia (A condition with difficulty in swallowing food or liquid. This may interfere in a person's ability to eat and drink), aphasia (a disorder resulting from damage or injury to the language area in the brain) and cerebral infarction (the pathologic process that results in an area of necrotic tissue in the brain). Record review of Resident #12's annual MDS assessment, dated 10/14/2024, reflected he had a BIMS score of 04, which indicated he had severe cognitive impairment. Section GG indicated he required supervision assistance for eating. Record review of Resident #12's comprehensive care plan, dated 1/13/2023 and revised on 9/23/2024, reflected Resident #12 was on a 2 Gram sodium, pureed texture, honey consistency liquid diet and was at risk for malnutrition. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #12's physician's order summery report, dated 11/20/2024, reflected he was ordered a 2 Gram sodium, dysphagia pureed level 1 regular diet with honey consistency for pleasure with a start date of 8/6/2024. 3. Record review of Resident #24's facility face sheet, dated 11/20/2024, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #24 had diagnoses which included dysphagia (A condition with difficulty in swallowing food or liquid. This may interfere in a person's ability to eat and drink) and cerebral palsy (a group of conditions that affect movement and posture). Record review of Resident #24's significant change in status MDS assessment, dated 8/13/2024, reflected she had a BIMS score of 08, which indicated she had moderate cognitive impairment. Section GG indicated she required supervision assistance for eating. Record review of Resident #24's comprehensive care plan, dated 6/11/2024 and revised on 10/15/2024, reflected Resident #24 was on a therapeutic regular pureed diet. Record review of Resident #24's physician's order summery report, dated 11/20/2024, reflected she was ordered a regular, dysphagia pureed level 1 diet with a start date of 7/10/2024. During an observation and interview on 11/19/24 at 11:35 AM with the Administrator and Director of Nursing, revealed they sampled the pureed pork on the State Surveyors' test tray was observed to be chewy and not a smooth, pudding-like consistency by the surveyor. During an interview with the Dietary District Manager on 11/19/2024 at 1:00 PM, she said she has been in her current position for 1 year. She stated after the test tray was served, she pureed more meat for the residents and replaced the original meat served with the meat with a smoother [NAME]. She said she started an in-service with the dietary staff on pureed texture and consistency. She said the consistency of pureed foods should be smooth and no texture should be detected. She said a smooth texture allowed for the foods to be swallowed easily. She stated broth or other recommended liquids should be added to foods to achieve the right consistency and texture. She stated foods should be precut to smaller pieces to allow the food to break down to a smoother texture. She said the registered dietician came to the facility every other week and did sample test treys with every visit. She said if pureed foods did not have a smooth consistency, it could cause the resident to choke. During an interview with the Dietary Manager on 11/20/2024 at 10:00 AM, revealed he had been working at the facility for 2 years. He said an in-service was started for staff on the correct consistency of pureed foods. He said the cook was responsible for preparing the pureed foods and pureed foods should have a smooth, mousse like consistency. He said the person who prepared the pureed foods should look at the food, take a spoon and check for smoothness. He said the meat should be chopped prior to the puree process. He said a resident could be at risk for choking if the ordered diet was not served. During an interview with the Administrator on 11/20/2024 at 10:30 AM, she said she had been in her position for 1 month. She stated the pureed consistency needed to be correct. She said she would be monitoring the consistency of the pureed diets. She said she was also going to get the speech therapists and dietician involved in the observation and the consistency. She said a resident could possibly aspirate or effect intake by pocketing food. (continued on next page)

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	676147	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stallings Court Nursing and Rehabilitation	4616 NE Stallings Dr Nacogdoches, TX 75965

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's document titled texture modification in-service from the dietary operations v2 policy reflected All foods must be pureed to a mousse-like texture . Blend food items until fine and smooth.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 43994 Based on an interview and record review the facility failed to maintain a Quality Assessment and Assurance Committee which consisted at a minimum of the director of nursing services, the Medical Director or designee, at three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role and the infection preventionist and the facility failed to ensure the Quality assessment and assurance committee met quarterly and as needed to coordinate and evaluate activities, including performance improvement projects required under QAPI program for 4 of 11 months (April 2024, May 2024, July 2024 and October 2024. reviewed for QAA/QAPI. 1. The facility failed to ensure the Medical Director attended their QAA and QAPI meetings for the months of April 2024, May 2024 and July 2024. 2. The facility failed to ensure they had QAA and QAPI meetings for the month of October 2024. These failures could place residents at risk for quality deficiencies being unidentified and no appropriate plans of actions developed or implemented. Findings include: Record review of the facility's QAA/QAPI meeting signature logs for the months of April 18, 2024, May 16, 2024, and July 18, 2024 reflected meetings were conducted each month during that period. Neither the Medical Director nor his/her designee signed the sign-in sheets, nor was it indicated on the sign-in sheet the Medical Director or his designee attended the QAA/QAPI meetings via zoom or by phone. Record review of the facility's QAA/QAPI meeting signature logs for the past year from October 18, 2023, to September 19, 2024. There was no record of a signature log for the month of October 2024. During an interview on 11/20/2024 at 1:30 PM, the Administrator said she had been employed at the facility since October 1, 2024. She said the facility had meetings for QA monthly. She said she was in the learning process of what the facility wanted. She said she was not aware the facility policy indicated they would have meetings monthly and knew the state regulation was for quarterly meetings. She said they had not had a meeting since she took over as the Administrator. She said in the meetings they should be discussing weights, skin issues, infection control, medications, and anything pertinent to care. She said recently she had been focused on falls with an action plan in place. She said all department heads and IDT team members would be included in the meetings along with the Medical Director. She said they planned to have monthly meetings going forward with it being scheduled on or around the 3rd week of the month. She said there was a risk of information being missed when all team members were not in attendance at the meetings. (continued on next page)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled Quality Assurance and Performance Improvement (QAPI) Committee, dated July 2016 reflected .This facility shall establish and maintain a Quality Assurance and Performance Improvement (QAPI) Committee that oversees the implementation of the QAPI program. 3. The following individuals will serve on the committee: c. Medical Director; Committee Meetings 1. The committee will meet monthly at an appointed time

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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** 46273 46436 Based on observation, interview, and record review the facility failed to establish and 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 3 of 10 residents (Residents #11, #65, and #181) and 2 of 6 staff (CNA C and CNA H) reviewed for infection control. 1.CNA C failed to change gloves and perform hand hygiene during incontinent care for Resident #11 on 11/18/2024. 2.The facility failed to ensure CNA C did not enter the isolation rooms of Residents #65 and #181 without PPE on 11/18/24. These failures could place residents at risk of exposure to infectious diseases . Findings include: 1.Record review of Resident #11's facility face sheet, dated 11/19/2024, reflected Resident #11 was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #11 had a diagnosis which included Atrial Fibrillation (an irregular heartbeat). Record review of Resident #11's comprehensive care plan, dated 9/19/2024, reflected Resident #11 had bowel and bladder incontinence and required incontinent care from staff. Record review of Resident #11's quarterly MDS assessment, dated 9/21/2024, reflected Resident #11 had a BIMS of 11, which indicated moderately impaired cognition. Resident #11 was dependent on staff for toileting. During an observation on 11/18/24 at 2:34 PM revealed CNA C and the ADON provided incontinent care to Resident #11. Both entered the room and applied gown and gloves for enhanced barrier precautions. CNA C opened Resident #11's brief and cleaned the front with wipes using a front to back technique. The ADON assisted Resident #11 to her right side. CNA C then cleaned Resident #11's buttock with wipes and the soiled brief and draw sheet was rolled under Resident #11. CNA C then placed a clean sheet and brief without removing her gloves or performing hand hygiene. CNA C proceeded to apply the clean brief, positioned Resident #11 in bed and adjusted Resident #11's pillows and linen with the ADON's assistance. CNA C then removed her gloves and gown, performed hand sanitization and left room. During an interview on 11/18/24 at 2:44 PM, CNA C said she had been a CNA for 2 years and at the facility 1 year . She said she was recently checked off on incontinent care and infection control. She said during incontinent care she should have removed her gloves and performed hand hygiene when going from soiled to clean. She said by not doing so she could cause spread of infections . (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 11/18/24 at 2:50 PM, the ADON said she had been at the facility for 3 years . She said she was responsible for competency checks for all staff and she and the CNA had recently had annual competency training. She said she should have talked to the CNA and made sure she was properly prepared and not nervous to perform care. She said care from soiled to clean gloves should be changed and hand hygiene performed. She said by not doing so, it put the residents at risk for cross contamination and infections. During an interview on 11/20/24 at 1:50 PM, the DON said the ADON was responsible for training on infection control and skill check offs for CNA's. He said all nursing staff were trained on infection control measures on hire, annually and as needed. He said he expected infection control measures were followed by all staff to prevent the spread of infections and cross contamination. During an interview on 11/20/24 at 2:13 pm , the Administrator said the DON and the ADON were responsible for the infection control program and training. She said training was completed on hire, annually and as needed. She said she expected infection control measures were always followed to prevent the spread of infections. Record review of a competency skills checkoff dated 9/11/24, reflected CNA C was competent on incontinent care and infection control. Record review of the facility's policy titled Perineal Care, dated December 2011, reflected, .the purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritations and to observe the resident's skin condition. 12. remove gloves and discard into designated container. Wash and dry your hands thoroughly. Put on clean gloves and place new brief and secure in place. Reposition the bed covers and make the resident comfortable 2. Record review of Resident #65's facility face sheet, dated 11/21/24, reflected he was a [AGE] year-old male who was admitted to the facility on [DATE] and subsequently readmitted on [DATE]. Resident #65 had diagnoses which included intraspinal abscess and granuloma (a collection of pus and infectious material in the spine), sepsis (a serious condition in which the body responds improperly to an infection, causing organ damage and sometimes death) and metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body). Record review of Resident #65's Nursing Home PPS MDS assessment, dated 11/9/24, reflected Resident #65 had a BIMS score of 15, which indicated he was cognitively intact. He was on isolation or quarantine for active infectious disease. Record review of Resident #65's comprehensive care plan, dated 11/6/24, for reflected Resident #65 was on MSSA/contact precautions and had the following intervention: .contact precautions due to MSSA Record review of Resident #65's physician's order summary report, dated 11/21/24, reflected he had the following order dated 11/5/24: .Contact Isolation Precautions for MSSA in wound (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 #181's facility face sheet, dated 11/19/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #181 had diagnoses which included infective endocarditis (a potentially fatal inflammation of your heart valves' lining and sometimes heart chambers' lining), sepsis (a serious condition in which the body responds improperly to an infection, causing organ damage and sometimes death) and hyperlipidemia (high cholesterol). Record review of Resident #181's electronic medical record indicated her entry MDS was in process and had not been completed yet. Record review of Resident #181's physician's order summary report, dated 11/19/24, reflected she had the following order dated 11/14/24: .Contact and Isolation Precautions for (MRSA) every shift Record review of Resident #181's comprehensive care plan, dated 11/15/24, reflected she required contact isolation and had the following intervention: .follow facility isolation policy During an observation on 11/18/24 at 11:13 AM revealed Resident #65's room had a contact isolation sign on door and a PPE box located outside doorway. During an observation on 11/18/24 at 11:15 AM revealed Resident #181's room had a contact isolation sign on the door and a PPE box located outside doorway. During an observation on 11/18/24 at 11:45 AM revealed CNA H passing meal trays and she entered Resident #65's room without donning PPE. When Resident #65 refused his meal, she returned to the hallway with his tray in hand and placed it back on the tray cart. She was then observed removing the meal tray for Resident #181 and entered her room without donning PPE. The DON walked down hall at this time and saw her in Resident #181's room. When she exited the room, the DON said something inaudible to her and she was then observed going into the shower room to wash her hands. During an interview on 11/18/24 at 11:55 AM, the DON said CNA H should not have entered the isolation rooms without donning PPE. He said she had been trained and the 2 residents were on Contact Isolation Precautions. During an interview on 11/18/24 at 12:00 PM, CNA H said she thought she only had to wear PPE if she was providing resident care. She said she thought Resident #65 was on precautions due to his wound and Resident #181 was on precautions due to having an IV. She said infections could be spread between residents if infection control techniques were not followed. During an interview on 11/20/24 at 2:55 PM, the DON said Enhanced Barrier Precautions had everyone confused and going forward he would continue to educate the staff regarding Contact Precautions versus Enhanced Barrier Precautions. He said residents could be at risk for cross-contamination if proper infection control procedures were not followed. During an interview on 11/20/24 at 3:10 PM, the Administrator said she would be in-servicing the staff on PPE usage and the different isolation types. She said if staff did not follow proper infection control precautions, infections could spread. Record review of a CNA Proficiency Evaluation, dated 8/6/24, reflected CNA H had received training on Infection Control. (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 Prevention and Control Program, dated 2001 and revised in August of 2016, reflected .7. Prevention of Infection a. Important facets of infection prevention include .(6) implementing appropriate isolation precautions when necessary Record review of the facility's policy titled Isolation - Initiating Transmission-Based Precautions, dated 2001 and revised in January 2012, reflected .Transmission-Based Precautions may include Contact Precautions, Droplet Precautions, or Airborne Precautions .Transmission-Based Precautions shall remain in effect until the Attending Physician or Infection Preventionist (or designee) shall: a. Ensure that protective equipment (i. e. gloves, gowns, masks, etc.) is maintained near the resident's room so that everyone entering the room can access what they need