STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676161	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Valley Healthcare and Rehabilitation Center	6850 Rufe Snow Dr Fort Worth, TX 76148

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for two (Resident #18 and Resident #43) of eighteen residents reviewed for Reasonable Accommodation of Needs. The facility failed to ensure the call light system in Resident #18 and Resident #43's rooms were in a position that was accessible to the resident on 04/15/2025. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. Findings included: Resident #18 Record review of Resident #18's Face Sheet, dated 04/16/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. Resident #18 was diagnosed with muscle weakness and gait abnormalities. Record review of Resident #18's Quarterly MDS Assessment, dated 03/03/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 03. The Quarterly MDS Assessment indicated the resident was dependent for transfer, toileting hygiene, shower, dressing, and personal hygiene. Record review of Resident #18's Comprehensive Care Plan, dated 03/04/2025, reflected the resident had a risk for fall related to gait problems and one of the interventions was to be sure the resident's call light is withing reach. Observation and interview on 04/15/2025 at 9:40 AM revealed Resident #18 was sitting in her wheelchair inside her room. It was observed that the resident's call light was on the floor at the foot of the bed. It was also observed that the resident's bed was already made. When asked where her call light was, the resident said her call light was nowhere to be found. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 04/15/2025 at 9:49 AM, CNA G stated call lights should always be within reach of the residents because that was how they called the staff if they needed something. She said without the call lights, the residents might be upset or might fall if they tried to do things by themselves. She went inside Resident's #18's room and saw the call light on the floor. She pulled the call light from the floor and put it on top of the resident's bed. She said she should have made sure the call light was on top of the resident's bed when she transferred the resident to her wheelchair and made her bed. Resident #43 Record review of Resident #43's Face Sheet, dated 04/15/2025, reflected a [AGE] year-old female admitted on [DATE]. Resident #43 was diagnosed with muscle weakness and lack of coordination. Record review of Resident #43's Quarterly MDS Assessment, dated 02/10/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 05. The Quarterly MDS Assessment indicated the resident was dependent for toileting hygiene, dressing, bed mobility, and transfer. Record review of Resident #43's Comprehensive Care Plan, dated 02/27/2025, reflected the resident had a risk for fall related to gait problems and one of the interventions was to be sure the resident's call light was within reach. Observation and interview with Resident #43 on 04/15/2025 at 9:53 AM revealed Resident #43 was in her bed, awake. It was observed that the resident's call light was on the floor and coiled around an IV stand. When asked where her call light was, the resident just smiled, but did not reply. Observation and interview on 04/15/2025 at 10:01 AM, LVN E stated call lights were important for the residents because the residents used them to call the staff when they needed something or needed assistance. She said the residents might fall trying to get the call light or trying to do some activities that needed assistance. She went inside Resident #43's room and saw the call light on the floor. She said she did not notice the call light was on the floor when she administered the resident's medication. She said she should have made sure the call light was with the resident before leaving the room, because the resident wanted to always hold her call light. In an interview on 04/16/2025 at 3:19 PM, the DON stated call lights were inside the residents' rooms so they can call the staff for assistance, a glass of water, pain medication, or because they needed to be changed. The DON said if the call lights were not within reach, their needs would not be met. The DON said all the staff were responsible for the call lights. The DON said the expectation was for the staff to scan the residents' room when they did their rounds and ensure the call lights were within reach of the residents before they leave the room. The DON said she would educate the staff about the importance of call lights for the residents. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/17/2025 at 7:22 AM, the Administrator stated call lights should be within the reach of the residents at all times. He said for some residents, the call light was their sense of protection that if something happened to them, they would be able to call the staff for help. He said the residents also used the call lights if they needed to be changed or they needed a pain medication. The Administrator said the residents might fall trying to get up and get what they needed. He said everybody was responsible in making sure the call lights were with the residents, whether the resident was independent or not. He said he would collaborate with the DON and the ADON about the issue regarding call lights. In an interview on 04/17/2025 at 8:49 AM, the ADON stated the call lights should always be with the residents. She said when the resident was already in her wheelchair, the call light should be on top of her bed so she could still call the staff if she needed to. She said the staff should make sure that the call lights were with the residents before they left the room. She said she would coordinate with the DON to do an in-service about call light placement. Record review of facility's policy Resident Call System Resident Call Light Policy revised 03/28/2023 revealed Policy: Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation . Policy Interpretation and Implementation . 1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review, the facility failed to treat each resident with respect, dignity, and care in a manner and environment that promoted maintenance or enhancement of his or her quality of life for three (Resident #4, Resident #61, and Resident #186) of residents reviewed for Privacy and Confidentiality. 1. The facility failed to ensure Resident #186's medical information was not left on top of a documentation cart on 04/15/2025. 2. The facility failed to ensure MA H did not leave Resident #61s' medical information on top of the medication cart unattended on 04/15/2025. 3. The facility failed to ensure Resident #4's medical information was not left on top of a cart on 04/15/2025. 4. The facility failed to ensure MA I did not leave Resident #4's medical information on top of the medication cart unattended on 04/17/2025. These failures could place the residents at risk of their medical information being exposed to unauthorized individuals. Findings included: 1. Record review of Resident #186's Face Sheet, dated 04/15/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with disorientation. Record review of Resident #186's Comprehensive MDS Assessment, dated 04/08/2025, reflected the resident had a moderate impairment in cognition with a BIMS score of 09. Record review of Resident #186's Comprehensive Care Plan, dated 4/12/2025, reflected the resident had a fall on 04/12/2025 and sustained a skin tear to right forearm and right lateral calf was to continue with the interventions. Record review of Resident #186's Physician Order, dated 04/13/2025, reflected Cleanse right arm with NS, pat dry, and apply dry dressing every other day and prn every day shift AND every 1 hours as needed. Record review of Resident #186's Physician Order, dated 04/13/2025, reflected Cleanse skin tear to right lateral calf with NS, pat dry and apply dry dressing every other day and prn every day shift every other day AND every 1 hours as needed. Record review of Resident #186's Progress Notes, dated 04/12/2025, reflected Resident went to restroom by herself without waiting for staff to assist and fell trying to pull her pants up. Sustained skin tear x 3 to right forearm/elbow and skin tear to right lateral calf. Denies pain. Areas cleaned and dressings applied. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/15/2025 at 10:40 AM revealed a piece of paper was left on top of a documentation cart parked on the hallway in front of the nurses' station. On the piece of paper was Resident #186's name and room number. On the same piece of paper were the skin tears the resident sustained during a fall. Observation and interview on 04/15/2025 at 10:45 AM, LVN C stated the piece of paper on top of the documentation table contained the name, room number, and some information about her skin tear. He said it should not be left on the documentation table for everyone to see. He said he was not aware who left the piece of paper. LVN C took the paper with him to the nurses' station. 2. Record review of Resident #61's Face Sheet, dated 04/15/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed asthma (lung disorder caused by narrowing of the airways). Record review of Resident #61's Comprehensive MDS Assessment, dated 04/10/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had asthma. Record review of Resident #61's Comprehensive Care Plan, dated 01/15/2025, reflected the resident had asthma related to allergies and one of the interventions was to administer medications as ordered. Record review of Resident #61's Physician Order, dated 04/13/2025, reflected Fluticasone Propionate Suspension 50 MCG/ACT 1 spray in each nostril one time a day for Congestion. Observation on 04/15/2025 at 11:49 AM revealed a piece of small piece of plastic bag packaging was observed on top of a medication cart. On the plastic bag was Resident #61's name, the name of the medication, the prescription number of the medication, the dose, the frequency, the physician's order, the diagnosis why the medication was being administered, and the name of the pharmacy. It was observed that nobody was attending the cart, and the cart was facing the hallway. Observation and interview on 04/15/2025 on 11:53 AM, MA H stated she left the cart because she administered Resident #61's medication. She said she should not leave any medication packaging on top of the medication cart unattended because they have information about the resident. She said she would be mindful that no information about the resident would be left on top of the cart. 3. Record review of Resident #4's Face Sheet, dated 04/15/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed hypertension (high blood pressure). Record review of Resident #4's Comprehensive MDS Assessment, dated 04/09/2025, reflected the resident was cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment indicated the resident had hypertension. Record review of Resident #4's Comprehensive Care Plan, dated 04/10/2025, reflected the resident had hypertension related and one of the interventions was to monitor for hypotension. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's Physician Order, dated 12/13/2024, reflected Amlodipine Besylate Tablet 10 MG Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) Hold for SBP < 110. Record review of Resident #4's Progress Note, dated 4/15/2025, reflected Amlodipine Besylate Tablet 10 MG Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) Hold for SBP < 110 held due to b\p 98\68-60. Observation on 04/15/2025 at 12:18 PM revealed a piece of paper was on top of a cart parked on the nurses' station. On the piece of paper was written Resident #4's name and his blood pressure. The cart was facing the hallway. Observation and interview on 04/15/2025 at 12:21 PM, the Administrator stated the paper should not be left on the cart because it contained medical information about the resident and it should be confidential. He said he would find out who left it on the cart so he could educate whoever left it. The Administrator took the piece of paper and placed it inside the nurses' station. In an interview on 04/16/2025 at 3:19 PM, the DON stated personal and medical information about a resident should not be exposed for everybody to see because it was confidential. She said the health information of a resident should be protected and could not be shared without the permission of the resident or the resident's responsible party. She said all employees were expected to provide full privacy and confidentiality of information for all residents. The DON stated she would start an in-service about privacy and confidentiality of the residents' information. In an interview on 04/17/2025 at 7:22 AM, the Administrator stated the staff must make sure the residents' information was not exposed and protected because it was a violation of the resident's privacy and confidentiality of the care/treatment they were receiving. He said the expectation was for all the staff to make sure the personal and medical information of a resident were not visible to unauthorized individuals. He said she would collaborate with the DON and the ADON to do an in-service about privacy and confidentiality. 4. Record review of Resident #4's Comprehensive MDS Assessment, dated 04/09/2025, reflected the resident the resident had heart failure. Record review of Resident #4's Comprehensive Care Plan, dated 04/10/2025, reflected the resident had heart failure and one of the interventions was to administer medications as ordered. Record review of Resident #4's Physician Order, dated 03/04/2025, reflected Isosorbide Mononitrate ER Tablet Extended Release 24 Hour 60 MG Give 60 mg by mouth one time a day related to ANGINA PECTORIS (chest pain), UNSPECIFIED. Do not crush. Observation on 04/17/2025 at 8:35 AM revealed a top potion of a blister pack was on top of the medication cart. On the top portion of the blister pack was Resident #4's name, the name of the medication, the prescription number of the medication, the dose, the frequency, the physician's order, the diagnosis why the medication was being administered, and the name of the pharmacy. It was observed that nobody was attending the cart and the cart was facing the hallway. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 04/17/2025 at 8:41 AM, MA I stated she went to a resident to administer medications. She said she would tear the top portion of the blister pack if the medication was done. She said she should have flipped it so the resident's information would not be exposed because it was HIPAA (violation). MA I took the top portion of the blister pack and flipped it. In an interview on 04/17/2025 at 8:49 AM, the ADON stated the staff should make sure that no information about any resident be left on top of the cart before leaving the cart unattended. She said the resident's information were confidential and should not be seen by unauthorized individuals. She said that was a HIPAA violation. She said the expectation was for the staff not to leave any personal or medical information about a resident. She said she would coordinate with the DON to do an in-service about privacy and confidentiality. Record review of the facility's policy, Charting and Documentation Nursing Services Policy and Procedures Manual for Long-Term Care, no revision date, revealed Policy Statement: All services provided to the resident shall be documented in the resident's medical record . Policy Interpretation and Implementation . information documented in the resident's clinical record is confidential.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observation, interview, and record review, the facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for 13 of 16 resident rooms on the 100 hall (Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, and #13), and the air condition unit on the 100 hall, reviewed for environment. 1. The facility failed to ensure resident rooms #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, and #13 were thoroughly cleaned and sanitized. 2. The facility failed to ensure the air condition unit on the 100 hall was thoroughly cleaned and sanitized. These deficient practices could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life. Findings include: An observation on 04/15/25 at 11:02 AM of resident room [ROOM NUMBER] reflected the air vent in the room had thick black dirt between the vents. The bathroom sink faucet had light brownish stains along the base of the faucet. The bathroom floor had light brown stains along the edges of the floor and the bathroom door frame. The handrail in near the toilet had a dark reddish stain on it. An observation on 04/15/25 at 11:07 AM of resident room [ROOM NUMBER] reflected the air condition unit in the room had black dirt along and between the vents. The bathroom floor had light brown stains along the edges of the floor and the bathroom door frame. The mini fridge in the resident room had orange stain inside the bottom of the fridge. The bathroom sink faucet had light brownish stains along the base of the faucet. The doorway had thick dirt in the corner of the floor behind the door. An observation on 04/15/25 at 11:13 AM of resident room [ROOM NUMBER] reflected the air condition unit in the room had thick black and brown dirt along and between the vents. There was also a thick white substance between the top vents. An observation on 04/15/25 at 11:17 AM of resident room [ROOM NUMBER] reflected the air condition unit in the room had thick black and brown dirt along and between the vents. There were thick white substances between the top vents. A bed frame in the resident room had brown stains in a lower portion of the frame. The bathroom floor had brown stains along the edges of the floor, in the corners, and the bathroom door frame. An observation on 04/15/25 at 11:22 AM of resident room [ROOM NUMBER] reflected the air condition unit in the room had thick black dirt along and between the vents. There was a thick white substance between the top vents. The air filters had thick dust on them. The bathroom sink faucet had brownish stains along the base of the faucet. The bathroom floor had brown stains along the edges of the floor, in the corners, and the bathroom door frame. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 04/15/25 at 11:27 AM of resident room [ROOM NUMBER] reflected the air condition unit in the room had thick black dirt along and between the vents. There was a thick white substance between the top vents. The bathroom sink faucet had brownish stains along the base of the faucet. The bathroom floor had brown stains along the edges of the floor, in the corners, and the bathroom door frame. An observation on 04/15/25 at 11:31 AM of resident room [ROOM NUMBER] reflected the air condition unit in the room had thick black and brown dirt along and between the vents. There were thick white substances between the top vents. The bathroom toilet had brownish stains along the base of the it. The bathroom floor had brown stains along the edges of the floor, in the corners, and the bathroom door frame. An observation on 04/15/25 at 11:33 AM of an air condition unit at the end of the 100-hall near an exit door, reflected the air condition unit had thick black dirt along and between the vents. There was a thick white substance between the top vents. The air filters had thick dust on them. An observation on 04/15/25 at 11:38 AM of resident room [ROOM NUMBER] reflected the air condition unit in the room had thick black and brown dirt along and between the vents. There were thick white substances between the top vents. One of the corners of the floor had thick black dirt. The bathroom floor had brown stains along the edges of the floor, in the corners, and the bathroom door frame. An observation on 04/15/25 at 11:41 AM of resident room [ROOM NUMBER] reflected the air condition unit in the room had thick black and brown dirt along and between the vents. There were thick white substances between the top vents. A picture frame hanging on the wall had thick black and brown stains all over it. The bathroom toilet had brownish stains along the base of the it. The bathroom floor had brown stains along the edges of the floor, in the corners, and the bathroom door frame. The bathroom sink faucet had brownish stains along the base of the faucet. An observation on 04/15/25 at 11:48 AM of resident room [ROOM NUMBER] reflected the air condition unit in the room had thick black and brown dirt along and between the vents. There were thick white substances between the top vents. The mini fridge in the resident room had brown stains inside the bottom of the fridge. An observation on 04/15/25 at 11:53 AM of resident room [ROOM NUMBER] reflected the air condition unit in the room had thick black and brown dirt along and between the vents. There were thick white substances between the top vents. The bathroom floor had brown stains along the edges of the floor, in the corners, and the bathroom door frame. The bathroom sink faucet had brownish stains along the base of the faucet. The room floor had thick black dirt along the edges of the floor, especially in the corners and near the room door. An observation on 04/15/25 at 12:00 PM of resident room [ROOM NUMBER] reflected the air condition unit in the room had thick black and brown dirt along and between the vents. There were thick white substances between the top vents. The bathroom floor had brown stains along the edges of the floor, in the corners, and the bathroom door frame. A vent on the wall had brown stains all over it. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 04/15/25 at 12:05 PM of resident room [ROOM NUMBER] reflected the air condition unit in the room had thick black and brown dirt along and between the vents. There were thick white substances between the top vents. The bathroom floor had brown stains along the edges of the floor, in the corners, and the bathroom door frame. The bathroom sink faucet had brownish stains along the base of the faucet. In an interview on 04/17/25 at 10:32 AM, Housekeeping I stated she had been at the facility for 3 years. She stated they were supposed to clean all areas of the resident rooms, including bathrooms. She stated they cleaned the mini fridges in the resident rooms if they were asked to clean them. She was shown pictures of the concerns observed in Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, and #13. She stated she would do a better job cleaning the rooms. She stated the risk of not thoroughly cleaning resident rooms is not good for the resident and their breathing. In an interview on 04/17/25 at 10:41 AM, the Housekeeping Supervisor stated he had been the supervisor for 5 years. He stated staff was responsible for cleaning the entire resident room, including the air condition units and the mini fridges in the rooms. He stated he checked the rooms once they finished cleaning the hall. He stated maintenance was responsible for cleaning the air filters and inside vents of the air condition units. He stated the risk of not cleaning the areas mentioned could impact the residents' breathing. He was shown pictures of the concerns observed in Resident rooms #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, and #13, and he stated they were working on correcting the issues. In an interview on 04/17/25 at 10:50 AM, the Maintenance Director stated he had been at the facility for [AGE] years. He stated he was responsible for cleaning the inside of the air condition units and the air filters in the resident rooms. He stated they were cleaned monthly. He was shown pictures of the concerns observed in the air condition units in Resident rooms #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13 and the air condition unit on the 100-hall, and he stated he was responsible for cleaning them. He stated the risk of not cleaning them could result in residents having respiratory problems. In an interview on 04/17/25 at 10:50 AM, the Administrator was shown pictures of the concerns observed in Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13 and the air condition unit on the 100-hall, and he stated housekeeping and maintenance were working on correcting the issues. He stated the risk of not cleaning the areas previously mentioned could impact the resident having a clean, homelike environment. He stated they completed leadership rounds daily, but may not had focused properly on the cleanliness of the rooms, and they will be more mindful of this. Record review of the facility's policy on Resident Room Cleaning (Undated) reflected Daily cleaning of resident rooms help to provide a sanitary environment, prevent odors, and prolong the useful life of furniture, equipment, paint, and floor finish.

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Green Valley Healthcare and Rehabilitation Center	6850 Rufe Snow Dr Fort Worth, TX 76148

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observations, interviews, and record reviews, the facility failed to ensure that residents' environment remained free of accident hazards as was possible for 2 of 6 residents (Residents #25 and #68) reviewed for accident prevention. 1. The facility failed to ensure Resident #25 had physician orders for the bolster pads that were applied to her mattress for fall prevention. 2. The facility failed to ensure Resident #68 had physician orders for her scoop mattress These failures could prevent the residents from having an environment that was free and clear of accidents and hazards. Findings include: 1. Record review of Resident #25's Face Sheet, dated 04/16/25, reflected she was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included unsteadiness on feet, dementia (cognitive decline), and muscle weakness. Record review of Resident #25's Quarterly Minimum Data Set (MDS) assessment, dated 12/24/24, reflected she had a BIMS score of 14 (intact cognitive response). For ADL care, it reflected for transfers, toileting, and bathing, the resident was totally dependent for assistance. Record review of Resident #25's Quarterly Care Plan, dated 02/17/25, reflected the resident was a high risk for falls and the need for safe environment with even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position, and personal items within reach. Record review of Resident #25's physician orders, dated 04/16/25, reflected no physician orders for the bolster pads. An Observation on 04/15/25 at 11:58 AM, revealed Resident #25 had bolster pads on her bed. 2. Record review of Resident #68's Face Sheet, dated 04/15/25, reflected she was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included unsteadiness on feet, dementia (cognitive decline), and history if falling. Record review of Resident #68's Quarterly Minimum Data Set (MDS) assessment, dated 03/14/25, reflected she had a BIMS score of 9 (moderate impairment). For ADL care it reflected for transfers, toileting, and bathing and the resident was totally dependent for assistance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #68's Quarterly Care Plan, dated 03/20/25, reflected the resident was a high risk for falls and the need for safe environment with even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position, and personal items within reach. Record review of Resident #68's physician orders, dated 04/16/25, reflected no physician orders for a scoop mattress. An observation on 04/15/25 at 11:58 AM, revealed Resident #68 had a scoop mattress on her bed. In an interview and observation at 04/16/25 at 09:45 AM, LVN M stated she was the floor nurse for Resident #25 and Resident #68. She observed the bolster pad that was attached to Resident #25's mattress, and she observed the scoop mattress Resident #68 was laying on. She stated both residents required orders for their equipment because it could restrict the resident's movement and could be a form of restraint. She stated she had checked and neither resident had orders for the equipment. She stated both residents were a fall risk. She stated the risk of not having physician orders was that the residents could injure themselves if they attempted to get out of their beds. She stated she had spoken with her DON, and they were investigating how the residents obtained the equipment. In an interview on 04/16/25 at 12:00 PM, the DON stated she was informed by LVN M of Resident #25 and Resident #68 having equipment without physician orders. She stated she was meeting with her staff to try and find out how Resident #25 received the bolster pads for her mattress and how Resident #68 was provided a scoop mattress. She stated they both should have physician orders to have the equipment to ensure there was no risk for the residents. She stated physician orders were required for the scoop mattress and the bolster pads, and she had obtained physician orders for both residents. The facility's policy Restraint Free Facility Initiative (01/23) reflected Achieving a restraint free facility status is certainly attainable and important but must be done methodically and strategically to ensure the safety and clinical best practice for our residents.

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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** 47743 Based observations, interviews, and record review, the facility failed to ensure residents who were incontinent of bowel and bladder received appropriate treatment and services to prevent urinary tract infections for one (Resident #41) of three residents observed for Incontinent Care. The facility failed to ensure that CNA F did not wipe Resident #41's perineal (area between the legs) area from back to front while providing incontinent care on 04/15/2025. This failure could place the residents at risk of cross-contamination and development of urinary tract infections. Findings included: Review of Resident #41's Face Sheet, dated 04/15/2025, reflected the resident was an [AGE] year-old female admitted on [DATE]. The resident was diagnosed with urinary tract infection on 01/31/2025. Review of Resident #41's Comprehensive MDS Assessment, dated 02/17/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 03. The Comprehensive MDS Assessment indicated Resident #41 was always incontinent for bladder and bowel. Review of Resident #41's Comprehensive Care Plan, dated 04/13/2025, reflected the resident had bladder and bowel incontinence and one of the interventions was clean peri-area with each incontinent care. Observation on 04/15/2025 at 11:39 AM revealed CNA F entered Resident #41's room to provide incontinent care. CNA F cleaned the resident's perineal area. After cleaning the resident's perineal area, CNA F instructed and assisted the resident to roll on her right side and began cleaning the bottom of the resident. She cleaned the bottom of the resident from back to front. She did it four times. In an interview on 04/15/2025 at 11:58 AM, CNA F stated the wiping during incontinent care should always be done from front to back to prevent urinary tract infection. She said she was not aware that when she cleaned the bottom of the resident, that she did it from back to front. She said she should be mindful of how she does incontinent care because the resident would be at risk for urinary tract infection. In an interview on 04/16/2025 at 3:19 PM, the DON stated cleaning the perineal area should be from front to back to prevent cross contamination and probable infection. She said the procedure should also be done when cleaning the bottom of the resident. She said it should also be done from front to back because if done the other way around, the germs from the resident's bottom will be introduced to the perineal area. She said the expectation was for the staff to practice the right procedure of incontinent care and to focus on the prevention of infection. She said she would do an in-service about incontinent care. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/17/2025 at 7:22 AM, the Administrator stated improper cleaning of the private parts could cause infection and the expectation was for the staff to follow the right procedure for incontinent care. He said he was not a clinician and would let the DON take the lead in educating the staff about the issue. In an interview on 04/17/2025 at 8:49 AM, the ADON stated the proper way of cleaning the resident's perineal area would be always front to back to avoid transfer of germs from the bottom to the front part of the resident. She said the purpose of which was to prevent infection. She said the expectation was for the staff to do incontinent care the right way which was cleaning the front part and the bottom from front to back. She said she would coordinate with the DON to do an in-service pertaining to incontinent care focusing on proper cleaning. Record review of facility policy, Perineal Care revised 02/2023 revealed Purpose: The purpose of this procedure is to prevent infection . Steps in the Procedure . For female resident . e. wash the rectal area thoroughly, wiping from the base of the labia (female reproductive organ) towards and extending over the buttocks.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observation, interview and record review, the facility failed to provide appropriate treatment and services to prevent complications of enteral feeding for two (Resident #9 and Resident #81) of two residents reviewed for Feeding Tube (a way of providing nutrition directly to the stomach). 1. The facility failed to ensure LVN C checked Resident #9's g-tube (gastrostomy tube: a tube inserted through the abdomen that delivers nutrition directly to the stomach) placement and residual before administering medication on 04/16/2025. 2. The facility failed to ensure LVN C checked Resident #81's g-tube placement and residual before administering medication on 04/16/2025. These failures could place residents with G-tubes at risk for infection, dehydration, and drug-to-drug interaction. Findings included: 1. Record review of Resident #9's Face Sheet dated 04/16/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with dysphagia (difficulty in swallowing). Record review of Resident #9's Comprehensive MDS Assessment, dated 03/28/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 02. The Comprehensive MDS Assessment indicated the resident had a feeding tube. Record review of Resident #9's Quarterly Care Plan, dated 04/07/2025, reflected the resident required tube feeding and one of the interventions was to verify g-tube placement and check for residual. Record review of Resident #9's Physician Order, dated 04/10/2025, reflected every shift Osmolyte 1.2 rate of 60 ml/hr X 22 hours to allow for ADLs. Record review of Resident #9's Physician Order, dated 04/10/2025, reflected every shift Verify G-tube placement & check for residual. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/16/2025 at 8:15 AM revealed LVN C was about to give Resident #9 morning medication. He said the resident only had one medication to take. LVN C sanitized his hands, put the medication in a small plastic cup, crushed it, and returned the crushed medication to the small plastic cup. After crushing the medication, he poured some water in a plastic cup. He said he would incorporate some water to the medication to dissolve it. He went inside the resident's room with the medication and the cup of water, and placed them on the resident's overbed table. He put some water on the medication to dissolve it. He took a 60 ml piston syringe from the resident's side table and placed it also on the overbed table. He raised the bed, lifted the resident's gown to expose the g-tube site, and disconnected the g-tube from the formula. After disconnecting the g-tube, he pulled the plunger of the syringe, attached the syringe to the g-tube, and flushed the g-tube. After flushing the g-tube, he poured the dissolved medication. He did not check for the placement of the g-tube and the residual before flushing and administering the medication. After pouring the medications, he flushed the g-tube, detached the syringe, connected the g-tube to the formula, and cleaned the table and the syringe. 2. Record review of Resident #81's Face Sheet dated 04/16/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with gastrostomy status (presence of surgical opening in the stomach to support nutrition). Record review of Resident #81's Comprehensive MDS Assessment, dated 02/13/2025, reflected the resident was unable to complete the interview to determine the BIMS score. The Comprehensive MDS Assessment indicated the resident had a feeding tube. Record review of Resident #81's Quarterly Care Plan, dated 02/14/2025, reflected the resident required tube feeding and one of the interventions was to monitor for distension (bloating or swelling of the stomach area). Record review of Resident #81's Physician Order, dated 04/10/2025, reflected every shift Tube Feeding Continuous: Formula: Jevity 1.2 at 55 cc/hr x 22 hours to allow for ADL care. Record review of Resident #81's Physician Order, dated 04/10/2025, reflected every shift Verify G-tube placement & check for residual. Record review of Resident #81's Physician Order, dated 04/10/2025, reflected Keppra 7.5 ml via g-tube two times a day. Record review of Resident #81's Physician Order, dated 04/10/2025, reflected Lactobacillus capsule via g-tube two times a day. Record review of Resident #81's Physician Order, dated 04/10/2025, reflected Metoprolol 12.5 mg via g-tube once daily for hypertension. Hold if SBP < 100. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/16/2025 at 7:43 AM revealed LVN C was about to give Resident #81's morning medication. He said he would check first the resident's blood pressure because one of the medication is an anti-hypertensive. He went inside the room and took the resident's blood pressure. He said he will just prepare two medications because the resident's blood pressure was 99/50 and he needed to hold the anti-hypertensive medication. LVN C sanitized his hands, put the medications in small plastic cups, crushed them, and returned the crushed medication to their respective small cups. After crushing the medications, he poured some water in a plastic cup. He said he would incorporate some water to the medication to dissolve it. He went inside the resident's room with the medications and the cup of water, and placed them on the resident's overbed table. He put some water on the medications to dissolve it. He took a 60 ml piston syringe from the resident's side table and placed it also on the overbed table. He raised the bed, lifted the resident's gown to expose the g-tube site, and disconnected the g-tube from the formula. After disconnecting the g-tube, he pulled the plunger of the syringe, attached the syringe to the g-tube, and flushed the g-tube. After flushing the g-tube, he poured a medication, flushed the g-tube, then poured the next medication. He did not check for the placement of the g-tube and the residual before flushing and administering the medication. After pouring the last medication, he flushed the g-tube, detached the syringe, connected the g-tube to the formula, and cleaned the table and the syringe. In an interview on 04/16/2025 at 8:39 AM, LVN C stated he forgot to check for the g-tube placement and to check the residual of both residents. He said the right procedure was to check the placement and the residual. He said g-tube placement was checked to ensure the tube was correctly positioned. He said the residual was also checked before administering medications to check if the stomach was not too full and could accommodate the medications and fluid to be introduced. He said he knew he needed to check for the placement and residual but failed to do so because he was nervous. In an interview on 04/16/2025 at 3:19 PM, the DON stated the placement of the g-tube and the residual should be checked. She said administering the morning medications would be the best time to check for placement to ensure the medications and the fluid would enter the stomach and not the lungs. She said the gastric residual should be checked before bolus feeding and medication administration to prevent aspiration and also to assess if the resident's stomach was emptying properly. She said the expectation was for the staff to follow the right procedure for medication administration via g-tube. She said she would do an in-service about enteral feeding. In an interview on 04/17/2025 at 7:22 AM, the Administrator stated the expectation was for the staff to follow the right procedure for administering medications via g-tube. He said he was not a clinician and would let the DON take the lead in educating the staff about the issue. In an interview on 04/17/2025 at 8:49 AM, the ADON stated both the residual and g-tube placement should be checked before giving the medications. She said g-tube placement should be checked to ensure the g-tube was in the right place. She said even though the residents were on continuous feeding, the placement should still be checked. She said the gastric residual was also checked to prevent aspiration and also to assess if the rate of the formula should be modified. She said the expectation was for the staff to check for g-tube placement and to check for gastric residual every time they administer medications. She said she would coordinate with the DON to do an in-service about enteral feeding. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy Enteral (food or medication administration directly through the digestive system) Nutrition revised [DATE] revealed Adequate nutritional support through enteral nutrition . Policy Interpretation and Implementation: 1. The interdisciplinary team . conducts nutritional assessment . clinical necessity of enteral feeding . resident's response to them . 12. Need for supplemental orders, including . Confirmation of tube placement . Checks for gastric residual volume.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for five (Resident #3, #4, #80, #187, and #188) of twenty residents reviewed for Respiratory Care. 1. The facility failed to ensure Resident #3's nasal cannula (flexible tube used to deliver oxygen to the nose through two prongs) was properly stored when not in use on 04/15/2025. 2. The facility failed to ensure Resident #4's humidifier bottle (a medical device designed to increase the moisture level in supplemental oxygen) had water in it on 04/15/2025. 3. The facility failed to ensure an Oxygen in Use sign was outside Resident #80's room on 04/15/2025. 4. The facility failed to ensure Resident #188's nasal cannula was properly stored when not in use on 04/15/2025. 5. The facility failed to ensure Resident #187's nasal cannula was properly stored when not in use on 04/16/2025. These failures could place residents at risk for respiratory infection and not having their respiratory needs met. Findings included: 1. Record review of Resident #3's Face Sheet, dated 04/15/2025, reflected an [AGE] year-old female admitted on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of Resident #3's Quarterly MDS Assessment, dated 04/13/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 10. The Quarterly MDS Assessment indicated the resident had oxygen therapy. Record review of Resident #3's Quarterly Care Plan, dated 01/21/2025, reflected the resident had COPD and one of the interventions was O2 at 2 liters per minute via nasal cannula continuously. Record review of Resident #3's Physician Orders, dated 02/26/2024, reflected O2 at 2 liters per minute via nasal cannula continuously. May titrate to 3-4 LPM to keep O2 sats >90% every shift for O2 sat >90%. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/15/2025 at 10:01 AM revealed Resident #3 was in her bed with eyes closed. It was observed that the resident was on oxygen therapy at 2 liters per minute via nasal cannula. An oxygen tank was observed near the door with a nasal cannula attached to it. The nasal cannula was coiled to the oxygen tank with the prongs touching the side of the oxygen tank. The nasal cannula was not bagged. During an observation and interview on 04/15/2025 at 10:06 AM, LVN E stated the oxygen tank at the side of the door was for Resident #3. She said the nasal cannula should not be coiled around the oxygen tank. She said it should be bagged to prevent respiratory infection. LVN E disconnected the nasal cannula and said she would get a new nasal cannula and a bag for it. She said she did not notice the nasal cannula not being bagged when she did her morning round. 2. Record review of Resident #4's Face Sheet, dated 04/15/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease. Record review of Resident #4's Comprehensive MDS Assessment, dated 04/09/2025, reflected the resident was cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment indicated the resident had COPD. Record review of Resident #4's Comprehensive Care Plan, dated 04/10/2025, reflected the resident had oxygen therapy and one of the interventions was to change from mask to nasal cannula during meals. Record review of Resident #4's Physician Order, dated 02/25/2025, reflected O2 at 3 liters per minute via nasal cannula as needed for shortness of breath. May titrate to 1- 4 LPM to keep O2 sats > 90% every shift for O2 sat >90%. Observation on 04/15/2025 at 9:42 AM revealed Resident #4 was in his bed with eyes closed. It was observed that the resident was on oxygen therapy at 3 liter per minute via nasal cannula. The nasal cannula was connected to an oxygen concentrator with a humidifier bottle in it. The pre-filled humidifier bottle had no water in it. During an observation and interview on 04/15/2025 at 9:48 AM, RN B stated she did not notice that Resident #4's humidifier bottle was out of water or was running low. She said she should have checked it when she did her morning round. She said the purpose of the humidifier bottle was to moisten the nose and the throat and to prevent irritation. RN B disconnected the empty humidifier bottle and said she would get a new one. 3. Record review of Resident #80's Face Sheet, dated 04/15/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with anxiety disorder. Record review of Resident #80's Physician Order, dated 04/13/2025, reflected O2 at 2 liters per minute via nasal cannula continuously/prn. May titrate to 3-4 LPM to keep O2 sats >90% every shift for shortness of breath or O2 sat <91%. Record review of Resident #80's Progress Notes, dated 04/13/2025, reflected the resident was readmitted to the facility from the hospital with a diagnosis of pneumonia (inflammation and fluid in the lungs caused by a bacterial, viral, or fungal infection). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Valley Healthcare and Rehabilitation Center	6850 Rufe Snow Dr Fort Worth, TX 76148

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/15/2025 at 9:47 AM revealed the resident was in her bed with eyes closed. It was observed that the resident was on oxygen therapy at 3 liters per minute via nasal cannula. It was also observed that there was no Oxygen In Use sign outside the resident's room. During an observation and interview on 04/15/2025 at 2:18 PM, LVN D said if a resident was using oxygen, there should be an oxygen sign outside the door of the resident to inform everybody that oxygen was being used. He said the sign served as a reminder for potential hazards connected to oxygen use such as fire and explosions. 4. Record review of Resident #187's Face Sheet, dated 04/16/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with respiratory failure (condition where there is not enough oxygen in the body or too much carbon dioxide in the body). Record review of Resident #187's Comprehensive MDS Assessment, dated 04/15/2025, reflected the resident was unable to complete the interview to determine the BIMS score. The Comprehensive MDS Assessment indicated the resident was on oxygen. Record review of Resident #187's Comprehensive Care Plan, dated 04/10/2025, reflected the resident had oxygen therapy and one of the interventions was to provide extension tubing during ambulation. Record review of Resident #187's Physician Order, dated 04/09/2025, reflected O2 at 2 liters per minute via nasal cannula continuously. May titrate to 3 - 4 LPM to keep O2 sats >90% every shift for O2 sat >90%. Observation and interview on 04/16/2025 at 8:36 AM revealed Resident #187 was in his bed awake. It was observed that the resident was on oxygen therapy. It was also observed that there was an oxygen tank at the back of the resident's wheelchair. A nasal cannula was attached to the oxygen tank. The nasal cannula was not bagged and was touching the back of the wheelchair. The resident said he had been using the oxygen for weeks. He said he also had oxygen on his wheelchair that he used when he went to therapy. During an observation and interview on 04/16/2025 at 10:15 AM, RN A said she did not notice that the nasal cannula at the back of Resident #187's wheelchair was not bagged. She said she went inside the resident's room to administer the breathing treatment but did not notice the nasal cannula. She said the nasal cannula should be bagged to prevent infection. She disconnected the nasal cannula and said she would get a new one and a plastic bag to store it. 5. Record review of Resident #188's Face Sheet, dated 04/15/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with chronic respiratory failure. Record review of Resident #188's Comprehensive MDS Assessment, dated 04/13/2025, reflected the resident was unable to complete the interview to determine the BIMS score. The Comprehensive MDS Assessment indicated the resident had respiratory failure. Record review of Resident #188's Comprehensive Care Plan, dated 04/07/2025, reflected the resident had oxygen therapy and one of the interventions was to change from mask to nasal cannula during meals. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #188's Physician Order, dated 04/06/2025, reflected O2 at 2 liters per minute via nasal cannula continuously. May titrate to 3 - 4 LPM to keep O2 sats >90% every shift for O2 sat >90%. Observation on 04/15/2025 at 11:46 AM revealed Resident #188 was in her bed with eyes closed. The resident was on oxygen therapy at 2 liters per minute via nasal cannula. It was also observed that the resident had an oxygen tank at the back of her wheelchair with nasal cannula attached to it. The nasal cannula was not bagged. Observation and interview on 04/15/2025 at 11:49 AM revealed LVN E disconnected the nasal cannula at the back of the wheelchair and said she would also get a new nasal cannula and a plastic bag for it. In an interview on 04/16/2025 at 3:19 PM, the DON stated the nasal cannulas were supposed to be in a bag when the residents were not using them to prevent cross contamination and worsening of respiratory issues the resident might already have. She said the humidifier should always have water in it to prevent dryness and irritation of the nasal passageway. She also said that if a resident was using oxygen, there should be a sign outside indicating that oxygen was being used. She said the sign was to alert the staff to avoid smoking and any potential sources of ignition. She said the expectation was for the staff to be mindful in making sure nasal cannulas were bagged when not in use, there was water in the humidifier bottle, and there was a sign outside the room when oxygen was being used. She said she would conduct an in-service about respiratory care. In an interview on 04/17/2025 at 7:22 AM, the Administrator stated everything that the residents were using should be kept clean to prevent infection. He said he was not a clinician and would let the DON take the lead in educating the staff about the issue of bagging the nasal cannula and the water in the humidifier. He said there should be sign outside the resident's room if oxygen was being used so the staff and the visitors would be aware. In an interview on 04/17/2025 at 8:49 AM, the ADON stated the nasal cannulas should be stored properly inside a plastic bag if the residents were not using them. She said the staff were responsible for ensuring the nasal cannulas and the breathing masks were clean every time the residents would use them. She said the expectation was for all nasal cannulas to be stored properly. She said another expectation was for the staff to check if the pre-filled humidifier bottle was running low or was empty. She said if it was running low, the staff should be ready to change it. She said the sign for oxygen use was to remind the staff to be careful not to cause any ignition that could cause fire. She said she would coordinate with the DON to do an in-service about respiratory care. Record review of the facility policy Oxygen Safety Health Oxygen Administration revised May 2024 reflected Oxygen Safety - General Rules . 5. No smoking signs shall be visible where oxygen is stored or being administered. Record review of the facility policy Oxygen Administration Health Oxygen Administration revised May 2024 reflected The purpose of this procedure is to provide guidelines for safe oxygen administration . Steps in procedure . 2. Place Oxygen in Use sign on the outside of the room entrance door . 12. Be sure there is water in the humidifying jar . 14. Periodically re-check water level in humidifier jar. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy for respiratory care specific for bagging the nasal cannula was requested on 04/16/2025 via email but was not provided prior to exit.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45055 Based on observation, interview, and record review the facility failed to store, prepare, distributed, and serve food in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food and nutrition services. 1. The facility failed to ensure the ice machine and ice scoop holder in the facility kitchen was thoroughly cleaned. 2. The facility failed to ensure kitchen cooking equipment was cleaned. 3. The facility failed to place a cover on top of the tea dispenser to avoid air borne contaminants. 4. The facility failed to ensure cooking equipment in the dining area was clean and sanitized. 5. The facility failed to label and date food stored in the refrigerator once it was opened and used. These failures could place residents at risk for cross contamination and other air-borne illnesses. Findings include: Observations on 04/15/25 from 9:08 AM to 9:22 AM in the facility's only kitchen revealed: The ice machine, located in the kitchen had brown stains on the inside of the door and along the opening of the machine. The ice scoop holder, hanging on a wall near the ice machine, had brownish stains inside the bottom of the holder. One large bread toaster had built up dark brown dirt along the inside walls of the machine and along the tracks. One microwave, located in the dining area, had white stains plastered all over the outside of it and the inside had dried food stains on the plate and the inside walls. One toaster oven, located in the dining area, had white stains plastered all over the outside of it and the inside had dried food stains on the pans and the inside walls. There were two baking pans on the counter that was heavily stained with food stains. One containers of pears, located in the refrigerator, was not dated with the month, day and year the item was stored after opening. One glassed container of milk, located in the refrigerator, was not dated with the month, day, and year the item was stored. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	One large tea dispenser, located in the kitchen area, had tea in it and it did not have a lid placed on the top of the dispenser to avoid air-borne contaminants. o Five large cans of Tropical fruit salad, located in the dry storage area, was not dated with the month, day, and year the items were received from the vendor. Five large cans of Great northern beans, located in the dry storage area, was not dated with the month, day, and year the items were received from the vendor. In an interview on 04/16/25 at 2:10 PM, the Dietary Manager was advised of the findings in the kitchen. He was shown pictures of the concerns observed in the kitchen and the dining area. He stated he dated the food whenever it was stored after use. He stated he usually reviewed the kitchen for cleanliness at the start of their day and he often cleaned the items. He stated he spoke with the dishwasher who prepared the tea and advised him that he needed to ensure the tea dispenser was covered once the tea has been made. He stated they had a vendor service the ice machine monthly, but they could wipe it down. He stated he had a cleaning schedule for the kitchen staff and the kitchen equipment was cleaned weekly. He stated the toaster oven, and the microwave was used by the Activity Director, and she was responsible for cleaning the cooking equipment. He stated he would have someone clean the items. He stated the risk of not addressing the issues discussed could result in residents getting sick and dying. In an interview on 04/17/25 at 10:50 AM with the Administrator, he was shown pictures of the concerns observed in the kitchen area. He stated he had spoken with the Dietary Manager and was advised of the concerns observed in the kitchen area. He stated the risk of not addressing the concerns could result in residents getting sick. Record review of the facility's policy on Sanitization(dated January 2024), revealed The food service area shall be maintained in a clean and sanitary manner. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions. Record review of the facility's policy on Food Receiving and Storage (dated October 2022), revealed Foods shall be received and stored in a manner that complies with safe food handling practices.

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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** 47743 Based 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 four (Resident #9, Resident #41, Resident #81, and Resident #187) of ten residents reviewed for Infection Control. 1. The facility failed to ensure CNA F changed her gloves and performed hand hygiene before, after, and while providing incontinent care to Resident #41 on 04/15/2025. 2. The facility failed to ensure LVN C wore a gown while administering Resident # 9's medications via g-tube 04/16/2025. 3. The facility failed to ensure LVN C wore a gown while administering Resident #81's medication via g-tube 04/16/2025. 4. The facility failed to ensure WCN J wore a gown while performing Resident #187's wound care and changed her gloves after touching the outside edge of the resident's foot on 04/16/2025. These failures could place residents at risk of cross-contamination and development of infections. Findings included: 1. Review of Resident #41's Face Sheet, dated 04/15/2025, reflected the resident was an [AGE] year-old female admitted on [DATE]. The resident was diagnosed with urinary tract infection on 01/31/2025. Review of Resident #41's Comprehensive MDS Assessment, dated 02/17/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 03. The Comprehensive MDS Assessment indicated Resident #41 was always incontinent for bladder and bowel. Review of Resident #41's Comprehensive Care Plan, dated 04/13/2025, reflected the resident had bladder and bowel incontinence and one of the interventions was clean perineal (area between the legs) with each incontinent care. Observation on 04/15/2025 at 11:39 AM revealed CNA F was about to provide (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	incontinent care to Resident #41. She entered the room while holding a brief and padding. Once inside the room, she put on a pair of gloves. She did not wash or sanitize her hands before putting on the gloves. She placed the clean brief and the padding on the resident's overbed table. She also placed some wipes, a box of gloves, and a plastic bag on the overbed table. She lowered the head of the bed, raised the bed, and pulled the resident's blanket towards the resident's feet. She unfastened the resident's brief and pushed it between the resident's thighs. She removed her gloves, threw them on the plastic bag placed on the overbed table, and put on a new pair of gloves. She did not sanitize her hands before putting on the gloves. She pulled some wipes and cleaned the resident's perineal area (area between the thighs) using the front to back technique. She did it three times. After cleaning the perineal area, she instructed and assisted the resident to roll towards the right side, and cleaned the resident's bottom. After cleaning the resident's bottom, she pulled the soiled brief and threw it on the plastic bag. After throwing the soiled brief, she changed her gloves but did not sanitize her hands before putting on a new pair of gloves. She took the padding and the brief from the overbed table, placed it under the resident, and fixed it. She then instructed and assisted the resident to roll to the other side. After rolling the resident to the other side, she touched the other half of the soiled padding and placed it in a plastic bag. She then fixed the new brief and padding. She did not change her gloves after touching the soiled brief. After fixing the brief and the padding, CNA F assisted the resident to roll back and fastened the brief on both sides. CNA F took off her gloves and threw them in the trash bag. She went out of the resident's room and threw the soiled items. She did not wash her hands after performing incontinent care. In an interview on 04/15/2025 at 11:58 AM, CNA F stated hand hygiene was important to prevent cross contamination and to prevent infection. She said she forgot to wash her hands before and after doing Resident #41's incontinent care. She said during the process, she changed her gloves but did not sanitize her hands before putting on a new pair of gloves. She said after touching the soiled padding on the plastic bag, she should have changed her gloves. She said she would be mindful the next time she does incontinent care to do hand hygiene and change her gloves after touching something soiled during incontinent care. 2. Record review of Resident #9's Face Sheet dated 04/16/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with dysphagia (difficulty in swallowing). Record review of Resident #9's Comprehensive MDS Assessment, dated 03/28/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 02. The Comprehensive MDS Assessment indicated the resident had a feeding tube (a way of providing nutrition directly to the stomach). Record review of Resident #9's Quarterly Care Plan, dated 04/07/2025, reflected the resident was on enhanced barrier precautions and one of the interventions was to use gloves and gown during use of the feeding tube. Record review of Resident #9's Physician Order, dated 04/10/2025, reflected every shift Osmolyte 1.2 rate of 60ml/hr X 22 hours to allow for ADLs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/16/2025 at 8:15 AM revealed LVN C was about to give Resident #9 morning medication. He said the resident only had one medication to take. LVN C sanitized his hands, put the medication in a small plastic cup, crushed it, and returned the crushed medication to the small plastic cup. After crushing the medication, he poured some water in a plastic cup. He said he would incorporate some water to the medication to dissolve it. He went inside the resident's room with the medication and the cup of water, and placed them on the resident's overbed table. He proceeded with medication administration via g-tube. He did not wear a gown before giving the medication. It was observed that there was a sign outside that the resident was on enhanced barrier precaution. 3. Record review of Resident #81's Face Sheet dated 04/16/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with gastrostomy status (presence of surgical opening in the stomach to support nutrition). Record review of Resident #81's Comprehensive MDS Assessment, dated 02/13/2025, reflected the resident was unable to complete the interview to determine the BIMS score. The Comprehensive MDS Assessment indicated the resident had a feeding tube (a way of providing nutrition directly to the stomach). Record review of Resident #81's Quarterly Care Plan, dated 02/14/2025, reflected the resident was on enhanced barrier precautions and one of the interventions was to use gloves and gown during use of the feeding tube. Record review of Resident #81's Physician Order, dated 04/10/2025, reflected every shift Tube Feeding Continuous: Formula: Jevity 1.2 at 55 cc/hr x 22 hours to allow for ADL care. Observation on 04/16/2025 at 7:43 AM revealed LVN C was about to give Resident #81's morning medication. He said he would check first the resident's blood pressure because one of the medication is an anti-hypertensive. He went inside the room and took the resident's blood pressure. He said he will just prepare two medications because the resident's blood pressure was 99/50 and he needed to hold the anti-hypertensive medication. LVN C sanitized his hands, put the medications in small plastic cups, crushed them, and returned the crushed medication to their respective small cups. After crushing the medications, he poured some water in a plastic cup. He said he would incorporate some water to the medication to dissolve it. He went inside the resident's room with the medications and the cup of water, and placed them on the resident's overbed table. He proceeded to administer the resident's medication via g-tube. He did not wear a gown when he was giving the medications. It was observed that there was a sign outside that the resident was on enhanced barrier precaution. In an interview on 04/16/2025 at 8:39 AM, LVN C stated he forgot to wear a gown before administering Resident #9 and Resident #81's medication. He said there was a sign outside the door that said if the feeding tube will be used, the staff must wear a gown to prevent cross contamination and infection. He said he will be mindful the next time he would administer medication via g-tube. 4. Record review of Resident #187's Face Sheet, dated 04/16/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with type 2 diabetes mellitus (high blood sugar). (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 #187's Comprehensive MDS Assessment, dated 04/15/2025, reflected the resident was unable to complete the interview to determine the BIMS score. The Comprehensive MDS Assessment indicated the resident had a diabetic foot ulcer (slow healing wound that commonly occur in individuals with diabetes). Record review of Resident #187's Comprehensive Care Plan, dated 04/10/2025, reflected the resident had a diabetic foot ulcer to the right foot and one of the goals was that the resident will not have any complications. Record review of Resident #187's Physician Order, dated 04/10/2025, reflected Cleanse Right Foot DFU with WC, apply Iodosorb ointment into wound bed, gently pack with 1/4 Iodoform packing strips into wound using a Q-Tip. Cover with Non adherent dressing and wrap with Kerlix secured with Ace wrap PRN every 24 hours as needed for DFU. Observation on 04/16/2025 at 8:36 AM revealed WCN J was about to change the dressing on Resident #187's wound to the right foot. She sanitized her hands and prepared the iodosorb ointment, iodoform packing strips, kerlix, dry gauze, surgical scissors, Q-Tips, and non-adherent dressing. After preparing the things needed for wound care, she went inside the room, and brought with her the things needed for wound care, and placed them on the overbed table that she sanitized. After placing them on the table, she washed her hands and put on a pair of gloves. She then started to clean the wound to the right foot. She did not wear a gown while cleaning the wound. During the process of cleaning, WCN J inspected the outside edge of the resident's foot by touching it. She then proceeded to cover the wound with the new dressing. She did not change her gloves after she touched the side of the right foot. In an interview on 04/16/2025 at 9:01 AM, WCN J said she should have worn a gown because the resident was on enhanced barrier precaution. She said the purpose of which was to prevent cross contamination and development of infection. She said she should have changed her gloves after touching the side of the foot and before touching the dressing. In an interview on 04/16/2025 at 3:19 PM, the DON stated hand hygiene was the most effective way to prevent cross contamination and spread of infection. She said staff should do hand hygiene before and after any care. She said gloves should be changed after touching anything soiled to make sure that microorganism will not transfer to the clean brief and clean dressing. She also said that if a resident was on enhanced barrier precaution, the staff should wear a gown when attending to them. She said residents with feeding tubes and open wounds required enhanced barrier precaution to decrease their exposure to pathogens that could cause infection. She said the expectation was for the staff to do hand hygiene before and after any care, change gloves from dirty to clean, and wear gowns when caring for residents on enhanced barrier precautions. She said she already started an in-service about infection control and hand hygiene. She said she would personally monitor the staff's adherence to the policy and procedure of infection control. In an interview on 04/17/2025 at 7:22 AM, the Administrator stated that staff must be mindful in preventing spread of germs and development of infection. He said he was not a clinician and would let the DON take the lead in educating the staff about the issue. (continued on next page)

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Green Valley Healthcare and Rehabilitation Center	6850 Rufe Snow Dr Fort Worth, TX 76148

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/17/2025 at 8:49 AM, the ADON stated staff must wash their hands before and after incontinent care. She said staff should be mindful that when they touched something dirty, they should change their gloves before touching something clean. She said this is true for both incontinent care and wound care. She also said that before putting on a new pair of gloves, staff must wash their hands or sanitize their hands. She said she would coordinate with the DON to do an in-service pertaining to hand hygiene, infection control, and wound care. Record review of facility policy, Handwashing-Hand Hygiene Policy and Procedures revised 10-2020 revealed Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections . Policy Interpretation and Implementation . 7. Use an alcohol-based hand rub . f. Before donning sterile gloves . g. Before handling clean or soiled dressing . h. Before moving from a contaminated body site to a clean body site during resident care . j. After contact with blood or bodily fluids . k. After handling used dressings, contaminated equipment, etc. Applying and removing Gloves . 1. Perform hand hygiene before and after applying non-sterile gloves. Record review of facility policy, Enhanced Barrier Precaution reviewed 03/19/2025 revealed EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care . Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. Record review of facility policy, Incontinent Care revised 04/16/2024 revealed Purpose: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation . Steps in the Procedure . 2. Wash and apply gloves . For a female resident . b. wash perineal area . 10. Remove gloves . 11. Wash and dry hands thoroughly.