STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elgin Nursing and Rehabilitation Center	1373 North Avenue C Elgin, TX 78621

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49099 Based on observation, interview, and record review the facility failed to use the results of an assessment to develop, review and revise a comprehensive care plan of each resident that included measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs for 4 (Resident #54, Resident #58, Resident #61 and Resident #63) of 22 Residents reviewed for care plans. A) The facility failed to develop and implement a comprehensive care plan that included interventions for when Resident #54 regularly refused his monthly weights to monitor malnutrition with signs or symptoms of muscle wasting/ significant weight loss. B) The facility failed to develop and implement a comprehensive care plan that included documentation of Resident #58's PTSD diagnosis and triggers to prevent re-traumatization or psychosocial harm. C) The facility failed to develop and implement a comprehensive care plan that included triggers for Resident #61, who has a diagnosis of PTSD to prevent re-traumatization or psychosocial harm. D) The facility failed to develop and implement a comprehensive care plan that included triggers for Resident #63, who has a diagnosis of PTSD to prevent re-traumatization or psychosocial harm. These failures placed residents at risk of not having their individualized needs met in a timely manner and communicated to providers and could result in adverse physical and psychosocial well-being. Findings included: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2024
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A) Record review of Resident #54's Face Sheet dated 03/05/24 revealed an [AGE] year old male admitted to the facility on [DATE] with a diagnosis of unspecified dementia-unspecified severity-without behavioral disturbance-psychotic disturbance-mood disturbance-and anxiety (a group of symptoms that affects memory, thinking and interferes with daily life), other specified interstitial pulmonary disease (disorder causing progressive scarring of lung tissue affecting the ability to breathe and get enough oxygen in the bloodstream), chronic respiratory failure with hypoxia (condition where the lungs cannot supply enough oxygen or remove enough carbon dioxide from the blood), cerebral infarction-unspecified (also called a stroke, refers to an area of the brain where death of tissue has occurred caused by disrupted blood/ oxygen supply), dysphagia-oropharyngeal phase (swallowing disorder that affects the mouth and throat making it difficult to swallow), hyperlipidemia-unspecified (abnormally high levels of any or all lipids or lipoproteins in the blood), type 2 diabetes mellitus without complications (a condition resulting from insufficient production of insulin causing high blood sugar), and benign prostatic hyperplasia without lower urinary tract symptoms (noncancerous increase in size of the prostate gland). Record review of Resident #54's Care Plan last revised 02/26/24 reflected Resident #54, has a nutritional problem or potential nutritional problem related to diet restrictions, with the goal of the resident maintaining adequate nutritional status as evidence by maintaining weight and no signs or symptoms of malnutrition daily through review date. The interventions listed for Resident #54's nutritional problem reflected, Monitor/record/report to MD PRN s/sx of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 3lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Review of the care plan did not reflect a problem identified or interventions for Resident #54 regularly refusing to be weighed to be able to monitor/ record/ report muscle wasting or significant weight loss. Record review of last recorded weights for Resident #54 revealed he weighed 129.6 lbs. on 08/05/23 and 119.2 lbs. on 09/05/23 which is a -8.02% loss, reflecting a significant loss within 1 month. Record review of Resident #54's PA visit dated 09/25/23 reflected Patient seen today for mandated visit. He continues to refuse meds and nursing care from staff. Prognosis very poor. He was to be on palliative care when admitted in May, but family/ patient changed his mind. He is high risk for death given his refusal of care. Record review of Resident #54's dietician notes dated 10/31/23 revealed, Missing October Wt.; September Wt. 119.2, 19.2 BMI. Resident showed a significant weight loss last month. Nutritional intervention in place from recommendation from last month. Diet: Regular diet, puree texture, thin liquids with 50-100% as per chart and observation at meals. Record review of Resident #54's weights for 10/2023, 11/2023, 12/2023, 01/2024 and 02/2024 reflected refusals by the resident. Record review of Resident #54's nursing progress note dated 12/05/23 from DON revealed, Monthly weight refused. Explained to resident purpose/ importance of allowing staff to obtain weight. Record review of Resident #54's late entry nursing progress note dated 01/08/24 from DON revealed, 01/05/23: Resident refused monthly weight. Educated resident on significance of obtaining weight to help determine nutritional needs. RP notified. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #54's nursing progress note dated 02/05/24 from DON revealed, Resident refused to allow staff to obtain monthly weight. Educated resident on importance of obtaining weight, to assess nutritional status. Record review of Resident #54's late entry progress note dated 03/06/24 for 03/05/24 from DON revealed, Resident refused monthly weight. Educated resident on importance of allowing staff to assess nutritional status. RP family member notified, stated he knows his dad refuses care and choses to stain in bed. Will continue to encourage resident to get up/ obtain weights. In an interview on 03/05/24 at 12:19 PM, Resident #54 stated he was refusing to have weights taken by staff. He said that they have to get him out of bed and put him in a wheelchair to go to the room next door to get his weight and he felt it was a waste of time because he was not losing much weight. Resident #54 was advised during his last weigh in he did have a significant loss in weight, and the importance of obtaining those weights. Resident #54 stated he still does not want to be weighed. In an interview on 03/05/24 at 12:45 PM, the DON stated that once Resident #54 began to refuse his monthly weights regularly she began to document on the progress notes his refusal. She stated that he often refuses almost all care to include medications, weights, and in the past even wound care. The DON said that the care plan should have been updated to reflect his frequent refusal of care in obtaining weights, but that it was missed. In an interview on 03/05/24 at 03:33 PM with the Administrator he said that if someone was frequently refusing care or treatments, that should be documented in the progress notes. He stated that it was his expectation that if the clinical outcomes are significant that the care plans should also be updated by nursing staff and there should be a reference to the refusal. The Administrator stated that a negative outcome to not having updated care plans reflecting identified problems in resident care such as monthly weights being refused could negatively affect the facility's ability to effectively mitigate resident weight loss. B) Review of Resident #58's Face Sheet dated 03/04/2024 reflected a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses: Hemiplegia (one-sided muscle paralysis or weakness), Chronic Post Traumatic Stress Disorder (mental health condition that can affect anyone who has experienced a traumatic event,), and Major Depressive Disorder (persistent feeling of sadness and loss of interest that can interfere with daily life). Review of Resident #58's Quarterly MDS assessment dated [DATE] reflected that he had a BIMS Score of 15, indicating cognition is intact. The MDS reflected that Resident #58 did not exhibit any behavior indicating rejection of care. The MDS reflected that Resident #58 had an active diagnosis for PTSD. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #58's Comprehensive Care plan reflected the follow problem areas with revised dates: 02/23/2024 The resident uses antipsychotic medications {used to treat symptoms of psychosis} for depression with psychosis {severe mental condition in which thought and emotions are so affected that contact is lost with external reality}, management of behavioral symptoms that present a danger to resident and other (anger, destructive behavior, conduct problems, grief / loss issues), significant distress and failed GDR's. 2/23/2024 The resident uses antidepressant medication related to depression. 02/23/2024 The resident uses anti-anxiety medications related to anxiety. Further review of the plan of care reflected no mention of PTSD and no identified triggers or interventions in reference to his active diagnosis. Observation and interview on 03/05/2024 at 8:38 AM, Resident #58 was seated on his bed eating breakfast and appeared aggravated. Resident #58 stated that one of the care staff had upset him this morning but did not provide details of what happened. Resident #58 stated that he was not aware that he had an active diagnosis for PTSD. Resident #58 stated that he served in the military for four years but could not think of anything from that time that bothered him. Resident #58 stated that when he was in the 5th grade he was run over by a car while skateboarding and injured. C) Review of Resident #61's face sheet dated 03/04/2024 reflected she was admitted on [DATE] and readmitted on [DATE] with the following diagnosis PTSD (A mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations.) Review of Resident #61's Quarterly MDS dated [DATE] reflected Resident #61 was assessed to have a BIMS score of 15 indicating she was cognitively intact. Resident #61 was assessed to have mood indicators of feeling down, depressed, or hopeless. Resident #61 was further assessed to have PTSD. Review of Resident #61's comprehensive care plan reflected a problem with the start date of 04/24/2020 The resident uses antidepressant medication for depression and PTSD. Further review of the plan of care reflected no identified PTSD triggers or interventions other than medication for her PTSD. Observation and interview on 03/04/2024 Resident #61 was up in her wheelchair stating she was getting dressed. She stated right now she feels ok her mood was better. She stated she really did not want to talk about anything that made her sad and stated again she was ok. D) Review of Resident #63's Face Sheet dated 03/04/2024 reflected a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: Unspecified Dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), Bipolar Disorder (mental health condition that causes extreme mood swings that include emotional highs and lows), and Chronic Post Traumatic Stress Disorder (mental health condition that can affect anyone who has experienced a traumatic event,). Review of Resident #63's Comprehensive MDS assessment dated [DATE] reflected that she had a BIMS Score of 15, indicating cognition is intact. The MDS reflected that Resident #63 did not exhibit any behavior indicating rejection of care. The MDS reflected that Resident #63 had an active diagnosis for Post Traumatic Stress Disorder (PTSD). Review of Resident #63's Comprehensive Care plan reflected the follow problem areas with revised dates: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*02/27/2024 The resident has a behavioral problem r/t bipolar disorder, PTSD, dementia, metabolic encephalopathy, anxiety and adjustment disorder. Examples of known behaviors include: throwing things, hitting the wall, yelling out for help, hx of paranoia and hallucinations (sees a man standing outside her window), hx of rape allegations towards her physician, and making the comment that male doctors are [NAME] and they should die. *03/09/2023 The resident uses antidepressant medication, see MD order, r/t PTSD. *03/09/2023 The resident has a mood problem r/t bipolar, PTSD, anxiety, adjustment disorder. Further review of the plan of care reflected medication interventions and to monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes but did not identify any PTSD triggers. Observation and interview on 03/05/2024 at 8:50 AM, Resident #63 was seated in her wheelchair and appeared to be happy. Resident #63 seemed uncertain about whether she had a PTSD diagnosis. Resident #63 was asked if she had suffered any trauma and stated that her mother had been a nurse for forty-five years and was good at putting out fires. Resident #63 did not continue with the story after the initial comment. Interview on 03/05/2024 at 10:06 AM, MDS Coordinator D stated that she was responsible for signing off on the MDS assessments and that care plans are put together with input from the interdisciplinary team. MDS Coordinator D stated that PTSD will automatically populate from the Residents diagnosis into the MDS Assessment. MDS Coordinator D stated that if a diagnosis of PTSD was removed by a doctor that it would be removed from the Resident's diagnoses and removed from the MDS assessment and care plans. MDS Coordinator D stated that PTSD would be coded on the MDS to ensure proper care was provided for the diagnosis. MDS Coordinator D stated that she would image that PTSD was touched on in the care plan but stated that she did not believe it had to be specially stated. MDS Coordinator D stated that triggers for a resident with PTSD would be a good idea to avoid setting off a resident, but that the Surveyor would have to speak with the Social Worker about resident triggers. At 10:16 AM, MDS Coordinator D reviewed the MDS Assessment and Care Plan for Resident #61. MDS Coordinator D confirmed that Resident #61 had a diagnosis of PTSD and was care planned for monitoring of adverse effects but should show triggers and include more detail. At 10:18 AM, MDS Coordinator D reviewed the MDS assessment and Care Plan for Resident #58. MDS Coordinator D confirmed that Resident #58 had a diagnosis of PTSD and commented that his Care Plan did not indicate PTSD or triggers. At 10:20 AM, MDS Coordinator D reviewed the MDS assessment and Care Plan for Resident #61 and confirmed the PTSD diagnosis and that it was stated in the Care Plan, but no triggers are present. MDS Coordinator D stated that failure to properly document triggers and PTSD was a quality-of-care issue and should be done to prevent a resident from becoming triggered. Interview on 03/05/2024 at 10:28 AM, MDS Coordinator E stated that if a resident has an MDS indicator for PTSD that it should be Care Plan independently and that triggers are supposed to be listed. MDS Coordinator E stated that triggers are necessary to ensure proper care and that interventions are done to prevent issues that may trigger a resident. MDS Coordinator E stated that the triggers should come from the Social Worker as well as possibly from psychological and doctor notes. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/05/2024 at 10:45 AM, the SW stated that if a resident has PTSD it should be care planned for. The SW stated that the triggers should have been identified through the interdisciplinary team as well as psychological and therapy notes and care planned for. SW stated that they will correct the issues and make sure triggers are known and care planned in the future. Interview on 03/05/2024 at 11:05 AM, the Administrator stated that if a resident has a diagnosis of PTSD it should be documented in their MDS Assessment as well as their Care Plan with documented triggers. The Administrator stated that failure properly care plan for PTSD and triggers associated with it could result in a resident becoming triggered and / or re-traumatized. Review of facility's Comprehensive Care Plans policy, dated 10/24/2022, revealed, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Policy Explanation and Compliance Guidelines: 1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma-informed. 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Cre Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidence in the clinical record. 3. The comprehensive care plan will describe, at a minimum, the following: a. The Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. b. Any services that would otherwise be furnished but are not provided due to the resident's exercise of his or her right to refuse treatment. g. Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated. Trigger-specific interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident. 4. The comprehensive care plan will be prepared by an interdisciplinary team 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32452 Based on observation, interview and record review the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choices of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interest of and support the physical, mental, and psychosocial well-being of each resident, encouraging independence in the community for 1 of 2 residents (Resident #43) reviewed for activities. The facility failed to assess and provide activities for Resident #43 after she experienced a change of condition. This failure could place residents at risk for a decline in social, mental, psychosocial well-being and a decreased quality of life. Findings include: Review of Resident #43's face sheet dated 03/03/2024, reflected an [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses Alzheimer's disease (A type of brain disorder that causes problems with memory, thinking and behavior. This is a gradually progressive condition.), Dementia (A group of symptoms that affects memory, thinking and interferes with daily life.) and contractures (A permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen and a decrease in ROM). Review of Resident #43's significant change MDS dated [DATE] reflected Resident #43 was assessed to not have a BIMS score conducted indicating she had severe cognitive impairment. Resident #43 was assessed used the staff assessment for daily and activity preferences to want family or significant other involved in care discussions and liked being around animals such as pets. Resident #43 was assessed to require dependent assists for all ADLs. Review of Resident #43's comprehensive care plan reflected a problem with the start date of 04/25/2023 The resident is dependent on staff for meeting emotional, intellectual, physical and social needs related to immobility. Goals included the resident will attend/ participate in activities of 3-5 times week . Interventions included The resident's preferred activities are: watching TV (travel channel), spending time with her husband and dog who visits frequently, going outside. Review of Resident #43's physician orders reflected an entry to admit to hospice on 01/26/2024. Review of Resident #43's medical record reflected no activity assessments from 03/03/2023 through 03/04/2024. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 03/03/2024 at 11:00 AM revealed Resident #43 in bed. Resident #43 was not interviewable. Resident #43 RP was at bedside he stated he was concerned about her not getting enough stimulation Resident #43's RP stated when he comes in to see her the room was dark, and the TV was off. He stated she used to get up, but they were not getting her up any more since her decline and she went on hospice. He stated he wanted her to have stimulation and at least have the TV and lights on during the day when he was not at the facility. Observation on 03/04/2024 at 9:00 AM revealed Resident #43 was in room in bed the lights were off, and the TV was not on. Observation on 03/05/2024 at 8:49 AM revealed Resident #43 in room in bed with the room lights off and no TV on. In an interview on 03/05/2024 at 8:58 AM, the AD stated after reviewing Resident #43's medical record that she did not see an activity assessment. The AD stated Resident #43 should have an activity assessment and was not sure why she does not. The AD stated her, and her assistant just went through and updated everyone so she must have missed it. She stated Resident #43 recently went on hospice and stop getting up and stated she should have updated her plan of care for in room activities and been monitoring to ensure she was getting enough activities. In an interview on 03/05/24 at 1:17 PM, the Administrator stated that he was the direct supervisor to the AD. The Administrator stated he expected the AD to assess residents when they have a change of condition, and the residents care plan should be updated for in room activities if they are no longer able to attend activities. In an interview on 03/05/24 at 2:42 PM, the AD she stated she did not update Resident #43's activity plan after her change of condition. She stated she was not sure how she missed it she felt like she was getting enough with her family visits. She further stated she should have a plan to ensure she had stimulation. Review of the facility policy Activity Policy dated 09/2014 reflected The facility has an on-going program of activities designed to meet the interests and the physical, mental, spiritual and psychosocial well-being of each resident in accordance with his/her comprehensive assessment .All residents, particularly bedfast and those residents unable to participate in group activities will be visited by Activity Director, Activity Assistant, and/or volunteers at least 3 times a week.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32452 Based on observation, interview, and record review the facility failed to ensure 1of 3 residents reviewed with limited range of motion (Resident #43), received appropriate treatment and services to prevent a decline in range of motion. The facility failed to ensure Resident #43 had interventions in place for her right- hand contracture (A permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen and a decrease in ROM) to prevent further decline of the range of motion in her right hand. This deficient practice placed residents with contractures at risk for decrease in mobility, range of motion, and contribute to worsening of contractures. Findings Include: Review of Resident #43's face sheet dated 03/03/2024, reflected an [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses Alzheimer's disease (A type of brain disorder that causes problems with memory, thinking and behavior. This is a gradually progressive condition.) , Dementia (A group of symptoms that affects memory, thinking and interferes with daily life.) and contractures (A permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen and a decrease in ROM). Review of Resident #43's significant change MDS dated [DATE] reflected Resident #43 was assessed to not have a BIMS score conducted indicating she had severe cognitive impairment. Resident #43 was assessed to require dependent assists for all ADLs. Resident #43 was further assessed to have functional limitations in range of motion for bilateral upper and lower extremities. Review of Resident #43's comprehensive care plan reflected a problem with the start date of 02/23/2023 The resident has limited physical mobility related to contractures of bilateral feet and hands. Interventions included monitor/ document/ report PRN any signs and symptoms of immobility: Contractures forming or worsening . Further review of Resident #43's care plan reflected a problem with the start date of 07/25/2022 The resident has an ADL self-care performance deficit related to muscle weakness, malaise, and Dementia. Interventions included Contractures: the resident has contractures of bilateral hands and feet. Provide skin care daily or as needed to keep clean and prevent skin breakdown. Review of Resident #43's physician orders reflected no entries related to Resident #43's bilateral hand contractures. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 03/03/2024 at 11:00 AM revealed Resident #43 in bed. Resident #43 was not interviewable. Resident #43 RP was at bedside he stated he was concerned about her fingernails being really long and her hand rolls not being in her hands. Resident #43's RP lifted Resident #43's right hand to reveal a contracted hand with fingers curled to the palm of her hand without a device in place. Resident #43's RP was able to open Resident #43's hand slightly to reveal long fingernails. Resident #43's RP stated her long fingernails were digging into her hand. Further observation revealed no open areas to her right palm. Resident #43 had a roll to her left hand. Resident #43's RP stated he did not know why they put one on her left hand and not her right hand. Observation on 03/04/2024 at 9:00 AM revealed Resident #43 was in room in bed no hand roll to in place to her right hand. Observation and interview on 03/04/2024 at 12:30 PM revealed Resident #43 in room in bed. CNA F was in room to get Resident #43 ready for her wound care treatment. Observation of Resident #43 revealed she did not have a hand roll in her right hand one was noted in her left hand. CNA F stated she was not working on the hall she was helping the treatment nurse, but she was familiar with Resident #43's care. She stated Resident #43 was supposed to have a hand roll in both her hands at all times because of her contractures. Observation on 03/05/2024 at 8:49 AM revealed Resident #43 in room in bed no hand roll was noted to right hand. In an interview on 03/05/2024 at 8:51 AM CNA G stated she was working with Resident #43. She stated she was not sure if Resident #43 needed a hand roll to her right hand. CNA G stated she thought that maybe therapy put them in. When asked if she was supposed to trim Resident #43's fingernails during care she stated she did not trim Resident #43's fingernails because she could not see them due to her being contracted. In an interview on 03/05/2024 at 8:54 AM LVN B stated Resident #43's hands were contracted, and she needed to have hand rolls in both her hands at all times. She stated since the resident was not diabetic anyone could trim her nails, but she usually trimmed her nails. She stated she had trimmed Resident #43's fingernails but stated they were still a little long. LVN B was not sure why Resident #43 did not have her hand roll in her right hand and was not sure who should be monitoring if the hand roll was in place. LVN B further stated she would find out. In an interview on 03/05/2024 at 9:10 AM the DON stated it was the CNAs job to ensure Resident #43's hand rolls were in place and her fingernails remained trimmed. The DON stated she just updated Resident #43's task list yesterday (03/04/2024) to include hand rolls and nail checks so the nurse aides would know to monitor Resident #43's hand rolls and nails. The DON stated the nurse aides did not know about it yet, but she would in-service them to make sure they are aware she needs a hand roll hand to keep her nails trimmed. The DON stated failure of staff to perform this treatment could lead to skin injury. In an interview on 03/05/2024 at 11:29 AM the PT stated Resident #43 should have hand rolls in both hands at all times. She stated Resident #43 was on PT service from 02/13/2023 to 01/25/2024 for contracture management and came off due to hospice admission. The PT stated she was discharged to restorative care for hands rolls. The PT stated failure to do this could lead to worsening contractures or skin issues. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elgin Nursing and Rehabilitation Center	1373 North Avenue C Elgin, TX 78621

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/05/24 at 12:15 PM the DON hand surveyor policies for ADLs and therapy screens and stated the facility did not have a policy specifically for contracture management. Review of the facility policy ADLs dated 05/26/2023 reflected .The facility may provide a maintenance and restorative program to assist the resident I achieving and maintaining the highest practicable outcome based on the comprehensive assessment .The facility will identify resident triggers through the care area assessment process to assess causal factors for decline, potential decline or lack of improvement .

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32452 48314 Based on interviews and record reviews the facility failed to ensure residents who are trauma survivors received culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization for 3 (Resident #58, Resident #61, and Resident #63) of 3 residents reviewed for trauma informed care. The facility failed to provide care in a manner to eliminate and /or mitigate triggers for Resident #58, Resident #61 and Resident #63, who had active diagnoses of Post-Traumatic Stress Disorder. This failure could place residents at increased risk for psychological distress due to re-traumatization. Findings included: A) Review of Resident #58's Face Sheet dated 03/04/2024 reflected a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses: Hemiplegia (one-sided muscle paralysis or weakness), Chronic Post Traumatic Stress Disorder (mental health condition that can affect anyone who has experienced a traumatic event, such as military combat, sexual or physical assault, or a natural disaster - chronic suffers my experience symptoms such as flashbacks, nightmares, and severe anxiety that can interfere with daily life), and Major Depressive Disorder (persistent feeling of sadness and loss of interest that can interfere with daily life). Review of Resident #58's Quarterly MDS assessment dated [DATE] reflected that he had a BIMS Score of 15, indicating cognition is intact. The MDS reflected that Resident #58 did not exhibit any behavior indicating rejection of care. The MDS reflected that Resident #58 had an active diagnosis for Post Traumatic Stress Disorder (PTSD). Review of Resident #58's Comprehensive Care plan reflected the follow problem areas with revised dates: 02/23/2024 The resident uses antipsychotic medications {used to treat symptoms of psychosis} for depression with psychosis {severe mental condition in which thought and emotions are so affected that contact is lost with external reality}, management of behavioral symptoms that present a danger to resident and other (anger, destructive behavior, conduct problems, grief / loss issues), significant distress and failed GDR's. 2/23/2024 The resident uses antidepressant medication related to depression. 02/23/2024 The resident uses anti-anxiety medications related to anxiety. Further review of the plan of care reflected no mention of PTSD and no identified triggers or interventions in reference to his active diagnosis. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 03/05/2024 at 8:38 AM, Resident #58 was seated on his bed eating breakfast and appeared aggravated. Resident #58 stated that one of the care staff had upset him this morning. Resident #58 stated that he was not aware that he had an active diagnosis for PTSD. Resident #58 stated that he did know of anything that triggered him but had never been asked the question. Resident #58 stated that he served in the military for four years but could not think of anything from that time that bothered him. Resident #58 stated that when he was in the 5th grade he was run over by a car while skateboarding and injured. Interview on 03/05/2024 at 11:37 AM, the ADON stated that PTSD triggers should be documented in resident care plans to ensure that staff members do not trigger a resident resulting in a negative outcome. The ADON stated that she knew, and all her staff knew that one trigger for Resident #58 was loud noises. B) Review of Resident #61's face sheet dated 03/04/2024 reflected she was admitted on [DATE] and readmitted on [DATE] with the following diagnoses Chronic obstructive pulmonary disease (COPD) (Is a common, preventable, and treatable disease that is characterized by persistent respiratory symptoms like progressive breathlessness and cough.) , Morbid obesity (Is a complex chronic disease in which a person has a body mass index (BMI) of 40 or higher or a BMI of 35 or higher and is experiencing obesity-related health conditions.) and PTSD (A mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations.) Review of Resident #61's Quarterly MDS dated [DATE] reflected Resident #61 was assessed to have a BIMS score of 15 indicating she was cognitively intact. Resident #61 was assessed to have mood indicators of feeling down, depressed, or hopeless. Resident #61 was further assessed to have PTSD. Review of Resident #61's comprehensive care plan reflected a problem with the start date of 04/24/2020 The resident uses antidepressant medication for depression and PTSD. Further review of the plan of care reflected no identified PTSD triggers or interventions other than medication for her PTSD. Review of Resident #61's Psychiatric Subsequent assessment dated [DATE] reflected Reason for referral: PTSD depression, anxiety and insomnia. Further review of assessment reflected no listed PTSD triggers. Observation and interview on 03/04/2024, Resident #61 was up in her wheelchair stating she was getting dressed. She stated right now she feels ok her mood is better. She stated she really did not want to talk about anything that made her sad and stated again she was ok. C) Review of Resident #63's Face Sheet dated 03/04/2024 reflected a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: Unspecified Dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), Bipolar Disorder (mental health condition that causes extreme mood swings that include emotional highs and lows), and Chronic Post Traumatic Stress Disorder (mental health condition that can affect anyone who has experienced a traumatic event, such as military combat, sexual or physical assault, or a natural disaster - chronic suffers my experience symptoms such as flashbacks, nightmares, and severe anxiety that can interfere with daily life). (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #63's Comprehensive MDS assessment dated [DATE] reflected that she had a BIMS Score of 15, indicating cognition is intact. The MDS reflected that Resident #63 did not exhibit any behavior indicating rejection of care. The MDS reflected that Resident #63 had an active diagnosis for Post Traumatic Stress Disorder (PTSD). Review of Resident #63's Comprehensive Care plan reflected the follow problem areas with revised dates: 02/27/2024 The resident has a behavioral problem r/t bipolar disorder, PTSD, dementia, metabolic encephalopathy, anxiety and adjustment disorder. Examples of known behaviors include: throwing things, hitting the wall, yelling out for help, hx of paranoia and hallucinations (sees a man standing outside her window), hx of rape allegations towards her physician, and making the comment that male doctors are [NAME] and they should die. 03/09/2023 The resident uses antidepressant medication, see MD order, r/t PTSD. 03/09/2023 The resident has a mood problem r/t bipolar, PTSD, anxiety, adjustment disorder. Further review of the plan of care reflected medication interventions and to monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes but did not identify any PTSD triggers. Observation and interview on 03/05/2024 at 8:50 AM, Resident #63 was seated in her wheelchair and appeared to be happy. Resident #63 seemed uncertain about whether she had a PTSD diagnosis. Resident #63 was asked if she had suffered any trauma and stated that her mother had been a nurse for forty-five years and was good at putting out fires. Resident #63 did not continue with the story after the initial comment. Resident #63 stated that she could not provide Surveyor with any triggers but advised that no has ever asked her the question. Interview on 03/05/2024 at 10:06 AM, MDS Coordinator D stated that she is responsible for signing off on the MDS assessments and that care plans are put together with input from the interdisciplinary team. MDS Coordinator D stated that PTSD will automatically populate from the Residents diagnosis into the MDS Assessment. MDS Coordinator D stated that if a diagnosis of PTSD was removed by a doctor that it would be removed from the Resident's diagnoses and removed from the MDS assessment and care plans. MDS Coordinator D stated that PTSD would be coded on the MDS to ensure proper care is provided for the diagnosis. MDS Coordinator D stated that triggers for a resident with PTSD would be a good idea to avoid setting off a resident, but Surveyor would have to speak with the Social Worker about resident triggers. At 10:16 AM, MDS Coordinator D reviewed the MDS Assessment and Care Plan for Resident #61. MDS Coordinator D confirmed that Resident #61 had a diagnosis of PTSD and was care planned for monitoring of adverse effects but should show triggers and include more detail. At 10:18 AM, MDS Coordinator D reviewed the MDS Assessment and Care Plan for Resident #58. MDS Coordinator D confirmed that Resident #58 had a diagnosis of PTSD and commented that his Care Plan did not indicate PTSD or triggers. At 10:20 AM, MDS Coordinator D reviewed the MDS and Care Plan for Resident #61 and confirmed the PTSD diagnosis and that it was stated in the Care Plan, but no triggers are present. MDS Coordinator D stated that failure to properly document triggers and PTSD was a quality-of-care issue and should be done to prevent a resident from becoming triggered. Interview on 03/05/2024 at 10:28 AM, MDS Coordinator E stated that if a resident has an MDS indicator for PTSD that it should be Care Plan independently and that triggers are supposed to be listed. MDS Coordinator E stated that triggers are necessary to ensure proper care and that interventions are done to prevent issues that may trigger a resident. MDS Coordinator E stated that the triggers should come from the Social Worker as well as possibly from psychological and doctor notes. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/05/2024 at 10:45 AM, SW stated that if a resident has PTSD it should be care planned for. SW stated that the triggers should be identified through the interdisciplinary team as well, which include psychological, therapy, and doctor's notes. SW stated that they should ensure that staff know what triggers to avoid when providing care to residents. Interview on 03/05/2024 at 11:05 AM, the Administrator stated that if a resident has a diagnosis of PTSD it should be documented in their MDS Assessment as well as their Care Plan with documented triggers. The Administrator stated that failure to do so could result in a resident becoming triggered and / or re-traumatized. Interview on 03/05/2024 at 11:37 AM, the ADON stated that PTSD triggers should be documented and made known to ensure that staff members do not trigger a resident resulting in a negative outcome. The ADON stated that she knew, and all her staff knew that one trigger for Resident #58 was loud noises. Review of facility's Trauma Informed Care policy, dated 10/13/22, revealed, It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization. Trauma-Informed Care is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization. Policy Explanation and Compliance Guidelines: 1. The facility will work to facilitate the principles of trauma informed care which include: d. Collaboration - an emphasis on partnering between residents and/or his or her representative, and all staff and disciplines involved in the resident's care in developing the plan of care. 2. The facility will use a multi-pronged approach to identifying a resident's history of trauma, as well as his or her cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), Admission Assessment, the history and physical, the social history/assessment, and others. 4. The facility will collaborate with the resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plan interventions. 6. The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the residents care plan. While most [NAME] are highly individualized, some common triggers may include, but are not limited to: a. Experiencing a lack of privacy or confinement in a crowded or small space. b. Exposure to loud noises, or bright / flashing lights. c. Certain sights, such as objects that are associated with their abuser. d. Sounds, smells, and physical touch. 10. In situations where a trauma survivor is reluctant to share their history, the facility will still try to identify triggers which may re-traumatize the resident, and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49099 Based on observation and interviews, the facility failed to ensure each resident received and the facility provided food and drink that was palatable, attractive and at a safe and appetizing temperature for residents who consumed foods orally from the only kitchen in the facility in that: 1. The facility failed to provide palatable food that was attractive or appetizing to residents' who complained about food texture, quality, appearance, and taste. 2. The facility failed to follow a recipe when preparing foods. 3. The test tray of the lunch meal foods were dry, over seasoned, and unattractive. This failure could place residents at risk of decreased food intake, hunger, unwanted weight loss, and diminished quality of life. The findings include: 1.Record review of Resident #2's Face Sheet dated 03/06/24 revealed a [AGE] year-old female admitted [DATE] with a diagnosis of heart failure-unspecified, unsteadiness on feet, dehydration, hypoxemia (abnormally low level of oxygen in the blood), hypothyroidism-unspecified (occurs when the thyroid gland doesn't make enough thyroid hormone), and vitamin D deficiency. In an interview and observation on 03/03/24 at 11:48 AM with Resident #2, she stated the food provided for lunch that day was not good. She said, I could not even cut into the meat it was so hard. An observation Resident #2's plate revealed her pork chop was not eaten, and she had consumed about 20-30 percent of her meal which included some broccoli, and a sweet potato casserole. Resident #2 stated, I don't waste my time asking for an alternative because the food it terrible regardless. In an interview on 03/04/24 at 07:24 AM the DM stated, food needs to be appealing to the residents. The texture has to be correct; it should taste good and have nutritional value. She stated that all meal tickets should be followed that was why they are there. She stated that if the residents request something different or make any changes it was noted on their meal tickets. She said that if food was not good it could lead to residents being unhappy and have weight loss. 2.An observation on 03/04/24 at 12:17 PM a lunch test tray was sampled. The test tray consisted of regular textured food items. The meal tray consisted of a beef patty with brown gravy and mushrooms, a side of steamed snap peas, and mashed potatoes. The meal included a wheat roll on the side, and a glass of sweet tea. The overall appearance of the gravy on the beef patty was gelatinous and unappealing. The texture of the meat patty was mush, as if it were microwaved before serving- the mushrooms on the meat had a slimy consistency paired with the gravy. The mashed potatoes had an overwhelming pepper and garlic taste which made it inedible. The wheat roll appeared flat, was dry and hard at the bottom making it inedible. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #245's Face Sheet dated 03/05/24 revealed a [AGE] year-old female admitted on [DATE] with a diagnosis of unspecified asthma-uncomplicated (long term disease of the lungs that causes inflammation and narrowing of the airways), iron deficiency anemia-unspecified, hyperlipidemia-unspecified (an abnormally high level of any or all lipids or lipoproteins in the blood), impaired fasting glucose (type of prediabetes), and depression-unspecified (mood disorder causing persistent feeling of sadness and loss of interest). Record review of clinical physician orders dated 02/28/24 reflected no added salt diet with mechanical soft texture, regular liquids, regular consistency. In an interview on 03/04/24 at 02:59 PM with Resident #245 she stated she had eaten the meat with gravy and mushrooms provided that day. She stated she did not enjoy her meal, I took two bites and did not finish it. She stated there was too much sauce and the texture was bad and too mushy. She stated she didn't realize there were mushrooms on the dish until something slimy went across her tongue and then she realized they were mushrooms, she said they weren't easily identified. Resident #245 stated when about the mashed potatoes, holy cow too much garlic it's nasty, a little garlic is ok but they go crazy. She said, the mashed potatoes were spicy, not spicy hot- but spicy from too much pepper and garlic. Record Review of Resident #4's Face Sheet dated 03/05/24 revealed an [AGE] year-old female admitted [DATE] with a diagnosis of chronic obstructive pulmonary disease- unspecified (chronic inflammatory lung disease causing obstructed airflow from the lungs), chronic respiratory failure with hypoxia (below level of oxygen in the blood), morbid (severe) obesity due to excess calories, anemia-unspecified (deficiency of healthy red blood cells in the blood), vitamin D deficiency, and hyperlipidemia (an abnormally high level of any or all lipids or lipoproteins in the blood). Record review of Resident #4's MDS dated [DATE] reflected a BIMS score of 15 suggesting cognition intact and reflected therapeutic diet. Record review of Resident #4's clinical physician orders dated 11/09/23 reflected no added salt diet, regular texture, regular liquids, regular consistency. In an interview on 03/04/24 at 03:00 PM with Resident #4 she stated she ate the lunch meat with gravy and mushrooms, the regular diet. She said, I took one bite, and it made me sick I thought I was going to regurgitate. She said, I like mushrooms but that was solid mushrooms. She said that her first bite was a mouthful of mushrooms which were overcooked and slimy, you got a taste of something that was bad. Resident #4 stated, after I took a bite of the mushrooms it ruined everything, and I couldn't eat anything. She said the mashed potatoes looked gray and unappealing. She said that she ate a little bit of the bread, but she did not like it because it was too tough and dry. Record Review of Resident #63's Face Sheet dated 03/05/24 revealed a [AGE] year-old female admitted on [DATE] with a diagnosis of unspecified dementia- unspecified severity-without behavioral disturbance-psychotic disturbance-mood disturbance-and anxiety (a group of symptoms that affects memory, thinking and interferes with daily life), urinary tract infection- site not specified, post-traumatic stress disorder-chronic (mental health condition that is triggered by a terrifying event), and muscle wasting and atrophy-not elsewhere classified-multiple sites. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #63's MDS dated [DATE] reflected a BIMS score of 15 suggesting cognition intact, and resident not on any mechanically altered diet. Record review of Resident #63's clinical physician orders reflected an active diet order dated 05/23/23 for regular diet, regular texture, regular liquids, regular consistency. In an interview on 03/04/24 at 03:05 PM with Resident #63 she stated the mashed potatoes were too salty and over seasoned. She stated that the food did not look appealing- and the gravy looked like goop. She said the meat was too mushy. Resident #63 stated they did not spend any time on the bread and let it rise, it was flat and dry. She said that she believes it was probably out of a bag because it appeared stale and not freshly made. In an interview and observation on 03/05/24 at 10:15 AM [NAME] H was observed not following the recipe when preparing the puree and regular texture items by failing to use measuring spoons to add seasonings per recipe measurements. [NAME] H was observed using a white plastic spoon (eating utensil) and pouring seasoning at various unmeasurable amounts into the food (vegetable medley, and chicken and dumplings). [NAME] H was seen asking DM if there were measuring spoons to which DM responded, no just measure to taste. [NAME] H was then observed returning to vegetable medley and pouring a large unmeasured amount of salt into the vegetables directly from the salt container pour spout. [NAME] H said, we are supposed to be using measuring spoons while preparing the food but said, some staff don't take care of equipment here and things get lost. In an interview on 03/05/24 at 10:25 with DM she stated they are supposed to have measuring spoons in order to measure out the appropriate amount of salt and seasonings. In an interview on 03/05/24 at 03:33 PM with the Administrator he stated it is his expectation that every menu item has a recipe with specific measurements and that it be followed. He stated, we should have a system to measure items and follow a recipe. He said by not following measurements the item would not taste the way it was designed to taste. The Administrator said the nutritional makeup of the recipe would be altered if it were not followed which could affect residents negatively when they have specific nutritional needs. He said that the food should be appetizing and something the residents enjoy.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49099 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 for 1 of 1 kitchen reviewed for food and nutrition services. 1. The facility failed to ensure dry storage food was properly labeled and dated. 2. The facility failed to ensure dry storage items were sealed properly. 3. The facility failed to ensure beverages left in the freezer were covered/ sealed. 4. The facility failed to ensure damaged or dented canned food items were kept in a separate designated area. 5. The facility failed to properly label and date items in the refrigerator and freezer. 6. The facility failed to ensure expired food was discarded- one container of jelly. 7. The facility failed to ensure kitchen staff practiced proper hand hygiene and glove use. 8. The facility failed to ensure hairnets were worn while in the kitchen. These failures could place residents at risk for food contamination and foodborne illness. Findings included: During the initial tour of the kitchen on [DATE] at 09:43 AM the following was observed: 1. Upon arrival to the kitchen DA J was observed in the kitchen with no hairnet or beard guard. 2. Reach in freezer #1 contained a light blue plastic bag contents unknown, later identified as squash by [NAME] H. Bag was not labeled and had a grapefruit size hole spilling contents to shelves below. 3. Reach in freezer #2 contained a zip seal bag containing ham identified by [NAME] H not sealed or labeled and contents exposed to freezer burn; a box of breakfast sausage in a plastic bag, bag was not tied or properly sealed exposing contents to freezer burn; and an opened glass bottle of staff Coca-Cola beverage mixed with resident food items. 4. Reach in refrigerator #1 contained a plastic container with a green lid of jelly that had two separate use-by dates one on the top and one on the side. Both dates had passed, written date on the top of the lid was [DATE] and the written date on the side of the lid was [DATE]. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Reach in refrigerator #2 contained a plastic bin with zip seal bags of sliced deli turkey meat not properly sealed. 6. The dry storage room contained 3 dented cans; 2 cans of sliced pears and 1 can of pineapple chunks not separated into the labeled and identified damaged canned food item shelf, 1 bag of medium cookie pieces not properly sealed, a bag of corn flakes cereal not properly sealed, and a damaged plastic container with a grey plastic bag holding sugar. The Bag of sugar was protruding from a tennis ball size hole at the bottom-bag had small tears spilling sugar onto the floor. In an interview and observation on [DATE] at 10:00 AM [NAME] H stated that items should not be exposed in the refrigerator or freezer. [NAME] H identified the light blue torn bag in freezer #1 of 2 as containing frozen chopped squash. He stated that it should not have been exposed and was observed throwing the item away and cleaning the contents that had fallen out of the bag onto the shelves below. [NAME] H said that all items should be sealed properly in order to prevent contamination of food. [NAME] H stated the jelly was originally in a large glass container but was moved to the plastic container, he stated he was not sure which label was correct as there were two expiration dates on it and that it should be thrown out because both dates have passed. [NAME] H stated that the sugar on the damaged container should have been replaced because the exposed product can be affected but that it can also invite pests with sugar on the ground. [NAME] H stated that all damaged canned food items have a separate shelf where they are supposed to go so they are not used and can be returned to supplier. He stated that when canned items are dented their seal can be broken allowing for bacteria to produce harmful toxins that could make anyone who eats the item sick. [NAME] H was then observed removing the 3 dented cans over to the appropriate shelf for dented cans. [NAME] H stated that the bag of cookies and cereal that was improperly sealed should have been sealed better because it affects the quality of the food item. During an observation and interview on [DATE] at 11:48 PM of lunch services, [NAME] I was observed walking around in the kitchen with no hairnet or beard guard during meal assembly onto residents' lunch trays. After seeing surveyors, [NAME] I was observed grabbing hairnet and beard guard. An attempt was made to interview [NAME] I moments later, but he had left the facility, the DM stated he was a PRN cook and had come to the building briefly to speak to her. During an observation on [DATE] at 09:27 AM of pureed foods in 1 of 1 kitchen, [NAME] H was observed putting his gloved hands in his pockets to retrieve alcohol wipes during food preparation and temperature checks. [NAME] H was then observed regularly changing his gloves but not washing his hands in between changing gloves and touching different food items or objects in the kitchen. In an interview on [DATE] at 10:15 AM with [NAME] H, he stated he did not know he was supposed to be washing his hands in between glove changes. He stated he knew he had to wash his hands when entering the kitchen but believed changing gloves was sufficient to prevent contamination if food items. [NAME] H stated he knew he should not have put his hands in his pants pocket while wearing gloves to pull alcohol wipes while preparing food and taking temperatures. He said by doing so he could cause contamination of food items and he did it by mistake. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 07:24 AM with the DM she stated that it was her expectation that all food items in the refrigerator, freezer, and dry storage are properly sealed to preserve the integrity of the food and prevent contamination. She stated the items observed in zip-seal bags should have been sealed correctly to prevent freezer burn. The DM stated that if the item is not labeled correctly, they would have no way of knowing what the contents are or when they should have been used by, so she expects them to be discarded. The DM stated that there was a designated section for damaged canned food items and that they should be inspected on arrival and separated. She stated using a damaged canned item has the potential to make people sick. The DM stated that it was her expectation that all staff wear hairnets or beard guards while working in the kitchen. She said a negative outcome to not wearing them could lead to cross contamination adding, it's a hazard and hair could also fall in the food. In an interview on [DATE] at 10:20 AM with DC he stated it is his expectation that items are stored in a manner to prevent food contamination and items should be sealed. The DC stated that he expected hairnets to be worn while working in the kitchen, and that staff should be washing their hands in between changing gloves. In an interview on [DATE] at 10:22 AM with DM she stated that staff should not be touching their clothing while wearing gloves and working with food items as it could contaminate the food. She stated it is her expectation that staff wash their hands in between changing gloves and while working with different food products or touching dirty items or anything that could contaminate the hands. She said that failure to follow proper hand/ glove hygiene would lead to contamination of food which could make people sick. In an interview on [DATE] at 03:33 PM with the Administrator he stated it was his expectation that all food products be appropriately sealed, dated, and labeled. The Administrator said that all stored food items should be meeting regulatory requirements and that failure to do so would result in contamination. The Administrator stated that every type of product needs to have a clear expiration date, and that it is the responsibility of the DM to know when it needs to be discarded. He said expired items should not be in the refrigerator. He stated that even if there are items with two expiration dates and one was not beyond expiration, he would still expect it to be discarded for food safety reasons. The Administrator stated that staff should not be storing personal items in the freezer he said, resident foods are purchased through vendors that maintain the integrity of products and its difficult to know if the integrity of their products are maintained if they are commingled with staff items. The Administrator stated that it is his expectation that there be a designated area in the kitchen and the area should be easily identified for the placement of dented or damaged canned food items. He said they should not be mixed with the undamaged canned items. He stated that a potential negative outcome for residents would be illness if the dented canned item is compromised and it compromises the food. The Administrator said that he expects dry storage items to be appropriately sealed to prevent it from being exposed to something that could cause illness. He said it is his expectation that hairnets and beard guards are worn in the service and/ or preparation of food fully covering hair to prevent contamination of food by hair. He said gloves should be worn and staff should be washing their hands in between changing gloves or working with different food items. The Administrator stated staff should not be contaminating those gloves by touching their clothing while working with food because it could also contaminate the food which has the potential to make residents sick. Policy: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Employee Sanitation policy last revised on [DATE] reflected: 1. Employee Cleanliness Requirements a) Hair restraints such as hats, hair coverings or nets, caps and beard/ moustache restraints (snoods) or other effective hair restraints are worn to keep hair from contacting food and food-contact surfaces. Hand Washing 2. Employees wash their hands and exposed portions of their arms at designated hand washing facilities at the following times: d. Immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles. e. During food preparation, as often as necessary to remove soil and contamination and prevent cross contamination when changing tasks. Use of Gloves 3. Gloves are not a substitute for thorough and frequent hand washing. When using gloves, employees always wash hands before touching or putting on new gloves. 5.Single use gloves are used for one task only. 6.Gloves are changed: a) Between each food preparation task. b) After touching items, utensils or equipment not related to task. c) After touching hair, face or any other source of contamination. d) When leaving food preparation area for any reason. e) When damaged, soiled or when interrupted. f) Every hour for all tasks taking longer than one hour. 7.Gloves are not stored in pockets or aprons.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 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 32452

48314

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 one of two medication aides (MA C) observed for infection control practices during medication pass.

MA C failed to sanitize her hands between residents and grabbed the drinking cups and medication cups by putting her fingers inside the cups during medication pass for Resident #146 and Resident #85.

This failure could place residents who require assistance with medication administration at risk for healthcare associated cross-contamination and infections.

Findings include:

Observation on 03/04/2024 at 8:19 AM revealed MA C leaving room [ROOM NUMBER] after administering medication MA C did not sanitize hand. MA C then went to room [ROOM NUMBER]. MA C without sanitizing hands grabbed a clear plastic water cup by grabbing the cup with her fore finger and thumb with the fore finger making contact with the inside of the water cup. MA C then grabbed a clear plastic medication cup with her fore finger and thumb with the fore finger making contact with the inside of the medication cup. MA C then prepared Resident #146 medications placing them in the medication cup. MA C then poured water into the clear plastic medication cup and took the medication into Resident #146 room and administered them to the resident. MA C without sanitizing hands went to room [ROOM NUMBER] Resident #85's room. MA C grabbed the water cup and mediation using her fore finger and thumb making contact with the inside of medication cup and water cup. MA C placed all of Resident #85's medication in the medication cup and put water inside the water glass and entered into Resident #85's room to administer her medication.

In an interview on 03/04/2024 at 8:35 AM MA C stated she did not sanitize her hands between residents and should not have grabbed the medications cups touching the inside of the cups with her hands.

In an interview on 03/04/2024 at 11:34 AM the DON stated she expected medication aides to wash or sanitize their hands when preparing and administering medication. The DON stated the MA should not touch the inside of the water cups or medication cups stating it could lead to cross contamination.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy Medication administration dated 10/01/2019 reflected .B. Handwashing and Hand Sanitization: The person administering medications adheres to good hand hygiene, which includes washing hands thoroughly before beginning a medication pass, prior to handling any medication, after coming into direct contact with a resident, and before and after administration of ophthalmic, topical, vaginal, rectal, and parenteral preparations and medications given via enteral tubes. Examination gloves are worn when necessary. Hand sanitization is done with an approved sanitizer between hand washings, when returning to the medication cart or preparation area (assuming hands have not touched a resident or potentially contaminated surface). Sanitization can be done at regular intervals during the medication pass such as after each room, again assuming handwashing is not indicated. Sanitization is not a substitute for proper handwashing, and washing should be done if there is any question