STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676154	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capstone Healthcare of Hughes Springs	215 Fm 161 Business South Hughes Springs, TX 75656

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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** 44128 Based on record review, observation, and interview , the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 1 of 15 residents reviewed for resident rights. (Resident #31) The facility failed to treat Resident #31 with dignity and respect by CNA F denying his request to have food brought by his family reheated on 02/12/2025. This failure could place residents at risk for decreased quality of life, decreased self-esteem and increased anxiety. Findings included: Record review of a face sheet dated 04/01/25 indicated Resident #31 was a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of heart disease, unsteadiness on feet, and generalized weakness. Record review of the quarterly MDS assessment dated [DATE] revealed Resident #31 had a BIMS of 15, which indicated intact cognition. Resident #31 required moderate to maximal assistance for most ADLs. Record review of a care plan dated 03/27/25 indicated Resident #31 had right hemiplegia/hemiparesis (a condition characterized by paralysis on one side of the body) related to a stroke and would maintain optimal status and quality of life within limitations imposed by hemiplegia/hemiparesis. Record review of a Nurse's Note for Resident #31 dated 02/12/25 at 8:00 p.m. indicated, .Res (resident) reports he is upset with CNA staff person due to her declining to heat food brought in by a family member . she made me feel like I didn't need any food. Explained policy of not being able to heat food brought in by family due to infection control, cross contamination and inability to control heat levels of food heated in the microwave. Res voiced understanding but states you know that's BS . The Nurse's Note was signed by RN G. (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	Record review of a Nurse's Note for Resident #31 dated 02/12/25 at 8:30 p.m. indicated, .Res on CL (call light) and CNA went to his aid. She returned to this nurse reporting res had her prepare some snacks for him. She reports res was crying saying he didn't have any supper. This nurse talked with res (resident) and he is calm and having his snacks. Offered crackers or a banana off snack cart and he declines saying he has plenty now . The Nurse's Note was signed by RN G. During an observation and interview on 03/31/25 at 1:55 p.m., Resident #31 said a family member had brought him food from a restaurant. He said the food had been in his refrigerator . There was a refrigerator beside his bed. He said he asked CNA F to reheat the food for him so he could eat it for dinner on 02/12/25. He said she told him it was not their practice to heat up food for residents. He said he had cancelled his supper tray. He said she should have told him that she could not reheat his food before she cancelled his supper for him. He said he was angry and upset that CNA F would not reheat his food for him. He said he skipped supper even though they offered him a sandwich. He said she made him uncomfortable. During an interview on 04/01/25 at 2:12 p.m., CNA F said she went in to Resident 31's room and he asked her to warm up some food that a family member had brought him. She said she carried the food to the kitchen and dietary staff told her they were not allowed to bring it into the kitchen to heat it up due to cross contamination. She said she then went to the nurse and the nurse told her the same thing. She said the nurse also told her she could not heat the food up in the employee breakroom microwave. She said when she went back to tell Resident #31 and he became very upset. She said all she told him was I can only do so much. She said the decision was not up to her. She said he then refused his evening meal tray. She said around 7:15 p.m. she went back in the room to get his roommates bed ready to put him to bed. She said Resident #31 became very upset and began yelling at her. She said he was yelling and hollering. She said again she tried to explain that she had nothing to do with it. That she was not allowed heat up his food. She said she told him to be upset with the nurse and the dietary staff. She said there were no witnesses to the conversation. During an interview on 04/01/25 at 3:18 p.m., RN G said CNA F never came to her and asked her about heating up Resident 31's food. She said staff had been told not to heat up residents' food because they could not regulate the temperature and it was an infection control issue. She said if she were in her home and could not have her food heated up it would make her feel terrible. She said it was Resident 31's right to have his food headed up. She said Resident #31 cried because his food was not heated up for him. During an interview on 04/01/25 at 3:56 p.m., the Social Services Assistant said she met with Resident #31, the DON, and Interim Administrator. She said there were no witnesses to the incident. She said she talked to him about his food not being heated up and he told her it pissed him off. He told her it made him feel like he was fat, and it would not hurt him to miss a meal. He told her that CNA F had not said that to him, but it was how it made him feel. During an interview on 04/02/25 at 9:04 a.m., the Dietary Manager said they did not reheat food that came from outside of the facility. She said this because they cannot prove where it came from or if it is safe or not. She said it would upset her if her food was not reheated but being in the business as long as she had, she would understand the rules and regulations. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/02/25 at 11:07 a.m., the DON said nursing staff could not reheat food for residents. He said food had to be served at a certain temperature and CNAs did not have food preparation training. He said he could not speculate on how not reheating a resident's food could negatively affect a resident. During an interview on 04/02/25 at 11:26 a.m., the Interim Administrator said Resident #31 had requested for CNA F to reheat food his family brought in. She said Dietary staff told CNA F that they could not reheat the food due to cross contamination. She said food brought in by family members was not reheated because they were not able to temp the food and the resident could be burned. She said if the food was old the resident could come in contact with a food borne illness. She said for as much as they were able to do so, she would expect 100% for the resident's preferences to be followed. She said resident preferences not being followed could affect their quality of life and their satisfaction could be negatively affected. Record review of a Foods Brought by Family/Visitors facility policy last revised in 03/2022 indicated, .Food brought to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of resident . Record review of a Food and Nutrition Services facility policy last revised in 10/2017 indicated, .Reasonable efforts will be made to accommodate resident choices and preferences . Record review of a Resident Rights facility policy last revised 02/2021 indicated, .Federal and state laws guarantee certain basic rights to all resident of this facility. These rights include the resident's right to .a dignified existence .self-determination .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49019 Based on observation, interviews and records reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident to ensure the comprehensive care plan described the services and interventions to be used to attain and maintain the resident's practicable physical, mental, and psychosocial well-being for 3 of 22 residents reviewed for care plans (Resident #8, Resident #29, and Resident #41). 1. The facility failed to develop a comprehensive person-centered care plan for Resident #29's depression and impaired coping with interventions following aggressive behaviors (scratched roommate on face) on 2/21/2025 and calling the police telling them he was being held hostage at gunpoint on 3/18/2025. 2. The facility failed to develop a comprehensive person-centered care plan for Resident #41's for wounds and enhanced barrier precautions (a set of infection control measures that use gowns and gloves to reduce the spread of multidrug-resistant organisms (MDROs; are bacteria that are resistant to multiple antibiotics and antifungals) implemented. 3.The facility failed to develop a comprehensive person-centered care plan for Resident #8's DNR code status (instruction to not perform life saving measures if a person's heart or breathing stops), diet, anorexia (abnormal loss of the appetite for food), use of a plate guard, mood, anxiety, impaired visual function, and urinary incontinence. These failures could place residents at risk of not having their individualized needs met, and a decline in their quality of care and life. Findings included: 1. Record review of Resident #29's face sheet dated 4/1/2025 indicated Resident #29 was a [AGE] year-old male readmitted to the facility on [DATE]. Resident #29 had diagnoses including unspecified displaced fracture of surgical neck of right humerus (a severe injury where the arm bone (humerus) is broken near the shoulder), fracture of the lower end of right radius (a fracture of the lower end of the right radius (wrist), fracture of unspecified part of neck of right femur (when the ball on top of the femur breaks off at its junction with the neck of the upper thigh bone within the hip joint), Atherosclerotic heart disease of native coronary artery (a buildup of plaque (a waxy, fatty substance) in the arteries), cirrhosis of the liver (is advanced scarring of the liver caused by many diseases and conditions, including hepatitis or alcohol use disorder) and Major depressive disorder(a mental disorder characterized by a persistent low mood, loss if interest or pleasure in activities). Record review of Resident #29's admission MDS assessment dated [DATE] indicated Resident #29 was usually understood and usually understood others. Resident #29 had a BIMS of 08 which indicated moderate cognitive impairment. Resident # 29 had a diagnosis of Depression and was prescribed antidepressant. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #29's care plan revised on 3/31/2025 indicated Resident #29 had impaired coping with an intervention to monitor the effectiveness of Resident's immediate support system. There was no care plan indicating resident had aggression toward roommate or others, interventions, or effective coping measures to prevent future behaviors. During an interview and observation on 3/31/2025 at 10:39 AM, Resident #29 observed lying in bed with fall mate next to bed. Resident #29 was disheveled in appearance. Resident #29 said he was not eating much because he had a stomachache and he said he was losing weight. Resident said his depression had not been addressed. Resident #29 said he did not want to be here anymore. Resident denied having a plan to harm himself. During an interview on 3/31/2025 at 11:50 AM, the DON was made aware of Resident #29's statement. The DON said he would get the SW and start interventions and a plan for Resident #29's depression. The DON said Resident #29 recently came off isolation and hospice care. During an interview on 3/31/2025 at 12:15 PM, the Social Worker said the resident told her that he has said those things many of times throughout his life and he would not do anything to harm himself. The Social Worker said an outside psychiatric group recently resumed care and the staff are encouraging Resident #29 to participate in activities. During an interview on 3/31/2025 at 1:00 PM, Resident # 29 said he was depressed, not suicidal. The DON came into the room during that time and started conversation with Resident #29. During an interview on 4/1/2025 at 3:35 PM, the Social Worker said Resident #29 should have a Trauma Informed Care assessment, but the Psychiatric group came to the facility while Resident #29 was on Covid restrictions. The Social worker said she had not completed his Trauma Informed care because the facility did not have an official form. The Social worker said she determined if a resident needed a Trauma Informed Care assessment and it was identified if a resident had a diagnosis of depression, other mental illness or behaviors. The Social Worker said she was out when Resident #29 came to the facility. During an interview on 4/1/2025 at 3:50, the Social Worker provided the Trauma Informed Care policy and said she made a referral a couple of weeks ago and the Psychiatric group came in while Resident #29 was on Covid (Coronavirus disease of 2019) restrictions. She said initially Resident #29 was on respite care. The Social Worker said the Psychiatric group would be returning to the facility on [DATE] and she was going to update Resident #29's care plan. During an interview on 4/1/2025 at 4:10 PM, Resident #29's RP said he was a negative person and said he stayed depressed. Resident #29's RP said Resident #29 had multiple losses in his past and past motor vehicle wrecks. Resident #29's RP said the facility was going to resume psychological therapy. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #41's face sheet dated 03/31/2025 indicated Resident #41 was an [AGE] year-old male readmitted on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (a lung condition caused by damage to the airways and alveoli, usually from smoking or other irritants), Chronic cystitis (infection or inflammation of the urinary bladder or any part of the urinary system cause by a bacteria), Diverticulitis of large intestine without perforation or abscess without bleeding (an inflammation with or without infection of a diverticulum (a pouch-like structure that form in the wall of the large intestine), which causes abdominal pain and can create a collection of pus around the inflamed diverticulum), pressure ulcer of head (an injury to the skin and the tissue below the skin that are due to pressure on the skin for a long time), and abnormal weight loss (a noticeable drop in your body weight without trying). Record review of Resident #41's comprehensive MDS assessment dated [DATE] indicated Resident #41 understood and was understood by others. Resident #41 had a BIMS score of 12 which indicated moderate cognitive impairment. Resident #41 was at risk of developing pressure ulcer/injuries. Record review of Resident #41's care plan initiated on 3/14/2025 indicated Resident #41 had an incomplete care plan and did not indicate he was on enhanced barrier precautions or had any skin concerns. Record review of Resident #41's treatment administration record dated 3/1/2025-3/31/2025 indicated Resident #41 had multiple abrasions documented as follows: o Abrasion to bridge of nose: Resolved 3/17/2025 o Pressure area to left top of ear: Resolved 3/12/2025 o Left lower knee- Resolved 3/3/2025, 3/17/2025 o Abrasion to left lower hip- Resolved 3/17/2025 o Abrasion to lower left lateral leg- ongoing o Left shoulder wound- Resolved 3/12/2025 o Left upper arm wound- Resolved 3/26/2025 o Right shoulder wound- Resolved 3/7/2025 o Right knee wound- Resolved 3/26/2025 o Right lower shin wound- Resolved 3/12/2025 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/2/2025 at 10:22 AM, RN B said the CNAs know what to do for each resident because they have been there for a while. RN B said the care should be on the care plan. RN B said the care plan was completed by the MDS nurse and the nurses complete the assessments and initiate the care plan along with the MDS nurse. RN B said the ADON, DON and the MDS nurse initiate the care plan. She said the nurse staff would also let the staff know if a resident had a foley catheter. She said the initiation of the care plan should be completed within 24 hours. She said if a resident did not have the proper care plan in place, the staff would know how a resident should be transferred, what medications, oxygen and how they eat. She said if a care plan was not initiated a resident could have a fall if improperly transferred, if foley care was not provided and resident could get an infection. RN B said it was the responsibility of everyone to ensure the care plan was being followed. During an interview on 4/2/2025 at 10:53 AM, the MDS nurse said she completes the care plan. She said the DON completes the baseline care plan and each department completes their part, and the baseline goes into the soft file. The MDS nurse said once the care plan goes into the EMR, it pulls over into the new EMR. She said the DON has a cheat sheet with CNA pocket workbook and they keep it at the front. The MDS nurse said she was responsible for ensuring the care plans were put in. The MDS nurse said the facility changed to a new system and she had to put in new care plans on everyone. The MDS nurse said she was adding new care plans to the new EMR when a new resident was admitted and working on the older residents who had been at the facility for a while as she could get to them. The MDS nurse said the facility has morning meetings and she said she tries to get the 24-hour report and updates the care plan. She said the DON ensured the Care plan was in the system and the staff follow the plan of care. The MDS nurse said she had not been adding the EBP to the care plans and said it was a new policy. During an interview on 4/2/2025 at 11:07 AM, the Social Worker said Resident #29 was on respite in October 2024 then discharged and returned on 11/15/2024 for skilled care, then discharged and returned on 1/9/2025. She said upon readmission, Resident #29 was more agitated due to having to return. The Social worker said there was an incident where the resident called the police. She said she knew Resident #29 prior and the RP was concerned about sundowners. The Social Worker said there were other illnesses that could cause delusions and hallucinations. The Social Worker explained Resident #29 had labs in February 2025 to rule out a medical concern before psychological. She said he had slightly elevated ammonia levels but not enough to trigger for hallucinations. She thought he had a urinary tract infection. The Social Worker said she reviewed a trauma informed care policy, and it says it should be performed but was not clear when it should be done, and the regulations were broad. The Social Worker said the facility turn it over the Psychologist. The Social Worker said Resident #29 does things to get RP's attention and had past behaviors of calling RP and cussing them out. The Social Worker said she felt the behaviors were medical and not psychological. The Social Worker said urinary tract infections can cause hallucinations. She said Resident #29 does have depression and was going to get an assessment and it would need to be care planned. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #8's undated Care Plan Report reflected the resident had a mood problem, impaired visual function, and bladder incontinence, but there were no interventions for those focus areas. The Care Plan Report reflected there were no focus areas or interventions related to her DNR code status, diet, anorexia, or use of a plate guard. During an observation on 3/31/25 beginning at 12:48 PM, Resident #8 was sitting in her wheelchair at a dining table. Resident #8 was served her meal on a plate with a plate guard and staff told her what foods and where each food was located on the plate. Resident #8 attempted to feed herself and staff sat at the table beside her to assist and give verbal cues during the meal service as needed. During an interview on 4/02/25 at 10:01 AM, the MDS Coordinator said she was still learning the new software since the new company took over the facility in October 2024. The MDS Coordinator said she was responsible for completing the Comprehensive Care Plans. The MDS Coordinator said the purpose of the Comprehensive Care Plan was to show areas including medications, ADL assistance, diagnoses, preferences, Code Status, oxygen, diet, pressure ulcer risks, and fall risks. The MDS Coordinator said if there was a problem care area on the Comprehensive Care Plan then there should be goals and interventions to manage the problem care area. The MDS Coordinator said she would correct Resident #8's Comprehensive Care Plan and did not know how she missed it. The MDS Coordinator said they had to create brand new care plans for each resident when they switched software systems beginning in October 2024 when the new company took over the facility and she could have missed those care areas then. During an interview on 4/02/25 at 10:38 AM, the DON said the MDS Coordinator and himself were responsible for ensuring the Comprehensive Care Plans were complete and included all the care areas pertinent to the resident. The DON said the purpose of the Comprehensive Care Plan was to paint a picture of the resident and to guide the care of the resident. The DON said care areas such as oxygen, diet, vision impairment, DNR code status, ADL assistance, diagnoses, and medications were care areas that should be included in the Comprehensive Care Plan. The DON said each care should include goals and interventions the Comprehensive Care Plan. The DON said he could not speculate what the risk to the resident would be if the Comprehensive Care Plan did not include all the pertinent care areas for the resident. During an interview on 4/02/25 at 12:17 PM with both the ADM and the Interim ADM, the ADM said the purpose of the Comprehensive Care Plan was to have a clear picture of how the team was to care for the resident, so the resident had the best optimum outcomes. The ADM said general quality of care could be impacted if the resident did not have a complete Comprehensive Care Plan with pertinent care areas specific to the resident and could result in a decreased quality of life. The Interim ADM said all areas of care for each resident needed to be addressed in the Comprehensive Care Plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a facility's Care Plans, Comprehensive Person-Centered revised March 2022 indicated .A comprehensive, person-centered care plan that includes measurable objectives and timetables .The interdisciplinary team, in conjunction with the resident and his/her family or legal representative, develop and implements a comprehensive .The comprehensive, person-centered care plan is developed within 7 days of the completion of the required MDS assessment (Admission, Annual, or Significant change in status), and no more than 21 days after admission .The care plan interventions are derived from a thorough analysis of the information gathered .Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate .including the right to .participate in the planning process, identify individuals or roles to be included, request meetings, request revisions to the care plan, participate in establishing the expected goals and outcomes of care, and participate in determining the type, amount, frequency and duration of care .Services provided for or arranged by the facility and outlines in the comprehensive care plan are: provided by a qualified person, culturally competent and trauma informed .Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes and relevant clinical decision making . When possible, interventions address the underlying source (s) of the problem area (s), not just symptoms triggers . Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change . Record review of a facility's Care Plans, Comprehensive Person-Centered revised March 2022 indicated .A comprehensive, person-centered care plan that includes measurable objectives and timetables .The interdisciplinary team, in conjunction with the resident and his/her family or legal representative, develop and implements a comprehensive .The comprehensive, person-centered care plan is developed within 7 days of the completion of the required MDS assessment (Admission, Annual, or Significant change in status), and no more than 21 days after admission .The care plan interventions are derived from a thorough analysis of the information gathered .Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate .including the right to .participate in the planning process, identify individuals or roles to be included, request meetings, request revisions to the care plan, participate in establishing the expected goals and outcomes of care, and participate in determining the type, amount, frequency and duration of care .Services provided for or arranged by the facility and outlines in the comprehensive care plan are: provided by a qualified person, culturally competent and trauma informed .Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes and relevant clinical decision making . When possible, interventions address the underlying source (s) of the problem area (s), not just symptoms triggers . Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change 46062

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	676154	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capstone Healthcare of Hughes Springs	215 Fm 161 Business South Hughes Springs, TX 75656

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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** 46062 Based on observation, interviews and record review, the facility failed to ensure a resident with urinary incontinence, based on the resident's comprehensive assessment, received appropriate treatment and services to prevent urinary tract infections (UTI) for 1 of 3 residents (Residents #7) reviewed for urinary catheters. 1. The facility failed to ensure CNA D performed hand hygiene and changed gloves appropriately during and after providing incontinent care to Resident #7. 2. The facility failed to ensure CNA D performed hand hygiene and changed gloves appropriately prior to providing indwelling urinary catheter care to Resident #7. These failures could place residents at an increased risk for urinary tract infections. Findings included: Record review of Resident #7's face sheet dated 4/01/25 revealed he was [AGE] years old and admitted to the facility on [DATE]. Resident #7 had diagnoses including dementia (forgetfulness), senile degeneration of brain (progressive decline in cognitive abilities, such as memory, thinking, and reasoning), diabetes (high blood sugar, places at higher risk of infection), retention of urine, and chronic kidney disease. Record review of Resident #7's annual MDS assessment dated [DATE] indicated he was unable to complete the BIMS, which indicated he had severe cognitive impairment. Resident #7 was dependent on staff assistance for most ADLs. The MDS indicated Resident #7 had an indwelling catheter (urinary catheter inserted into the bladder to drain urine). The MDS indicated Resident #7 was always incontinent of bowel. Record review of Resident #7's undated Care Plan Report indicated he had an indwelling catheter related to retention of urine with interventions including catheter care daily and PRN; he was at risk for self-care deficit with interventions including toileting-dependent x 2 staff; he had bowel incontinence with interventions including to check resident every two hours and assist with toileting as needed, and provide peri (human private area) care after each incontinent episode. Record review of Resident #7's Order Summary Report dated 4/02/25 revealed an order for foley (urinary) catheter care every shift with an order date of 2/06/25. (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 observation on 4/01/25 beginning at 3:30 PM to observe incontinent care and urinary catheter care, observed an Enhanced Barrier Precautions sign and an isolation cart outside the door of Resident #7. CNA D and CNA E both donned (put on) isolation gowns prior to entering Resident #7's room. Upon entering Resident #7's room, CNA D and CNA E washed their hands and donned gloves. CNA D picked up Resident #7's fall mat off of the floor, folded it, and placed against the wall. Then CNA D pulled Resident #7's bed away from the wall and CNA E went between the wall and Resident #7's bed. CNA D without performing hand hygiene or changing gloves, she proceeded to pull Resident #7's bed sheet back toward his feet, unfastened his brief, then assisted CNA E turn Resident #7 onto his right hip toward CNA E by putting one gloved hand on Resident #7's shoulder and the other gloved hand on his hip and pushed him toward CNA E. CNA D then removed Resident #7's soiled brief and proceeded to cleanse feces (bowel movement) from his buttocks using wipes. CNA D then assisted CNA E assist Resident #7 back on to his back by placing one gloved hand on his shoulder and the other gloved hand on his hip and she did not perform hand hygiene or change her gloves after cleaning feces from his buttocks. CNA D, without performing hand hygiene or changing her gloves, then proceeded to use a wipe to cleanse Resident #7's head of his penis, then used a wipe to cleanse down each side of his testicles, then CNA D used another wipe to cleanse down his urinary catheter tubing and repeated twice. CNA D then assisted CNA E to roll Resident #7 over onto his right hip toward CNA E and placed a new brief on him. CNA D then placed her same gloved hands on his hip and shoulder to turn Resident #7 onto his back. CNA D and CNA E then used a draw sheet to pull Resident #7 up in bed. CNA D placed a positioning wedge under Resident #7's left side, then placed his urinary catheter bag back on the side of his bed, then covered Resident #7 with a bed sheet, then moved his bed back against wall, then CNA D used his bed remote to let Resident #7 down to a low position. CNA D did not perform hand hygiene or change her gloves at any point while providing incontinent care, urinary catheter care, positioning, or arranging Resident #7's furniture, except upon entering Resident #7's room and prior to exiting Resident #7's room. During an interview on 4/01/25 at 3:44 PM, CNA E said she had worked at the facility for approximately six years and normally worked on the 6 AM - 2 PM shift. CNA E said staff should perform hand hygiene and change gloves when a resident has had a bowel movement and before placing clean stuff underneath resident. CNA E said CNA D should have changed her gloves after handling the floor fall mat and prior to providing care to the Resident #7. CNA E said CNA D should have changed gloves and washed her hands after cleaning the bowel movement off Resident #7. CNA E said staff could give the resident an infection, such as a UTI (urinary tract infection), if they use the same gloves used to clean bowel movement and whatever bacteria could have been on the floor fall mat. CNA E said CNA D should have washed her hands and changed gloves prior to handling the residents bedding, bed remote, or anything that was not contaminated. CNA E said CNA D could have given Resident #7 any bacteria that could have been on her gloves onto his urinary catheter, clean brief, clothing, bedding, positioning wedge, bed, and bed remote and then the resident could have touched them and even put his hand in his mouth and given him an infection. CNA E said she had received training on performing incontinent care, urinary catheter care, and infection control, and when to perform hand hygiene and when to change gloves. CNA E said it was an infection control issue when CNA D contaminated Resident #7's urinary catheter, his clothing, clean brief, bed, bedding, bed remote, positioning wedge, and urinary catheter bag. (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 4/01/25 at 3:55 PM, CNA D said she had worked at the facility for a little over a year as a CNA and normally worked the 6 AM - 2 PM shift. CNA D said she should have changed her gloves after picking up the floor fall mat and prior to providing care to Resident #7. CNA D said she should have performed used hand sanitizer and changed her gloves after cleaning bowel movement off Resident #7's back half and then flipped him back to do his front half. CNA D said not sanitizing and changing her gloves after cleaning bowel off Resident #8's back half and then performing incontinent/urinary catheter care and then touching multiple things in Resident #7's room was cross contamination and could cause the resident an infection. CNA D said she had been trained on performing hand hygiene, when to change gloves, incontinent care, urinary catheter care, and infection control and prevention. CNA D said she was just nervous. CNA D said it all was an infection control issue. During an interview on 4/01/25 at 4:02 PM, LVN C said staff should wash hands, put gloves on, change gloves when going from dirty to clean, wash hands, change gloves, and then finish dressing or other things. LVN C said it would be cross contamination if staff did not change their gloves from picking something up off the floor, then performing bowel incontinent care, then urinary catheter care, and then proceeding to touch multiple surfaces and bedding in the resident's room. LVN C said the nursing facility residents had a weaker immune system and it placed them at a higher risk of infection. LVN C said it was cross contamination and an infection control issue. During an interview on 4/02/25 at 9:42 AM, RN B said staff should gather their supplies for incontinent care and/or foley catheter care, then wash their hands, and put on gloves. RN B said staff should perform hand hygiene and change their gloves when going from a dirty area to a clean area. RN B said staff should have removed the resident's fall mat and moved his bed prior to beginning resident care and then washed their hands and applied new gloves. RN B said staff should have changed gloves prior to performing front perineal area care and foley catheter care after cleaning bowel movement from the buttocks of the resident. RN B said it was an infection control issue and it was unsanitary by touching everything around the resident without performing hand hygiene or changing gloves. RN B said residents were on Enhanced Barrier Precautions because they were at a higher risk of infection due to having medical implanted devices such as feeding tubes or urinary catheters. RN B said by staff not changing gloves after cleaning bowel movement and then performing urinary catheter care, there was an increased risk of introducing E-coli (Escherichia coli-bacteria found in feces/bowel movement) into the system and placed the resident at a higher risk of infection. During an interview on 4/02/25 at 10:38 AM, the DON said CNA D should have approached the resident with clean gloves and should have changed gloves and sanitized after performing bowel movement incontinent care and after performing incontinent /urinary catheter care, and again before touching anything clean. The DON said the staff had received training on appropriate hand hygiene, changing gloves, incontinent care, urinary catheter care, and infection control. The DON said he could not speculate what the risk to the resident would be from CNA D not performing hand hygiene or changing her gloves appropriately and then touching multiple surfaces in close proximity of Resident #7. The DON said Resident #7 was on Enhanced Barrier Precautions because he had a urinary catheter because that was the way the Enhanced Barrier Precautions guidelines were written. The DON said he could not speculate if Resident #7 was at a higher risk of infection or urinary tract infections from CNA D not changing her gloves or performing hand hygiene appropriately. (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 4/02/25 at 12:17 PM, the ADM said by the CNA not performing hand hygiene or changing her gloves appropriately, it could be an infection control concern. The ADM said by the CNA touching multiple things in the resident's room, it was cross contamination and could place the resident at a higher risk of infections and UTIs (urinary tract infections). The ADM said she would expect staff to follow the facility's policies related to infection control, hand hygiene, incontinent care, and urinary catheter care. Record review of CNA Orientation/Competency check-off form dated completed on 1/09/25 for CNA D indicated she was evaluated by the DON on 1/09/25 on Incontinent Care to include perineum care and foley catheter care and had a check mark in the Passed column . Record review of the facility's policy titled Perineal Care dated revised February 2018 indicated . the purpose of this procedure was to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition . steps in the procedure . wash and dry your hands thoroughly . fold the bedspread or blanket toward the foot of the bed . fold the sheet down to the lower part of the body . put on gloves . for a male resident . wash perineal area (private area) starting with the urethra (opening at head of penis) working outward . if the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about three inches, gently rinse and dry the area . wash and rinse the rectal area thoroughly . remove gloves and discard . wash and dry hands thoroughly . reposition the bed covers, make the resident comfortable . wash and dry your hands thoroughly . Record review of the facility's policy titled Catheter Care, Urinary dated revised August 2022 indicated . purpose of this procedure was to prevent urinary catheter-associated complications, including urinary tract infections . infection control . use aseptic technique when handling or manipulating the drainage system . Record review of the undated CDC (Centers for Disease Control and Prevention) Indwelling Urinary Catheter Insertion and Maintenance revealed CAUTI (catheter-associated urinary tract infections) were costly and increased morbidity . maintenance catheter care essentials . when an indwelling urinary catheter was indicated, the following interventions should be in place to help prevent infection . use indwelling catheters only when medically necessary . properly secure indwelling catheters to prevent movement and urethral traction . maintain good hygiene at the catheter-urethral interface . maintain unobstructed urine flow . maintain drainage bag below level of bladder at all times . use a catheter securement device to anchor the catheter . perform peri and catheter care per facility policy . assess the patient for any pain or discomfort . inspect for redness, irritation and drainage . once a urinary catheter was inserted, maintaining it according to evidence-based guidelines was crucial to prevent CAUTI . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled Handwashing/Hand Hygiene dated revised August 2019 indicated . the facility considered hand hygiene the primary means to prevent the spread of infections . all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . wash hands with soap and water for the following situations . when hands are visually soiled . use alcohol-based hand rub or soap and water in the following situations . before and after direct contact with residents . before and after handling an invasive device (urinary catheters, intravenous access sites, etc.) . before moving from a contaminated body site to a clean body site during resident care . after contact with objects in the immediate vicinity of the resident . the use of gloves does not replace hand washing/hand hygiene . integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 1 medication storage room (medication storage room [ROOM NUMBER]) reviewed for medication storage. The facility failed to ensure Zinc 50mg was not expired in medication storage room [ROOM NUMBER]. The unopened bottle of Zinc expiration date was 3/2025. The facility failed to ensure Acetaminophen Suppositories 650mg were not expired in the medication storage room [ROOM NUMBER]'s medication refrigerator. The suppositories expiration date was 12/10/24. The facility failed to ensure an opened box of Bisacodyl Suppositories 10mg were not expired in the medication storage room [ROOM NUMBER]'s medication refrigerator. The suppositories expiration date was 2/28/25. These failures could place residents at risk for adverse effects and reduced therapeutic effects of medication and supplies. Findings included: During an observation on 4/1/25, starting at 9:40 a.m., this surveyor reviewed 1 of 1 medication storage rooms and found the following medications with expired expiration dates: *One, unopened bottle of Zinc Tablets 50mg with dated expiration of March 2025. *One package of Acetaminophen Suppositories 650 mg with dated expiration of 12/10/24. *One, opened box of Bisacodyl Suppositories 10mg with dated expiration of 2/28/25. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/2/25 at 11:14 a.m., MA H said there was no designated person responsible for checking expiration dates on medications in the storeroom. She said there was also no set day expiration dates were checked on medications. She said expiration dates were checked before the medication ordering was done. She said the ADON ordered the medications in the storeroom. She said the nurse checked expiration dates on the medications stored in the refrigerator. She said the nurses normally gave the medications stored in the refrigerator. She said expired medications should not be in the storeroom because staff could mistakenly grab an expired medication and give it to a resident. She said if an expired medication was given, the resident would not get the full dose of the medication. During an interview on 4/2/25 at 11:47 a.m., the ADON said, the MAs, LVNs, and RNs were responsible for ensuring expired medications were not in the storeroom. She said they had a MA that kept a pretty good track of expired medications being removed. She said she looked at the expiration dates when ordering more medications. She said the Pharmacy Consultant also performed a monthly sweep for expired medications. She said the nurses were responsible for the medications in the storeroom refrigerator. She said expired medications lost effectiveness and changed their chemical makeup. She said she was ultimately responsible for ensuring expired medications were not stored in the medication storeroom. During an interview on 4/2/25 at 12:00 p.m., RN B said MAs and nurses were responsible for ensuring expired medication were not in the storeroom. She said expiration dates were checked randomly. She said if the medication was close to expiring, the nursing staff circled the expiration date. She said there was no designated person responsible for checking expiration dates on medications in the storeroom. She said there was also no set time expiration dates were checked on medications. She said expired medications should not be stored in the medication room because it could be given to the resident, and it would not work. She said the expired medication would not do its job. During an interview on 4/2/25 at 12:11 p.m., the DON said nursing administration was responsible for ensuring expired medications were not stored in the storeroom. He said MAs and nursing staff were also responsible. He said the pharmacy consultant did a sweep for expired medication once or twice a year. He said expired medication should not be stored in the medication room. He said it increased the risk of a resident being administered an expired medication. He said he could not speculate on how an expired medication affected the resident. During an interview on 4/2/25 at 12:44 p.m., the Administrator, with the Interim Administrator present, said nursing was responsible for ensuring expired medications were not stored in the storeroom. She said she did not know the process of how the facility ensured expired medications were not stored in the storeroom. She said when expired medications were stored, they could potential be given to the residents. She said it could negatively impact the health of the resident if they received an expired medication. She said the DON was ultimately responsible for ensuring expired medications were not stored in the medication storeroom. Record review of a facility's Storage of Medications revised 11/2020 indicated, .all drugs and biologicals in a safe, secure, and orderly manner . nursing staff is responsible for maintaining medication storage and preparation . discontinue, outdated or deteriorated drugs .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 44933 Based on observations, interviews, and record review, the facility failed to provide food that was palatable, attractive, and at a safe and appetizing temperature for 10 of 10 residents in a confidential group meeting (Anonymous Resident (AR)1-Anonymous Resident (AR) 10), and 1 of 1 meal (Lunch meal) reviewed for food and nutrition services. The facility failed to ensure on 4/1/25, AR 1through AR 10 were not served hard, burnt dinner rolls at the noon lunch meal. This failure could place residents who ate food from the kitchen at risk of weight loss, altered nutritional status, and diminished quality of life. Findings included: During an interview and observation, of a confidential resident group meeting on 4/1/25 at 2:30 p.m., AR1-AR 10 were in attendance and wished to remain anonymous. All residents in the confidential meeting said they attended regularly. Anonymous Resident 1 said the facility served burnt rolls today (4/1/25). Anonymous Resident 1 presented a roll wrapped in a paper towel. The roll was dark brown on top and black on the bottom. The roll presented by AR 1 was hard. All residents in the confidential meeting said they had been served burnt bread today and at other mealtimes. The residents said they did not eat the burnt bread or only ate the top portion of the roll. During an interview on 4/2/25 at 10:48 a.m., the Dietary Manager said the rolls served yesterday (4/1/25) were burnt. She said she noticed the rolls were burnt before they were served. She said she did not instruct [NAME] K to discard the rolls and serve something else. She said bread products for the resident's meals had been burnt and served before. She said the oven cooked unevenly. She said no residents, until today, had complained about breads being served burnt. She said it was important not to serve burnt food because it affected the appearance and flavor. She said she was responsible for ensuring food was not served burnt to the residents. She said she should be doing that by inspecting the meals before they were served to the residents. During an interview on 4/2/25 at 11:24 a.m., CNA D said yesterday (4/1/25) a lot of the resident's rolls were burnt. She said none of the residents she served asked for something else. She said on 4/1/25, most of the residents ate the top portion of the roll. She said occasionally the resident's bread has been burnt in the past. She said most of the time, the residents just ate the top portion of the bread. She said serving the residents burnt bread could upset the residents. She said the residents could have been looking forward to eating a nice, soft roll but then were served a burnt one. During an interview on 4/2/25 at 12:00 p.m., CNA J said she noticed the burnt rolls served on 4/1/25. She said several of the residents did not eat the burnt rolls. She said sometimes the resident's bread was served burnt. She said no alternated bread option was offered to the residents on 4/1/25. She said burnt food affected the appearance and flavor. She said the rolls served yesterday were like little rocks! (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/2/25 at 12:11 p.m., the DON said he did not know burnt rolls were served on 4/1/25. He said he expected the dietary staff to follow the guidance of the Dietary Manager in what should or should not be served. He said he could not speculate how the burnt rolls affected the residents. He said burnt food was not palatable. He said the Dietary Manager was responsible to ensure palatable food was served. During an interview on 4/2/25 at 12;44 p.m., the Administrator, with the Interim Administrator present said the dietary team and Dietary Manager were responsible for serving palatable and appetizing meals. She said she expected the dietary team to not serve burnt rolls and to substitute something more palatable. She said serving residents burnt food decreased their quality of life. She said the Dietary Manger was overall responsible for ensuring the dietary team served palatable food to the resident. Record review of a facility's Food and Nutrition Services policy revised 10/2017 indicated, .each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs .food and nutrition service staff will inspect food trays .the food appears palatable and attractive .

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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** 46062 Based on observations, interviews, 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 2 of 15 residents (Residents #7 and Resident #41) reviewed for infection control practices. 1. The facility failed to ensure CNA D performed hand hygiene and changed gloves appropriately prior to, during, and after providing incontinent care/indwelling urinary catheter care to Resident #7. 2. The facility failed to ensure CNA D did not contaminate Resident #7's clothing, clean brief, bed, bedding, bed remote, positioning wedge, and urinary catheter bag after CNA D had performed bowel incontinent care and incontinent/urinary catheter care. 3. The facility failed to ensure Resident #41 had signage to identify the resident was on Enhance Barrier Precaution (EBP) and the use of personal protective equipment (PPE) due to open wounds on 4/02/25. 4. The facility failed to ensure Treatment Nurse followed the Enhanced Barrier Precautions (EBP) (interventions to prevent spread of infection in high-risk residents) policy of wearing a gown during Resident #41's wound to left lateral ankle and right mid back wound care to on 4/2/25. These failures could place residents at risk for cross contamination, at an increased risk of infection, and the spread of infection. Findings included: 1. Record review of Resident #7's face sheet dated 4/01/25 revealed he was [AGE] years old and admitted to the facility on [DATE]. Resident #7 had diagnoses including dementia (forgetfulness), senile degeneration of brain (progressive decline in cognitive abilities, such as memory, thinking, and reasoning), diabetes (high blood sugar, places at higher risk of infection), retention of urine, and chronic kidney disease. Record review of Resident #7's annual MDS assessment dated [DATE] indicated he was unable to complete the BIMS, which indicated he had severe cognitive impairment. Resident #7 was dependent on staff assistance for most ADLs. The MDS indicated Resident #7 had an indwelling catheter (urinary catheter inserted into the bladder to drain urine). The MDS indicated Resident #7 was always incontinent of bowel. Record review of Resident #7's undated Care Plan Report indicated he had an indwelling catheter related to retention of urine with interventions including catheter care daily and PRN; he was at risk for self-care deficit with interventions including toileting-dependent x 2 staff; he had bowel incontinence with interventions including to check resident every two hours and assist with toileting as needed, and provide peri (human private area) care after each incontinent episode. (continued on next page)

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	676154	A. Building B. Wing	04/02/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #7's Order Summary Report dated 4/02/25 revealed an order for foley (urinary) catheter care every shift with an order date of 2/06/25. During an observation on 4/01/25 beginning at 3:30 PM of incontinent care and urinary catheter care, surveyor observed an Enhanced Barrier Precautions sign and an isolation cart outside the door of Resident #7. CNA D and CNA E both donned (put on) isolation gowns prior to entering Resident #7's room. Upon entering Resident #7's room, CNA D and CNA E washed their hands and donned gloves. CNA D picked up Resident #7's fall mat off of the floor, folded it, and placed against the wall. Then CNA D pulled Resident #7's bed away from the wall and CNA E went between the wall and Resident #7's bed. CNA D without performing hand hygiene or changing gloves, she proceeded to pull Resident #7's bed sheet back toward his feet, unfastened his brief, then assisted CNA E turn Resident #7 onto his right hip toward CNA E by putting one gloved hand on Resident #7's shoulder and the other gloved hand on his hip and pushed him toward CNA E. CNA D then removed Resident #7's soiled brief and proceeded to cleanse feces (bowel movement) from his buttocks using wipes. CNA D then assisted CNA E assist Resident #7 back on to his back by placing one gloved hand on his shoulder and the other gloved hand on his hip and she did not perform hand hygiene or change her gloves after cleaning feces from his buttocks. CNA D, without performing hand hygiene or changing her gloves, then proceeded to use a wipe to cleanse Resident #7's head of his penis, then used a wipe to cleanse down each side of his testicles, then CNA D used another wipe to cleanse down his urinary catheter tubing and repeated twice. CNA D then assisted CNA E to roll Resident #7 over onto his right hip toward CNA E and placed a new brief on him. CNA D then placed her same gloved hands on his hip and shoulder to turn Resident #7 onto his back. CNA D and CNA E then used a draw sheet to pull Resident #7 up in bed. CNA D placed a positioning wedge under Resident #7's left side, then placed his urinary catheter bag back on the side of his bed, then covered Resident #7 with a bed sheet, then moved his bed back against wall, then CNA D used his bed remote to let Resident #7 down to a low position. CNA D did not perform hand hygiene or change her gloves at any point while providing incontinent care, urinary catheter care, positioning, or arranging Resident #7's furniture, except upon entering Resident #7's room and prior to exiting Resident #7's room. During an interview on 4/01/25 at 3:44 PM, CNA E said she had worked at the facility for approximately six years and normally worked on the 6 AM - 2 PM shift. CNA E said staff should perform hand hygiene and change gloves when a resident has had a bowel movement and before placing clean stuff underneath resident. CNA E said CNA D should have changed her gloves after handling the floor fall mat and prior to providing care to the Resident #7. CNA E said CNA D should have changed gloves and washed her hands after cleaning the bowel movement off Resident #7. CNA E said staff could give the resident an infection, such as a UTI (urinary tract infection), if they use the same gloves used to clean bowel movement and whatever bacteria could have been on the floor fall mat. CNA E said CNA D should have washed her hands and changed gloves prior to handling the residents bedding, bed remote, or anything that was not contaminated. CNA E said CNA D could have given Resident #7 any bacteria that could have been on her gloves onto his urinary catheter, clean brief, clothing, bedding, positioning wedge, bed, and bed remote and then the resident could have touched them and even put his hand in his mouth and given him an infection. CNA E said she had received training on performing incontinent care, urinary catheter care, and infection control, and when to perform hand hygiene and when to change gloves. CNA E said it was an infection control issue when CNA D contaminated Resident #7's urinary catheter, his clothing, clean brief, bed, bedding, bed remote, positioning wedge, and urinary catheter bag. (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 4/01/25 at 3:55 PM, CNA D said she had worked at the facility for a little over a year as a CNA and normally worked the 6 AM - 2 PM shift. CNA D said she should have changed her gloves after picking up the floor fall mat and prior to providing care to Resident #7. CNA D said she should have performed used hand sanitizer and changed her gloves after cleaning bowel movement off Resident #7's back half and then flipped him back to do his front half. CNA D said not sanitizing and changing her gloves after cleaning bowel off Resident #8's back half and then performing incontinent/urinary catheter care and then touching multiple things in Resident #7's room was cross contamination and could cause the resident an infection. CNA D said she had been trained on performing hand hygiene, when to change gloves, incontinent care, urinary catheter care, and infection control and prevention. CNA D said she was just nervous. CNA D said it all was an infection control issue. During an interview on 4/01/25 at 4:02 PM, LVN C said staff should wash hands, put gloves on, change gloves when going from dirty to clean, wash hands, change gloves, and then finish dressing or other things. LVN C said it would be cross contamination if staff did not change their gloves from picking something up off the floor, then performing bowel incontinent care, then urinary catheter care, and then proceeding to touch multiple surfaces and bedding in the resident's room. LVN C said the nursing facility residents had a weaker immune system and it placed them at a higher risk of infection. LVN C said it was cross contamination and an infection control issue. During an interview on 4/02/25 at 9:42 AM, RN B said staff should gather their supplies for incontinent care and/or foley catheter care, then wash their hands, and put on gloves. RN B said staff should perform hand hygiene and change their gloves when going from a dirty area to a clean area. RN B said staff should have removed the resident's fall mat and moved his bed prior to beginning resident care and then washed their hands and applied new gloves. RN B said staff should have changed gloves prior to performing front perineal area care and foley catheter care after cleaning bowel movement from the buttocks of the resident. RN B said it was an infection control issue and it was unsanitary by touching everything around the resident without performing hand hygiene or changing gloves. RN B said residents were on Enhanced Barrier Precautions because they were at a higher risk of infection due to having medical implanted devices such as feeding tubes or urinary catheters. RN B said by staff not changing gloves after cleaning bowel movement and then performing urinary catheter care, there was an increased risk of introducing E-coli (Escherichia coli-bacteria found in feces/bowel movement) into the system and placed the resident at a higher risk of infection. During an interview on 4/02/25 at 10:38 AM, the DON said CNA D should have approached the resident with clean gloves and should have changed gloves and sanitized after performing bowel movement incontinent care and after performing incontinent /urinary catheter care, and again before touching anything clean. The DON said the staff had received training on appropriate hand hygiene, changing gloves, incontinent care, urinary catheter care, and infection control. The DON said he could not speculate what the risk to the resident would be from CNA D not performing hand hygiene or changing her gloves appropriately and then touching multiple surfaces in close proximity of Resident #7. The DON said Resident #7 was on Enhanced Barrier Precautions because he had a urinary catheter because that was the way the Enhanced Barrier Precautions guidelines were written. The DON said he could not speculate if Resident #7 was at a higher risk of infection or urinary tract infections from CNA D not changing her gloves or performing hand hygiene appropriately. (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 4/02/25 at 12:17 PM, the ADM said by the CNA not performing hand hygiene or changing her gloves appropriately, it could be an infection control concern. The ADM said by the CNA touching multiple things in the resident's room, it was cross contamination and could place the resident at a higher risk of infections and UTIs (urinary tract infections). The ADM said she would expect staff to follow the facility's policies related to infection control, hand hygiene, incontinent care, and urinary catheter care. Record review of CNA Orientation/Competency check-off form dated completed on 1/09/25 for CNA D indicated she was evaluated by the DON on 1/09/25 on Incontinent Care to include perineum care and foley catheter care and had a check mark in the Passed column . 2. Record review of Resident #41's face sheet dated 3/31/2025 indicated Resident #41 was an [AGE] year-old male readmitted on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (a lung condition caused by damage to the airways and alveoli, usually from smoking or other irritants), Chronic cystitis (infection or inflammation of the urinary bladder or any part of the urinary system cause by a bacteria), Diverticulitis of large intestine without perforation or abscess without bleeding (an inflammation with or without infection of a diverticulum (a pouch-like structure that form in the wall of the large intestine), which causes abdominal pain and can create a collection of pus around the inflamed diverticulum), pressure ulcer of head (an injury to the skin and the tissue below the skin that are due to pressure on the skin for a long time), and abnormal weight loss (a noticeable drop in your body weight without trying). Record review of Resident #41's comprehensive MDS assessment dated [DATE] indicated Resident #41 understood and was understood by others. Resident #41 had a BIMS score of 12 which indicated moderate cognitive impairment. Resident #41 was at risk of developing pressure ulcer/injuries. Record review of Resident #41's care plan initiated on 3/14/2025 indicated Resident #41 had an incomplete care plan and did not indicate he was on enhanced barrier precautions or had any skin concerns. Record review of Resident #41's skin assessment completed on 4/1/2025 indicated Resident #41 had a new sebaceous cyst that opened measuring 0.5 cm x 0.4 cm x 0 with no drainage and wound bed appearance was white. During an observation and interview on 3/31/2025 at 10:18 AM, Resident #41 was sitting up in his wheelchair with observed bruising to bilateral upper arms, and a bandage on his left lower leg. Resident #41 said he had sores all over him and an area on his back that was giving him problems. Resident #41 said the nurse had been keeping his wounds covered. Resident #41 did not have signage and/or PPE outside his door. During an observation on 4/2/2025 at 9:35 AM, Resident #41 did not have signage to identify the resident was on EBP and/or PPE outside his door. The Treatment Nurse performed wound care to Resident #41's left lateral ankle and right mid back without gown. The Treatment Nurse said the wound on Resident #41's back did have some drainage and redness was observed on the peri-wound (skin surrounding the wound). (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 4/2/2025 at 10:10 AM, CNA A said personal protective equipment would be worn while providing care to residents with catheters, wounds, and peg tubes. CNA A said the plan of care would be on the computer and a container would be set up outside a resident's door indicating a resident was on enhanced barrier precautions. CNA A said the enhanced barrier precautions would be documented on the care plan. She said the facility had PPE which included gowns, gloves, and mask. CNA A said the nurse was responsible for ensuring proper PPE was worn. CNA A said the staff could cross-contaminate or get an infection from the resident if PPE was not worn. She said the staff had been in-serviced on EBP precautions. During an interview on 4/2/2025 at 10:22 AM, RN B said the staff had been in-serviced on enhanced barrier precautions. She said anyone providing direct care should wear the proper PPE. RN B said the Infectious Disease nurse was responsible for ensuring PPE was worn. RN B said the care plan indicates what care would be provided to a resident. She said not wearing proper PPE with a resident with wounds could cause infection if not worn properly. During an interview on 4/2/2025 at 11:55 AM, the Treatment Nurse said the Centers for Disease Control (CDC) says PPE should be worn for chronic wounds and Resident #41's has small abrasions when he came into the facility. The Treatment Nurse said she did not place Resident #41 on enhanced barrier precautions because it was not a chronic wound and it was not required with small wounds. She said he was on precautions when he first came to the facility and after he completed an antibiotic, he got much better. The Treatment nurse said the Centers for Disease Control (CDC) leaves things unclear. The Treatment nurse said she had gone over enhanced barrier precautions with the aides on how to properly wear PPE. The Treatment Nurse said enhanced barrier precautions should be worn with Resident's with foley catheters, tracheostomies (a surgical procedure that involves creating an opening through the neck into the trachea (windpipe) to facilitate breathing) , gastrostomy (a medical devices that delivers liquid nutrition directly to the stomach or small intestine through a flexible tube), and wounds. The Treatment nurse said the enhanced barrier precautions were not required for wounds that only required a bandage. During an interview on 4/2/2025 at 12:10 PM, the ADON said enhanced barrier precautions are for residents who have foley catheters, peg tubes and wounds. The ADON said personal protective equipment (PPE) should be worn while providing care for residents with foley catheters, peg tubes and wounds. She said the facility had PPE for staff and she just ordered 400 more gowns. The ADON said if a resident was on enhanced barrier precautions, it should be on the resident's care plan, have a container outside the resident door and a sign on the door. She said she could not speculate what could happen if proper PPE was not worn. During an interview on 4/2/2025 at 12:34 PM, the DON said he would have to review with the Infection Preventionist. He said he did not want to speculate on what could happen if PPE was not worn during care. During an interview on 4/2/2025 at 12:59 PM, the Interim Administrator said the treatment nurse should have worn PPE while providing care to Resident #41. The Interim Administrator said enhanced barrier precautions would be care planned if on precautions and signage should be placed on the door. The Interim Administrator said the facility had in-serviced the staff on enhanced barrier precautions. The Interim Administrator said if a resident was not placed on proper enhanced barrier precautions and the staff was not wearing proper personal protective equipment (PPE), it could place a resident at risk for infection and negatively impact their quality of life. (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 revised October 2018 indicated . an infection prevention and control program was established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections . important facets of infection prevention include . educating staff and ensuring that they adhere to proper techniques and procedures . implementing appropriate isolation precautions when necessary . following established general and disease specific guidelines such as those of the Centers for Disease Control (CDC) . Record review of the facility's policy titled Perineal Care dated revised February 2018 indicated . the purpose of this procedure was to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition . steps in the procedure . wash and dry your hands thoroughly . fold the bedspread or blanket toward the foot of the bed . fold the sheet down to the lower part of the body . put on gloves . for a male resident . wash perineal area (private area) starting with the urethra (opening at head of penis) working outward . if the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about three inches, gently rinse and dry the area . wash and rinse the rectal area thoroughly . remove gloves and discard . wash and dry hands thoroughly . reposition the bed covers, make the resident comfortable . wash and dry your hands thoroughly . Record review of the facility's policy titled Handwashing/Hand Hygiene dated revised August 2019 indicated . the facility considered hand hygiene the primary means to prevent the spread of infections . all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . wash hands with soap and water for the following situations . when hands are visually soiled . use alcohol-based hand rub or soap and water in the following situations . before and after direct contact with residents . before and after handling an invasive device (urinary catheters, intravenous access sites, etc.) . before moving from a contaminated body site to a clean body site during resident care . after contact with objects in the immediate vicinity of the resident . the use of gloves does not replace hand washing/hand hygiene . integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections . Record review of Centers for Medicare and Medicaid Services (CMS) guideline titled Center for Clinical Standards and Quality/Quality, Safety & Oversight Group dated 3/20/2025 indicated . Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use . used in conjunction with standard precautions and expand the use of personal protective equipment (PPE) to donning of gown and gloves during high-contact resident care activities . indicated for residents with any of the following: . infection or colonization . wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with MDRO . Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage . Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies (a surgical procedure that involves creating an opening through the neck into the trachea (windpipe) to facilitate breathing).Facilities should ensure protective personal equipment (PPE) and alcohol-based hand rub are readily accessible to staff. Protective personal equipment PPE for enhanced barrier precautions (EBP) were only necessary when performing high-contact care activities and may not need to be donned prior to entering a resident's room . 49019