| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 676167 | A. Building<br>B. Wing | 05/15/2024 |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958<br><br>Based on observation, interview, and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs were provided for 1 of 17 residents (Resident #1) reviewed for resident rights.<br><br>The facility failed to ensure Resident #1 had a call light within reach.<br><br>This failure could place residents at risk of injury that could lead to possible falls, major injuries, hospitalization , and unmet needs.<br><br>Findings Included:<br><br>1.Review of Resident #1's face sheet dated 05/15/2024 indicated Resident #1 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses including dementia (a group of thinking and social symptoms that interferes with daily functioning), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid) and parkinsonism (a disorder of the central nervous system that affects movement, often including tremors).<br><br>Review of Resident #1's quarterly MDS assessment dated [DATE] indicated Resident #1 did not have a BIMS conducted. The MDS indicated Resident #1 was incontinent of bowel and bladder. The MDS indicated Resident #1 was dependent with all activities of daily living.<br><br>Review of Resident #1's comprehensive care plan dated 04/01/2024 revealed Resident #1 was admitted to hospice with decreased activity level. attend . Resident responds on 1:1 activity, contacts with brief eye-opening contacts needs 1:1 activity to promote sensory, mental and social contacts. Interventions: provide 1:1 activities visits individualized to resident former interests: soft music, reading to her out loud her church's newsletters. Introduce self and purpose for visit. Call her name during visit. Observe her for signs of overstimulation.<br><br>Record review of Resident #1 comprehensive care plan dated 10/25/2022 revealed Resident #1 was a fall risk. Resident #1 was incontinent to bowel and bladder. Resident #1 had impaired communication related hearing difficulty. She also had difficulty expressing needs and was rarely understood. Her speech was unclear. Interventions staff to assist member with activities of daily living and transfer. May use lift for transfers. Keep bed in lowest position when member is in bed. Member to utilize call light system for all needs.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 05/13/2024 at 11:05 AM, Resident #1 was lying in bed asleep with feeding running The call light was on the back of a chair about 2 feet away from Resident #1 and her bed.<br><br>During an observation on 05/14/2024 at 1:12 PM, Resident #1 was lying in bed asleep with her feeding running. The call light was on the back of a chair about 2 feet away from Resident #1 and her bed.<br><br>During an observation on 05/15/2024 at 11:20 AM, Resident #1 was lying in bed asleep with her feeding running. The call light was on the back of a chair about 2 feet away from Resident #1 and her bed.<br><br>During an interview on 05/15/24 at 11:29 AM with CNA B, she said she was told that the call light was not close to Resident #1, because she had parkinson's disease and she would just keep hitting the call light if it was close to her. CNA B said Resident #1 was nonverbal and staff were supposed to check on her every two hours. CNA B said Resident #1 does understand and she could use the call light if it was in reach of her. CNA B said Resident #1 was nonverbal and people do not really try to figure out what she needs.<br><br>During an interview on 05/15/24 at 11:42 AM with LVN A she said there should be no reason why Resident #1 call light would not be accessible to her. LVN A said she does not believe Resident #1 could use the call light if it was close to her. LVN A said there are several negative effects that could happen to Resident #1 if she wanted to call for help and could not.<br><br>During an interview on 05/15/24 at 1:02 PM with the DON she said all staff know the call light should be in a place where the resident s could reach them. The DON said Resident #1 was nonverbal and she was not able to use the call light for over two years now, but the call light should aways be available for the residents.<br><br>During an interview on 05/15/2024 at 1:13 PM with the Administrator said call lights should be always within reach of a resident. The Administrator said staff should be attaching the call light to Resident #1's bed. The Administrator said Resident #1 had the right to have her call light close to her. The Administrator said the call light should be accessible in case Resident#1 needs assistance.<br><br>Record review of facility policy titles Resident Rights revised dated April 16,2024, indicated, Residents are encouraged to exercise their rights and privileges fully. The community will support the resident in the exercise of his/her rights. Residents have the right to the reasonable accommodation of the resident's needs so long needs so long as it does not endanger the health or safety of the resident or other residents.<br><br>On 05/15/2024 at 9:22 AM the surveyor requested a copy of the call light policy from Administrator. The administrator said they did not have a policy for call lights. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958<br><br>Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for 1 of 17 residents reviewed for environment. (Resident #1)<br><br>The facility failed to ensure Resident #1's air vent and closet was free from a black substance.<br><br>The facility failed to repair the open space where the airconditioning unit was. The facility covered the open space with cardboard and tape.<br><br>These failures could place residents at risk of an unsafe or uncomfortable environment and a decrease in quality of life and self-worth.<br><br>Findings included:<br><br>Review of Resident #1's face sheet dated 05/15/2024 indicated Resident #1 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), and pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid).<br><br>Review of Resident #1's quarterly MDS assessment dated [DATE] indicated Resident #1 did not have a BIMS conducted. The MDS indicated Resident #1 was incontinent of bowel and bladder. The MDS indicated Resident #1 was dependent with all activities of daily living.<br><br>Review of Resident #1's comprehensive care plan dated 04/01/2024 revealed a care plan that indicated Resident #1 was admitted to hospice with decreased activity level attend. Resident responds on 1:1 activity, contacts with brief eye-opening contacts needs 1:1 activity to promote sensory, mental and social contacts. Interventions: provide 1:1 activities visits individualized to resident former interests: soft music, reading to her out loud her church's newsletters. Introduce self and purpose for visit. Call her name during visit. Observe her for signs of overstimulation.<br><br>Record review of Resident #1 comprehensive care plan dated 10/25/2022 revealed a care plan that indicated Resident #1 was a fall risk. Resident #1 was incontinent to bowel and bladder. Resident #1 had impaired communication related hearing difficulty. She also had difficulty expressing needs and was rarely understood. Her speech was unclear. Interventions staff to assist member with activities of daily living and transfer. May use lift for transfers. Keep bed in lowest position when member is in bed. Member to utilize call light system for all needs.<br><br>During an observation and interview on 05/13/2024 at 11:05 AM, Resident #1 was lying in bed asleep with feeding running. A black substance was on Resident #1's air vent above her closet door. Further observation revealed the blackthe black substance was on the closet walls, floor, and on the inside of the closet door. The closet had several different cardboard boxes thrown in there. There was also a piece of cardboard box that was mounted into a cut-out area where an air conditioning unit sat previously. The box was the wall separating the closet from the outside. The facility had 2 pieces of insulation on the cardboard box, but one side had fell off.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 05/14/2024 at 10:55 AM, with Resident #1's family member she said her only concerns with the facility was the issue with Resident #1's closet. The family member said she thought the facility finally got the unit fixed in Resident #1's room. The family member said she brought the Maintenance man into Resident #1's room to look at her closet a month ago and he said he was going to get the closet fixed. The family member said she though the black substance in the closet was mold and was an environmental issue. The family member said the facility does not pay enough attention to the building and maintenance concerns.<br><br>During an interview on 05/15/2024 at 9:34 AM with the Administrator this surveyor asked her was she aware of the condition of Resident #1's closet in her bedroom. The Administrator said she was not aware of the black substance in Resident #1's closet. This surveyor showed the Administrator pictures of Resident #1's air vent and her closet in bedroom. This surveyor also notified the Administrator that there was a piece cardboard box separating the closet wall from outside. This surveyor notified the Administrator that Resident #1 family member and sitter complained of bugs and flies in resident's room; came in from the poorly secure area. The Administrator said maintenance needed to fix that and conditions were unacceptable.<br><br>During an observation and interview on 05/15/2024 at 10:37 AM with the Director of Facility Management, he said he was not aware of Resident #1's closet, until thattoday, this morning. The Director of facility Management said most of the rooms in the facility had a package air condition unit, but we changed the unit in Resident #1's room to a ptac unit. He said he had assigned a housekeeper to clean the closet in Resident #1's room. He the staff were going to get the room cleaned up. He said he does not think the room would have a negative effect on the resident in his opinion. The Director of Facility Management stated he had not seen Resident #1's air vent or closet. This surveyor showed him pictures of Resident #1's air vent and closet; after viewing the pictures he said that the area was nasty and the facility will get the area cleaned up. He said the facility was going to replace the wall and apply insulation.<br><br>During an interview on 05/15/2024 at 11:29 AM, CNA B said she had been working for the facility a year and Resident #1's room had the black substance in the closetbeen that way since she started. CNA B said she put a piece of a cardboard box in front of the vent in Resident #1's room to prevent the bugs from coming into the resident's room. CNA B said she felt like the black substance on Resident #1's vent and in her closet could cause infections such as flu, pneumonia and other upper respiratory infections. CNA B said Resident #1 was nonverbal. CNA B said if something was to bite Resident #1 staff would not know and she could not tell staff.<br><br>During an interview on 05/15/24 at 11:42 AM with LVN A said she was not aware that Resident #1 had a closet with a black substance on the walls and on the air vent. LVN A said if the substance was mold or mildew that could cause respiratory issues. LVN A stated she was not sure if Resident #1 had any respiratory issues lately.<br><br>During an interview and observation on 05/15/2024 at 1:02 PM, the DON said he was not aware of the situation in Resident #1 closet. She said she heard from other staff looked like a dirty surface. The DON said she was not sure what the black substance was in the closet. After this surveyor shower her the pictures of Resident #1's closet, she said she did not like the look of the closet. She said the black substance on the vent and in the closet could cause or made Resident #1 at risk for respiratory infections. She said the substance could cause an exacerbation of an underlying condition Resident #1 currently had.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 05/15/2024 at 1:13 PM, the Administrator said she would not tell what the black substance was in Resident #1's closet. She said she thought it was dirt. She said had not heard any complaints of bugs or flies in Resident #1's room. She said no one had mentioned the condition of the closet to her prior to today. She said the facility had a local pest control company in the facility often and no one had mentioned there was a pest issue in Resident #1's room.<br><br>Record review of the maintenance work order report dated 01/01/24-05/15/24 revealed work order for Resident #1 had several issues with the air conditioning and heating unit.<br><br>Record review of an invoice of a local electric company dated 3/27/2024 indicated, furnish labor and material to terminate existing wiring to new air compressor. Also, install two new circuit breakers one to air conditioning unit in Apt 721 and one to air conditioning unit in laundry.<br><br>Record review of facility policy titles Resident Rights revised dated April 16,2024, indicated, .Residents have the right to a safe, clean, comfortable, and home-like environment that allows the resident to be as independent as possible. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>49019<br><br>Based on observation, interviews and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation in that:<br><br>1. Paint, primer, WD 40 and GOO gone stored near dry food storage.<br><br>2. Sanitizer sprayed on surface and not allowed to dry prior to setting cutting board and preparing food.<br><br>3. Improperly secured hair from kitchen staff member.<br><br>These deficient practices could place residents who received meals from the kitchen at risk for chemical contamination and food-borne illness.<br><br>The findings were:<br><br>During an observation on 5/13/2024 at 9:25 AM, it was observed a utility cart with 3 cans of paint, 1 can of primer, 4 bottles of goo gone and WD 40 located in dry food storage area near juice box storage.<br><br>During an observation on 5/14/2024 at 8:10 AM, it was observed the utility cart remained in dry storage room with 3 cans of paint, 1 can of primer, 4 bottles of goo be gone and WD 40 located in dry food storage area near juice box storage.<br><br>During an observation and interview on 5/14/2024 at 8:50 AM, the Director of Culinary Services said the cart was maintenance and the cart was usually stored in the boiler room. She said she would move it and it was not ok for it to be near the dry storage. The Director of culinary services said she would get maintenance to move it.<br><br>During an observation on 5/14/2024 at 8:50 AM, toured kitchen area/food prep area and observed bucket with cleaning chemicals located under the dry containers labeled as corn meal, sugar, flour, and rice. Bucket has suds with liquid in green bucket and a storage compartment for a spray bottle labeled Sani-Quad Food service sanitizer. The green buckets were located throughout the kitchen and below stainless-steel table next to stove top and where food was prepared.<br><br>During an interview on 5/14/2024 at 10:20 AM, [NAME] C said there was no concern with cleaning supplies under the dried food containers or under the stainless-steel table in the kitchen next to the oven. He said it was below the food. He said it cannot be stored above or next to the food.<br><br>During an observation on 5/14/2024 at 10:47 AM, [NAME] D's hair was not properly restrained with a proper hair restraint. [NAME] D was wearing a bandana with hair exposed in the back.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 5/14/2024 at 11:15 AM, during food preparation, observed [NAME] D wiped down stainless-steel surface next to hot stove with soap and water that was in a green bucket below the table. [NAME] D sprayed the stainless-steel surface with sani-quad, then placed a cutting board directly on the wet surface. [NAME] D was observed to place a pork loin on the cutting board, cut up meat and placed on serving plate. [NAME] D then placed a Styrofoam container next to cutting board on wet surface and then with her gloved hands touched the bottom of the Styrofoam container transferring to the serving table. She then opened the container with gloved hand, placed the sandwich on a serving plate and placed plate on serving cart.<br><br>During an interview on 5/14/2024 at 11:32 AM, [NAME] D said she cleaned as she goes. She said the sanitizer was to sit on the surface and not to be wiped off. She said the cleaner was supposed to air dry. [NAME] D said the surface was dry when she placed the Styrofoam container on the stainless-steel table. [NAME] D said she did not think she touched the bottom of the Styrofoam when preparing the plate. She said her gloved hands could have transferred the cleaning solution (Sani-Quad) to the sandwich. [NAME] D left the kitchen and went to retrieve the tray and threw it away and made a new turkey sandwich.<br><br>During an interview on 5/15/2024 at 10:14 AM, Maintenance technician G said the kitchen area was off limits for maintenance to use. We normally do not store products in dry food area.<br><br>During an interview on 5/15/2024 at 10:16 AM, Utility worker E said the facility was about to remodel a room. He said some of the things currently stored in dry food storage area of the kitchen were to paint and fix walls with during the remodel. Utility worker E said the paint, goo gone, WD 40 should not be stored with food, and it was moved closer to the mechanical closet. Utility worker E said staff who have hair should wear hair nets and facial restraints if men have facial hair while in kitchen. He said hair should be tucked in and not exposed or hanging out the back of restraints. Utility worker E said buckets of soap and water and Sani quad can be stored below food, but it cannot be stored above food. He said sanitizer should be allowed to air dry before use. Utility worker E said If a surface was sanitized and not allowed to dry, it could cause cross contamination and he was unsure specifically what chemical was nearby, but it could cause inflammation of esophagus or make a resident sick in ingested.<br><br>During an interview on 5/15/2024 at 11:46 AM, [NAME] D said hairnets or covering are supposed to be worn while in kitchen and hair should be completely covered. [NAME] D said her hair came down and she had to fix it.<br><br>During an interview on 5/15/2024 11:50 AM, the DON said she expected kitchen staff to be wear a hair net while in the kitchen and not a bandana. She said all hair should be completely covered, and no hair should be showing. The DON said Sani Quad should not be stored near food or during food preparations. She said the kitchen staff should never spray sani quad on surface while preparing food. The DON said the staff should not set cutting boards on wet surface from sani quad spray. The DON said a resident could be in harm and cause sickness to a resident. The DON said it would not be appropriate to touch food with gloved hand that could be contaminated sandwich with sani quad cleanser.<br><br>During an interview on 5/15/2024 at 11:50 AM, the DON said paint, goo gone, and WD- 40 should not be stored in dry food area. She said it could contaminate the food and make a resident sick or get illness.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 5/14/2024 at 12:00 PM, the ADM said the kitchen staff should be wearing hair net and not a bandana. She said it was not appropriate for hair to be sticking out of the back while working in the kitchen. The ADM said it was not appropriate for cleaning sani quad to be stored in the kitchen near food or during food preparation. The ADM said it was not appropriate for a kitchen staff to spray sani quad on surfaces while cooking or preparing food. She said the chemical could get transferred to food and it was not appropriate for kitchen staff to touch chemical then food. The ADM said food could be contaminated with chemical and a resident could eat it making them sick.<br><br>During an interview on 5/15/2024 at 12:17 PM, the Director of Culinary Services said the staff should be wearing hair nets and [NAME] D's hair was restrained. She said cleaning supplies could be placed under food just not on the table. The Director of Culinary Services said [NAME] D should wait for the surface to dry before placing cutting board or Styrofoam on surface. She said there is a risk for cross continuation to food that is being served and could make a resident sick.<br><br>Review of the facility document revised April 16, 2024, titled Food and supplies storage provided by the ADM revealed .Procedure . Safe Food Storage . dry food storage should be maintained in a clean and dry area free of contaminants.<br><br>Review of the facility document revised 1/23/2024, titled Food Safety revealed All food handling and safety must comply with the Texas Food Establishment Rules and the CMS and Texas Health and Human Services Commission regulations . 6. Food will be stored, prepared, distributed and served in accordance with professional standards for food service safety.<br><br>Review of safety data sheet dated 5/24/2019 titled Sani Quad Food Service Sanitizer revealed Hazard statement . Harmful if swallowed or in contact with skin . if swallowed, call poison center or Doctor . Rinse mouth . Do no induce vomiting . Store locked up .Section 7: Handling and Storage . Advice of safe handling . Do not ingest .Wash hands thoroughly after handling . Potential Health effects: Harmful if swallowed .Causes digestive tract burns . |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019<br><br>Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 3 laundry rooms. ([NAME] House laundry room)<br><br>The facility failed to ensure soiled laundry was properly bagged in 1 of 3 laundry rooms.<br><br>These failures placed residents at risk for cross contamination and infection.<br><br>Findings included:<br><br>During an observation on 5/15/2024 at 10:46 a.m., CNA K opened the laundry door at the [NAME] House and located in front of the washer was soiled clothing, towels, wash clothes sitting in a shower chair and a white laundry basket seated on the floor directly in front of the shower chair. Located in the washer was 1 load of clothing sitting in the washer. CNA K said big blankets go in the yellow bins and was transferred to the bigger laundry room located in the main building. CNA K said soiled and dirty clothing were to be placed in a bag and not sitting out exposed. CNA K said bacteria and germs could contaminate surfaces and shower chair.<br><br>During an interview on 5/15/2024 at 10:52 a.m., CNA L said laundry was to be properly bagged and not sitting open in the laundry room. CNA L said soiled or dirty laundry sitting out openly could cause smells or odors. CNA L said the clothing could contaminate and develop mold if left out and contaminate other items and linens that are clean.<br><br>During an interview on 5/15/2024 at 11:09 a.m., Housekeeper F said big blankets were bagged and placed in bins. Housekeeper F said soiled linens from isolation residents are placed in red bags.<br><br>During an interview on 5/15/2024 at 11:15 a.m., Director of Facilities J said the facility has hoppers with lids to transport soiled or dirty laundry to and from the laundry room. He said his staff does not do the laundry in the cottages other than sometimes at night. The Directory of Facilities J said soiled laundry should be bagged and taken to the laundry room. He said the clothing should not be wheeled or brought through the facility due to risk for other areas of the facility could get contaminated.<br><br>During an interview on 5/15/2024 at 11:18 a.m., Lead environmental service technician H said she was not responsible for laundry and said Housekeeper F was responsible for the laundry and the Director of Facilities was over housekeeping. The Lead environmental service technician H said it was not appropriate to wheel soiled clothing in the facility and leave in the laundry room. She said the clothing should be bagged.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676167 | A. Building<br>B. Wing | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Buckner Westminster Place | 2201 Horseshoe LN<br>Longview, TX 75605 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 5/15/2024 at 11:50 a.m., the DON said she expected soiled clothing to be bagged and taken to the laundry room. The DON said laundry that was dirty with soiled feces or soiled clothing, it would be an infection control issue. The DON said staff should be wearing proper PPE with isolation and EBP precautions to prevent contamination. The DON said environmental services was responsible for laundry and the person in charge was the Director of facilities.<br><br>During an interview on 5/15/2024 at 12:00 p.m., the ADM said soiled clothing should be bagged and placed in barrel with lid on it. The ADM said clothes should be bagged in the resident room and then transported to the laundry room. The ADM said it was not appropriate to place laundry in a shower chair and move it to the laundry room. The ADM said Director of facilities was responsible for the laundry.<br><br>Review of facility policy revised on 10/5/2023 titled, Laundry revealed Service standard was to Care of community laundry will be performed in a way that is consistent with CDC requirements to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease. All used laundry should be handled as potentially contaminated and use standard precautions: gloves, gowns when rinsing and sorting. Procedure- .Dirty linen should be bagged before leaving a resident's room .Dirty laundry must be kept in a separate space from clean laundry .Clean and disinfect clothes hampers according to guidance from appropriate surfaces. |