STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676163	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesquite Post Acute Care	4510 27th St Lubbock, TX 79410

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41480 Based on interview and record review, the facility failed to ensure all residents had the right to formulate an advance directive for 1 of 20 residents (Residents #38) reviewed for advanced directives, in that: Residents #38's OOH-DNR form was missing required information. This failure could place residents at risk for not having their end of life wishes honored and incomplete records. Findings included: Record review of Resident #38's face sheet, dated 03/27/25, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include peripheral vascular disease (progressive disorder that causes narrowing or blocking of the blood vessels outside the heart), diabetes (high blood sugar), schizoaffective disorder (mental illness), and dementia (cognitive loss). The face sheet also revealed under the advance directive section - DNR-Do Not Resuscitate. Record review of Resident #38's physician order summary dated 03/27/25 revealed the following order: Code Status: DNR dated 08/28/24. Record review of Resident #38's care plan, dated 02/12/25, revealed care plan for DNR. Record review of Resident #38's Out of Hospital Do Not Resuscitate form dated 08/02/224 revealed no witness names or signature, or notary signature. Under the section, All persons who have signed above must sign below, revealed no witness or notary signature and no resident signature. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/27/25 at 09:59 AM with the DON, she stated the social worker was responsible for completing the OOH DNR form. She stated they did not have a social worker. She verified Resident #38's DNR did not have a witness or notary signature, and the signatures at the bottom of form was also not there. She stated an OOH DNR was not valid unless the form was completely filled out. She stated she had not been trained on how to complete an OOH DNR. She stated she was not aware the OOH DNR was incomplete. She stated they have not had time to do a complete audit of all DNR's since taking the building over on 02/01/25. She stated the potential negative outcome could be not having the proper documentation during an emergency or during a code. During an interview on 03/27/25 at 10:08 AM with the ADM, she stated the social worker and nursing staff were responsible for completing OOH DNRs. She stated they do not have a social worker. She stated the DON was responsible for validating the OOH DNR was complete. She stated she was not aware of any incomplete OOH DNR forms. She stated an OOH DNR was not valid if not completely filled out. She stated the potential negative outcome could be during an emergency they would not follow residents wishes if there was no appropriate documentation. Record review of the Out of Hospital Do Not Resuscitated (OOH-DNR) order Instructions for issuing an OOH-DNR order dated revised October 12, 2023, revealed the following: In addition, the OOH-DNR Order must be signed and dated by two competent adult witnesses, who have witnessed either the competent adult person making his/her signature in section A, or authorized declarant making his/her signature in either sections B, C, or E, and if applicable, have witnessed a competent adult person making an OOH-DNR Order by nonwritten communication to the attending physician, who must sign in Section D and also the physician's statement section. Optionally, a competent adult person or authorized declarant may sign the OOH-DNR Order in the presence of a notary public. However, a notary cannot acknowledge witnessing the issuance of an OOH-DNR in a nonwritten manner, which must be observed and only can be acknowledged by two qualified witnesses. Witness or notary signatures are not required when two physicians execute the OOH-DNR Order in section F. The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professionals.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 46425 Based on observation, interview, and record review, the facility failed to provide information to resident's and their representatives on their rights related to filing grievances for 12 of 20 confidential residents. The facility failed to ensure 12 of 20 confidential residents were provided, through postings in prominent locations; the grievance procedures, were provided access to the Grievance form, information regarding who the facility grievance officer was, their contact information, how to file an anonymous grievance, and their right to obtain a written decision related to their grievance. These failures could place the residents at risk of unresolved grievances and decreased quality of life. Findings include: Interviews during Resident Council on, 03/26/2025 at 3:00pm, 12 of 20 confidential residents, revealed they did not have access to the Grievance form, they did not know they could file a Grievance anonymously, the Grievance procedure had never been discussed in Resident Council, and they had not observed a posting of the Grievance procedure in prominent locations. Residents attending Resident Council did not know where to acquire a grievance form, who to turn the form into, and what happened once a grievance was filed. Residents stated Grievance forms had previously been available in the Social Worker's office; however, the Social Work position was now vacant. The residents did not know they had the right to receive a written decision once their grievance was resolved. Twelve Residents attended the meeting, the 12 Residents in attendance had all been Residents of the facility for 6 plus months. Observed prominent postings on 3/27/2025 at 11:17am; the facility did not include instructions regarding the Grievance procedures with any of the prominent postings. Grievance forms were placed in manila folder on a bulletin board to the right of the nurses' station, the folder was not reachable to Residents in wheelchairs. There was a wire basket on the wall outside of the Social Worker's office, however, the basket was not labeled and was not covered or secure. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the ADM on 3/27/2025 at 11:05am; the ADM stated she was the Grievance Officer for the facility. The ADM stated she was responsible for the review of Grievances and assigned them to department heads during morning meeting. The ADM stated the Grievance form was kept at the Social Worker and all offices would have a Grievance form. ADM stated there is a folder on a bulletin board next to the Nurses' Station with Grievance forms. The ADM stated there was a wire basket outside of the Social Worker's office that could be for completed Grievances. The ADM stated the basket was not labeled, it does not have a cover, and it is not secured. The ADM stated the folder, and the basket are not a successful system if the Residents are unaware of the availability of the form or where the Grievance form can be submitted. The ADM stated she was unaware the Grievance process was not being discussed in Resident Council. The ADM agreed the Grievance process cannot be successful if Residents are not educated on the process. The ADM stated the facility has 72 hours to resolve Grievances once they were submitted. The ADM stated she assigned the Grievance to the appropriate department, that department addresses the grievance with the complainant, resolved the grievance, and explained the resolution to the complainant. The resolution was documented on the Grievance form and the completed form was submitted to the ADM for review. The ADM stated completed Grievance forms were kept in a notebook. The ADM stated she monitored the Grievance process for success by following up with the staff member assigned to resolve the Grievance; the ADM stated she would also meet with the complainant to ensure they were satisfied with the resolution. The ADM stated she was responsible for ensuring staff were trained on the Grievance process. Record Review of the Grievance Policy last updated in 2023, revealed the following: Policy Statement: The facility will establish a grievance process that allows the residents a way to execute their right to voice concerns or grievances to the facility or other agency/entity without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as their facility stay. The facility will make information on how to file a grievance available to the residents and make prompt efforts to resolve grievances that the resident may have. Procedure: 1. The facility will make available information on how to file a grievance available to residents, family, and staff. a. Residents or their representative have the right to file a grievance orally , in writing, and/or anonymously. b. Contact information of the facility grievance office to include name, business, and email address, phone number, and reasonable expected time frame for completing review of the grievance. c. Contact information of independent entities with whom grievances may be filed, which include the state agency, Quality Improvement Organization, State Survey Agency, Ombudsman, or protection/advocacy agencies. d. The right to obtain a written decision regarding their grievance. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The Administrator or designed will assign the responsibility of investigating the grievance. 3. General concerns may be voiced at Resident and/or Family Council meetings. 4. The Administrator or designee evaluates and investigates the concern and takes immediate action to resolve the concern and prevent further potential violations of any resident's right while the alleged violation is being investigated. 5. The Grievance Official will immediately report all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property to the Administrator; and as required by State Law. 6. The resident, or person acting on behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended, within 3 working days of the filing of the grievance. 7. If during the investigation abuse, neglect, misappropriation and/or injuries of unknown source are identified, the facility will refer to the Abuse Policy. a. Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and b. Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievances for period of no less than 3 years from the issuance of the grievance decision.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49279 Based on observation, interview, and record review, the facility failed to establish a system of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation and determine that drug records are in order and that an account of all controlled drugs were maintained and periodically reconciled for 1 of 1 storage areas and 1 of 2 medication carts (Med Cart A) reviewed for medication storage. 1. The facility failed to keep a record of a receipt of controlled medications awaiting disposition to allow accurate and periodic reconciliation. 2. The facility failed to ensure expired medications were not kept in Med Cart A. These failures could place residents at risk of not receiving the therapeutic benefit of medications, loss of prescribed medications and drug diversion. The findings included: 1. During an observation and interview with the DON on 3/26/25 at 11:17 AM, the following unlogged medications were observed in the controlled medications storage area waiting to be disposed of: -Morphine 100/5 -- 29.5 mls -Temazepam 30 mg - 28 capsules -Clonazepam 1 mg - 9 tablets -Alprazolam 0.2 mg - 7 tablets -Tramadol HCl 50 mg - 29 tablets -Lorazepam 1 mg - 75 tablets -Tramadol HCl 50 mg - 29 tablets -Alprazolam 0.5 mg - 46 tablets -Morphine 20mg/ml - 16 mls -Lorazepam 1 mg - 9 tablets -Lorazepam 2mg/ml - 19 mls -Hydroco/APAP 5-325 mg - 36 tablets (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Ativan 2mg/ml - 16 mls -Morphine 500/5 - 27.5 mls -Lorazepam Intensol 2mg/ml - 29 mls -Tramadol HCl 50 mg - 42 tablets -Morphine Sulfate 100 mg/5 ml - 29.5 mls -Tramadol HCl 50 mg - 46 tablets -Lorazepam 2 mg/ ml - 2.25 mls -Temazepam 15 mg - 7 tablets -Lorazepam 2 mg/ ml - 80 mls -Temazepam 15 mg - 3 capsules -Tramadol HCl 50 mg - 15 tablets - Alprazolam 0.25 mg - 20 tablets -Tramadol HCl 50 mg - 44 tablets -Lorazepam 1 mg - 37 tablets During the observation of the unlogged medications, the DON stated her process for reconciliation and storage of controlled medications that needed to be disposed of was as follows: The DON and the nurse that brought her the medications would review the narcotic sheet indicating how much medication was left, then the DON and nurse would each sign the narcotic sheet. The narcotic sheet was placed with the medication, and the medication and narcotic sheet were placed in the locked cabinet until the medication destruction was completed with the pharmacist. The DON stated she was unaware that the stored medications needed to be logged upon receipt, prior to their destruction with the pharmacist. The DON stated she would log the medications and put in a request for the pharmacy consultant to visit the facility to conduct a medication destruction. During an interview on 3/26/25 at 11:25 AM, the Clinical Resource Nurse stated controlled medications that were being stored for destruction should be logged. She stated best practice was to log discontinued controlled medications upon receipt, then properly store the medications for destruction with the pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up interview on 3/27/25 at 9:47 AM, the DON stated she was responsible for logging discontinued medications that were being stored for destruction. She stated the reason the controlled medications had not been logged was because she was overwhelmed on which tasks to prioritize after the facility's recent change of ownership and being recently hired to her position. She stated she was not aware that she needed to log the controlled medications in addition to reconciling and signing the narcotic sheets and securely storing the medications. She stated the pharmacy consultant had briefly visited the building on the same day the survey team entered for the recertification survey. The DON stated the pharmacy consultant would return to complete her visit and conduct medication destruction following the survey. She stated the policy of the facility was for the DON to log discontinued controlled medications upon receipt, prior to destruction with the pharmacist. The DON stated a potential negative outcome for failure to accurately inventory discontinued controlled medications prior to disposal would be that the medications could go missing and be unaccounted for. During an interview on 3/27/25 at 11:30 AM, the ADM stated she was not aware that discontinued controlled medications were not logged. She stated it was the responsibility of the DON to keep an inventory of discontinued controlled medications that were being stored for destruction. She stated her expectation of staff for logging discontinued controlled medications was to follow the facility's policy. The ADM stated a potential negative outcome for failure to accurately log discontinued controlled medications being stored for disposal would be missing medications. During a phone interview on 3/27/25 at 2:02 PM, the Clinical Consultant Pharmacist stated she was the pharmacist assigned to the facility and would be responsible for medication destruction during her visits. She stated discontinued controlled medications should be reconciled upon receipt then logged and stored for destruction, in order to maintain an accurate inventory while awaiting disposal. She stated her expectation upon entering the facility for drug destruction was that all controlled medications were logged. She stated her process for reconciliation of controlled medications prior to destruction was to check the DON's medication log against the count on the narcotic sheet and then against the actual quantity of the medication being stored. 2. During an observation of Medication Cart A with CMA C on 3/26/2024 at 10:13 AM, a bottle labeled Vitamin B-12 (an essential water-soluble vitamin that plays a crucial role in various bodily functions) 1,000 mcg Dietary Supplements, had an open date of 9-1-24 and an expiration date of 2/25, was found on the top drawer of the cart. During an interview with the DON on 3/26/2025 at 5:22 pm, she stated the DON, ADON and nurses were responsible for checking the medications carts for expired medications. She stated medication cart audits are done as well and the pharmacy consultants come out monthly and conducts cart checks as well. She stated the last audit was 3/25/2025 when the pharmacy consultant came out. She stated the potential negative outcome of expired medication being in the carts could be a negative reaction to the medication if used. She stated the nurses should be checking their carts daily. She stated the last training for the medications carts was in February 2025. During an interview with CMA C on 3/27/2025 at 9:54AM, she stated she had been trained on checking the carts but does not remember the last training they had. She stated they were told by the ADON's and DON to check the carts weekly and daily. She stated the potential negative outcome of having expired medication is the med cart is not having the same therapeutic effect needed if the expired medication is used. She stated she had the cart check recently and must have missed the expired bottle of medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled Discontinued Medications, from the Pharmacy Policy and Procedure Manual 2007, revised 01/24 revealed: Policy When medications are discontinued by prescriber order, a resident is transferred or discharged and does not take medication with him/her, or in the event of a resident's death, the medications are marked as discontinued and destroyed or returned the issuing pharmacy, if applicable per state regulations. Procedures . 2. Medications awaiting disposal or return are stored in a locked secure area designated for that purpose and separate from active orders until destroyed or picked up by pharmacy staff. Medications awaiting destruction that cannot be disposed of immediately should be recorded on a log to include the name of the individual(s) storing the medication, the strength of the medication and the date of disposition. . Record review of the facility's policy titled Disposal of Medications, from the Pharmacy Policy and Procedure Manual 2007, revised 01/24 revealed: Policy . 2. Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances (or those classified as such by state regulation) are subject to special handling, storage, disposal, and record keeping in the nursing care center in accordance with federal and state laws and regulations. . 4. Prior to return, disposal, movement to separate storage area for medications awaiting destruction or discharge to home with resident, medications should be documented on a disposition including the following information: a. Date of disposition b. Nurse's or other responsible person's initials or signature verifying the information c. Resident's name d. Name, strength, and form of medication (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. Prescriber (Rx) number f. Quantity . Record review of the facility's policy titled Medication Access and Storage last revised 5/2007 revealed: .13. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction and reordered from the pharmacy, if a current order exists .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41480 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services, in that: The facility failed to seal foods stored in the refrigerator. This failure could place residents at risk for food contamination and foodborne illness. The findings included: The following observations were made on 03/25/25 at 09:58 AM during initial observation of the kitchen: Observed the following in the refrigerator: -[NAME] Slaw in plastic bag not sealed. -Lunch meat in plastic bag not sealed. During a follow up visit on 03/16/7 at 02:10 pm the following was observed: -Sliced cheese in plastic bag not sealed. During an interview on 03/26/25 at 02:15M with DM, she stated all food in the refrigerator should be sealed. She stated all staff were responsible for sealing food place in the refrigerator. She stated all staff have had proper training. She stated the potential negative outcome of not sealing food in refrigerator could affect the quality of the food. During an interview on 03/27/25 at 10:08 AM with the ADM, she stated all food placed in the refrigerator should be covered or sealed. She stated the DM was responsible for monitoring the refrigerator along with all dietary staff. She stated all staff had been trained. She stated the potential negative outcome could be food spoiling or cross contamination of food. Record review of the facility's undated policy, titled Food Storage, reflected the following: It is the policy of this facility that food storage areas shall be maintained in a clean, safe, and sanitary manner . 8. The dietary manager, or his/her designee will check refrigerators and freezers at least daily. Record review of the facility policy, titled Food, Sanitary Condition for, undated reflected the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procedures: 1. The facility will store, prepare, distribute, and serve food under sanitary conditions .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49305 Based on observation, interview and record review, the facility failed to maintain an infection control program designed to provide a safe, comfortable, and sanitary environment to help prevent the development and transmission of communicable diseases for 2 of 20 residents (Resident #254 and Resident #5) reviewed for infection control. 1. LVN A failed to sanitize his hands between glove changes during wound care for Resident # 5. 2. CNA B failed to wear proper PPE when providing direct care for Resident #254 who was on Enhanced Barrier Precautions. These failures could place residents at risk for spread of infection and cross contamination. Findings included: 1. Record review of Resident #5's face sheet dated 03/26/25 revealed a [AGE] year-old female admitted on [DATE] with the following diagnoses: psychotic disturbance (a collection of symptoms that affect the mind), major depressive disorder (mood disorder), atherosclerotic heart disease (the buildup of substances in the artery walls), hypertension (high blood pressure), and cognitive communication deficit (communication difficulty caused by cognitive impairment). Record review of Resident #5's MDS assessment dated [DATE] revealed a BIMS score of 09, indicating the resident's cognition was moderately impaired. Record review of Resident #5's comprehensive care plan dated 02/12/25 revealed a focus area of: Resident has actual impairment to skin integrity on left foot 2nd toe and an intervention of: Monitor/document location, size and treatment of skin injury. Record review of Resident #5's current physician's orders revealed an order with a start date of 03/19/25 for wound care: Cleanse wound on second toe on left foot and apply dressing daily. During an observation on 03/26/25 at 9:40 AM of wound care for Resident #5, LVN A washed his hands, put on PPE, removed the dressing to Resident #5's left foot, and performed wound care according to physician's orders. LVN A changed gloves and applied a new dressing to Resident #5's left foot. LVN A removed his PPE and washed his hands. LVN A did not sanitize his hands between the glove change during wound care. During an interview on 03/26/25 at 4:05 PM, LVN B stated he did not sanitize his hands between glove changes during wound care for Resident #5. He stated he did not know why he skipped the step of sanitizing his hands. He stated, I even had a bottle of sanitizer in my cart and forgot to use it. LVN B stated hands should be sanitized before the wound care procedure, when gloves are changed, and after the procedure. He stated he was trained on proper hand hygiene through in-services conducted by nursing administration. LVN B stated a potential negative outcome of failure to perform hand hygiene between glove changes was cross-contamination and infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676163	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesquite Post Acute Care	4510 27th St Lubbock, TX 79410

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #254's face sheet dated 03/26/25 revealed a [AGE] year-old male admitted on [DATE] with the following diagnoses: cerebral palsy (congenital disorder of movement due to abnormal brain development), contracture of muscle (tightening of muscle that restricts normal movement), and cognitive communication deficit (communication difficulty caused by cognitive impairment). Record review of Resident #254's admission MDS dated [DATE] revealed a BIMS score of 15, indicating the resident's cognition was intact. Section M-Skin Conditions, revealed the resident had a stage 3 pressure ulcer and received treatment for pressure ulcer/injury care. Record review of Resident #254's comprehensive care plan dated 02/16/25 revealed the following wound care intervention: Use Enhanced Barrier Precautions. Record review of Resident #254's current physician's orders revealed an order with a start date of 03/26/25 to cleanse open areas to coccyx with wound cleanser and apply ointment daily. Further review revealed an order with a start date of 03/17/25 for Enhanced Barrier Precautions: PPE required for high resident contact care activities- every shift for wound care. Record review of sign on Resident #254's door revealed: Enhanced Barrier Precautions Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following High-Contact Resident Care Activities: . Changing Briefs or assisting with toileting During an observation on 03/26/25 at 10:06 AM of incontinent care for Resident #254, CNA B washed her hands, put on gloves, and performed incontinent care for the resident. Following the procedure, CNA B washed her hands and exited the room. Signage on Resident #254's door stated, Enhanced Barrier Precautions and a storage container with PPE was observed outside the resident's door. CNA B did not put on a gown prior to performing incontinent care for Resident #254. During an interview on 03/26/25 at 4:02 PM, CNA B stated she did not put on a gown prior to performing incontinent care for Resident #254. CNA B stated EBP required a staff member who was doing direct care to gown and glove up for the protection of the resident. She stated she should have put a gown on before performing incontinent care for Resident #254 because the resident had a wound. CNA B stated she made a mistake by not putting on a gown and she realized it after she had already started incontinent care. She stated she was trained on EBP approximately monthly through in-services conducted by the DON. CNA B stated a potential negative outcome for failure to wear PPE during direct care of a resident on EBP would be the spread of infection between residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/26/25 at 5:37 PM, the DON stated she was not aware staff were not performing hand hygiene between glove changes and were not utilizing PPE while performing direct care on residents on EBP. She stated hand hygiene should be performed before wound care, each time gloves were changed and following the wound care procedure. She stated any resident with non-intact skin or an invasive line, such as a urinary catheter, should be on EBP. The DON stated staff were trained on proper hand hygiene and on EBP through in-services, computer-based training and competency checks conducted by nursing administration. She stated a potential negative outcome for failure to follow hand hygiene protocol during wound care and failure to utilize proper PPE during direct care of a resident on EBP, would be cross-contamination and the spread of infection, including drug-resistant organisms. During an interview on 03/27/25 at 11:30 AM, the ADM stated she was not aware staff were not performing hand hygiene between glove changes and were not utilizing PPE while performing direct care on residents on EBP. She stated it was the DON's responsibility to assure staff were trained on proper hand hygiene and EBP. She stated her expectation of staff regarding hand hygiene and EBP was that staff follow policies at all times. The ADM stated a potential negative outcome for failure to observe proper hand hygiene and failure to follow EBP protocol would be infection and cross-contamination between residents. Record review of the facility's document titled, In-service Training Report and dated 03/11/25 with a subject of Hand Hygiene was conducted by the DON and signed by LVN A and seventeen other staff members. Record review of the facility's document titled, In-service Training Report and dated 03/11/25 with a subject of Infection Control was conducted by the DON and signed by CNA B and forty-four other staff members. Record review of the facility's policy titled, Hand Hygiene, revised 12/23 revealed: Policy It is the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene, which is one of the most effective measures to prevent the spread of infection, based on accepted standards. . Procedure 2. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: . k. After handling used dressings, contaminated equipment, etc.; . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	m. after removing gloves Record review of the facility policy titled, Standard and Transmission-Based Precautions, revised 03/24 revealed: Policy It is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions . Procedure 3. Enhanced Barrier Precautions (EBP): used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident-resident. . a. PPE: The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with: i. Wounds and/or indwelling medical devices . -Wounds include, but are not limited to chronic wounds, pressure injuries . c. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: . vi. Changing briefs or assisting with toileting .

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41480 Based on observation, interview, and record review, the facility failed to provide at least 80 square feet per resident in multiple resident bedrooms for 4 (Rooms #407, 602, 604 and 611) of 48 semi-private rooms reviewed for physical environment. The facility failed to ensure resident Rooms #s 407, 602, 604 and 611, met the required minimum of 80 square feet per resident. This failure could place residents at risk of crowding and cause difficulty in providing resident care. Findings include: Record review of the CASPER 3 (facility assessment report) during preparation for survey revealed a waiver for room size requirements had been done yearly by the facility. Record review of Room Size Wavier for Facilities dated 02/15/24, during preparation for survey, revealed a wavier for rooms #s 407, 602, 604, and 611. Record review of Texas Health and Human Services Form 3740 (Bed Classifications (Numbers and Location) dated 03/25/25 documented that rooms #'s 407 were listed as a Title 18/19 bed classification semi-private rooms for two residents. rooms [ROOM NUMBER] were listed as a Title 19 bed classification semi-private rooms for two residents. During an interview on 03/25/25 at 10:23 AM with the ADM regarding the square footage for room #'s 407, 602, 604 and 611. When asked if she wanted to continue the room wavier for the room size waiver, she stated, Yes, I want to continue the room waiver. The ADM stated room #'s 407, 602, 604, and 611 had a waiver in the past. She stated, the rooms are not being used at this time but will be used once they complete renovation and open the unit back up. During an observation on 03/25/25 from 1:00 PM to 1:30 PM, of the following rooms - 407,602, 604 and 611 revealed the rooms was not occupied. No policy was provided by the ADM. She stated they followed the regulation of life safety related to room size.