STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676188	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millbrook Healthcare and Rehabilitation Center	1850 W Pleasant Run Rd Lancaster, TX 75146

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35747 Based on observations, interviews, and record review the facility failed to care for each resident in a manner that promoted maintenance and enhancement of their quality of life for one (Resident #36) of 8 residents reviewed for privacy and dignity. The facility failed to ensure Resident #36 was afforded visual privacy when receiving incontinent care; her coccyx was left exposed to passers-by in the hallway. This failure could place residents at risk for diminished quality of life and loss of dignity and self-worth. Findings included: Review of Resident #36's Face Sheet, dated 02/11/25, reflected she was a [AGE] year-old female, who initially admitted to the facility on [DATE], with diagnoses including major depressive disorder (a mental health condition that can cause persistent feelings of sadness and hopelessness) and anxiety disorder (a mental health condition that involves excessive fear, worry, or dread). Review of Resident #36's MDS Assessment, dated 12/28/24, reflected she was always incontinent of bladder and bowel. Review of Resident #36's Care Plan, initiated on 01/31/24, reflected she was incontinent of bladder and bowel. Her Care Plan reflected she required the use of briefs and staff assistance for incontinent care. Observation of Resident #36 on 02/09/25 at 9:41AM revealed she was lying in bed. There were no concerning marks or bruises noted on her person. It was noted that Resident #36's call light had been activated. Resident #36 reported she had soiled herself and needed to be changed. Observation from the hallway on 02/09/25 at 9:55AM revealed Resident #36's door was open as CNA E was providing incontinent care. The privacy curtain was pulled closed for the majority of the time, but at one point CNA E opened the privacy curtain as she was throwing away trash. This left Resident #36's coccyx exposed to anyone who was walking in the hallway. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA E on 02/09/25 at 10:07AM, she stated she normally closed the door to resident rooms prior to providing care. She did not think to do it when providing care for Resident #36 because she was trying to get her assigned tasks completed. She stated the risk of not closing the door to resident rooms prior to providing care was that residents wouldn't be provided with dignity. During an interview with the Director of Nursing on 02/09/25 at 1:38PM, she stated the expectation was for facility staff to ensure resident privacy and dignity during care by pulling the privacy curtain closed and keeping the door shut. The Director of Nursing stated the risk of not ensuring a resident's visual privacy during care included decreased dignity. Review of the facility's Resident Rights - Dignity and Respect policy, dated 10/2015, reflected, .Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or drawn curtain shields the Resident from passers-by .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on observations, interviews, and record review, the facility failed to ensure each resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 3 of 8 (Resident #16, Resident #61, and Resident #27) residents reviewed for call lights. 1. The facility failed to ensure Resident #16 had a call light device appropriate to her limited use of her hands. She was provided a button type call light when she was unable to bend her fingers. 2. The facility failed to ensure Resident #61 had a call light device appropriate to her limited use of her hands. She was provided a button type call light device when both her hands were contracted into fists. 3. The facility failed to ensure Resident #27's call button was within reach while Resident #27 was in her bed. Findings included: 1. Record review of Resident #16's Admission Record dated 2/9/25 reflected a [AGE] year-old female originally admitted to the facility on [DATE]. Record review of Resident #16's Quarterly MDS assessment dated [DATE] reflected she had a BIMS score of 12 indicating moderately impaired cognition. Her diagnoses included stroke, aphasia (language disorder affecting speech); hemiparesis (muscle weakness or partial paralysis on one side); depression; gastrostomy (feeding tube); and muscle wasting and atrophy (loss of muscle mass and strength). She had limited range of motion in all limbs. She was usually understood and usually understood others. She was dependent on staff for all ADL s, was incontinent of bowel and bladder. Record review of Resident #16's Care plan reflected the following: At risk for falls r/t CVA with left sided weakness, incontinence, decreased mobility . Interventions included, Anticipate and meet needs.; Be sure the call light is within reach and encourage to use it to call for assistance as needed . Date initiated: 10/25/22. Has bowel/bladder incontinence r/t cognitive deficit secondary to history of CVA . Interventions included: Check as required for incontinence . Date initiated: 10/25/22. During an observation and interview on 2/9/25 at 9:21 AM Resident #16 was observed awake and sitting up in bed in her room. Her hands were observed to be extended in a flat manner. She had a button-type call light clipped to her blanket. Resident #16 stated she was unable to use that type of call light and stated she could not use her hands well since her stroke. She stated she was unable to bend her fingers in a way to press the button. She stated the staff were nice to her, but they were not in her room very often. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/9/25 at 12:20 PM, Resident #16 was observed in her room, sitting up in bed. She shook her head when greeted. She stated, I'm need help, I'm wet. She motioned with her hands and stated again that she was unable to use her call light. She asked this state surveyor to tell someone she was wet. There was a strong odor of urine and stool in the room. During an interview on 2/9/25 at 12:23 PM, the DON stated RN B was the charge nurse for Resident #16. She stated if a resident could not use their hands or could not talk, they should use the pad type of call light (round flat pad that activates with light touch). During an observation and interview on 2/9/25 at 12:25 PM, RN B stated she had worked with Resident #16 and did not know if she had enough strength in her hands to use the push button type of call light. She stated the resident was able to use her TV remote by laying her hand on top of the remote to press the buttons. She stated, we check on her a lot and ask her if she needs to be changed, she'll let us know. She stated she would need to check with the DON to determine how residents were assessed for the call light type they needed. RN B was observed entering Resident #16's room and asked her if she needed to be changed and the resident nodded. RN B informed her she would be right back. CNA A entered the room carrying wipes. Incontinent care was provided by CNA A and RN B. CNA A stated Resident #16 was unable to use her call light, so staff checked on her a lot. 2. Record review of Resident #61's Admission Record dated 2/11/25 reflected an [AGE] year-old female admitted to the facility on [DATE]. Record review of Resident #61's Quarterly MDS assessment dated [DATE] reflected she usually made herself understood and usually understood others, her vision was severely impaired, and she had moderate hearing difficulty. Her BIMS interview indicating cognitive level was not completed. She had limitations in both upper extremities. She was incontinent of bowel and bladder. Her diagnoses included non-Alzheimer's dementia; depression; muscle weakness; and cognitive communication deficit. Record review of Resident #61's BIMS assessment dated [DATE] reflected a score of 5 indicating severe cognitive impairment. Record review of Resident #61's Functional Performance Observation dated 2/6/25 reflected she was dependent on staff for eating, toileting, bathing, dressing, mobility, personal hygiene, and transfers. Record review of Resident #61's Care Plan reflected the following entries: At risk for communication problem r/t nonverbal. Interventions included: Anticipate and meet needs. Ensure/provide a safe environment: Call light within reach . Date initiated: 9/22/23. At risk for falls r/t new environment, dementia with Lupus [illness that occurs when the immune system attacks tissue and organs], Legal blindness. Interventions included: Be sure call light is within reach and encourage to use it to call for assistance as needed .Needs a safe environment .a working and reachable call light . Date initiated 9/15/23. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/9/25 at 9:27 AM, Resident #61 was observed in her room. Her bed was in a low position and a fall mat was on the floor alongside her bed. Her eyes were closed, and she did not respond to greeting. Her right hand appeared to be contracted and was in a fist. She had a button-type call light clipped to her blanket. During an observation and interview on 2/9/25 at 12:30 PM, Resident #61 was heard crying out. Both hands were observed clinched in fists. Her call light was clipped to her blanket near her hands. CNA A approached her and asked her what was wrong. When the resident continued to cry out, CNA A repositioned her and told her lunch was coming. Resident #61 calmed down and became quiet. CNA A stated Resident #61 was unable to use her call light. RN B was in the room and stated Resident #61 was unable to use her call light, so they checked on her often. She stated she was unsure whether the resident could utilize the pad type call light. She stated call light access was important because otherwise residents could not get help when needed and were at increased risk for falls. 3. Record review of Resident #27's Admission Record dated 2/9/25 reflected she was an [AGE] year-old female admitted to the facility on [DATE]. Record review of Resident #27's Quarterly MDS assessment dated [DATE] reflected she had a BIMS score of 4 indicating severe cognitive impairment. She could make herself understood and understood others. She was dependent on staff for personal hygiene, dressing, and transfers. Her diagnoses included diabetes; seizure disorder; muscle weakness; dementia; and cognitive communication deficits. Record review of Resident #27's Care Plan reflected the following entries: Alteration in musculoskeletal status . Interventions included: Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance . Date initiated 9/13/22. ADL self care performance deficit . Interventions included: Encourage to use bell to call for assistance . Date initiated 9/13/22. At risk for falls r/t dementia . Interventions included: .Be sure the call light is within reach and encourage to use it to call for assistance as needed . Date initiated 7/7/22. During an observation on 2/9/25 at 9:30 AM, Resident #27 was observed sleeping in her bed. Her call light was observed on the floor beyond the foot of her bed. During an observation on 2/9/25 at 12:48 PM, Resident #27 was observed in bed sleeping. Her call light was clipped to her blanket and within reach. CNA A was in the room and stated Resident #27 was able to use her call light and did not know why it was on the floor earlier. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/9/25 at 12:55 PM, the DON stated Resident #16 previously had a pad type call light and she did not know if someone had changed it out. She stated the ADON checked on her regularly. The DON stated Resident #61 used to be in a different room and had a pad type call light there and it was possible the device did not move with her when she changed rooms. She was unsure when the room change occurred. The DON stated management staff performed Angel rounds daily, Monday through Friday, and that was one of the things that should be checked. The DON stated she was unaware Resident #27's call light was not within her reach and staff should be checking them anytime they were in the rooms. She stated the risk for not having access to a call light was not receiving timely care. An observation on 2/9/25 at 12:59 PM revealed the ADON's name was posted outside Resident #16 and Resident #61's door on a sign that reflected, Angel indicating she was responsible for the rooms during Angel rounds. During an interview on 2/9/25 at 1:00 PM, the ADON stated she was responsible for conducting daily rounds in Resident #16 and Resident #61's rooms. She stated Resident #16 always had a pad type of call light but was unsure when she last saw it. She stated it may have been 3 weeks or so ago and she hadn't noticed it was changed. The ADON stated Resident #61 had moved from a room down the same hall and she believed the resident had a pad type call light in her previous room. She stated she had not noticed the button type was being used. She stated they established the appropriate type of call light to be used during their initial assessment when admitted and with any change of condition. She stated the nurses should let them know if a different type of device was needed and should ensure the call lights were in reach. The ADON stated risks for the inability of a resident to use a call light was falls, choking, and a delay in care. During an interview on 2/9/25 at 2:17 PM, the Administrator stated Resident #16 usually had the flat type of call light and she had seen her with it. She stated the resident would call out to them as well when she saw them in the hall. She did not know when the call device was changed. The Administrator stated Resident #61 was blind and did not use her call light. She stated she had moved from another room down the hall, and she was certain she had the pad type there. She stated Resident #61 was up during the day a lot and had frequent visits from her family. She stated Resident #27's call light should have been placed within reach and any staff should look for that when entering the room. She stated the risk of not having access to a call light was needs may not be met in a timely fashion. The Administrator stated the type of call device should be determined on initial assessments. She stated any concerns can be brought to daily stand-up meetings and be addressed immediately. She stated management staff conducted daily Angel rounds to catch issues in the rooms and the charge nurses were responsible for addressing the issues as well. Record review of the facility's policy titled, Accommodation of Needs dated Reviewed 08/2023 reflected: Policy: It is the policy of this facility to assure that a resident has a right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences . Definitions: Reasonable accommodations of individual needs and preferences means the facility's efforts to individualize the resident's physical environment including: Resident's bathroom and bedroom . Procedures: 1. The facility will evaluate the resident's unique needs and make environmental accommodations to the extent reasonable 6. Have call light within reach.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on interviews and record review, the facility failed to ensure assessments accurately reflected the resident's status for 2 of 4 residents (Resident #61 and Resident #34) reviewed for accuracy of assessments. The MDS Nurse failed to ensure Section C0200-C0500-Brief Interview for Mental Status (BIMS) was completed for Resident #61's Quarterly MDS assessment dated [DATE] and Resident #34's Quarterly MDS assessment dated [DATE] when she signed Section Z0400 indicating the sections had been completed. These failures could place residents at risk for not receiving care and services to meet their needs, diminished function of health, and regression in their overall health. Findings included: Resident #61 Record review of Resident #61's Admission Record dated 2/11/25 reflected an [AGE] year-old female admitted to the facility on [DATE]. Record review of Resident #61's Quarterly MDS assessment dated [DATE] reflected she usually made herself understood and usually understood others. Section C0100 Should Brief Interview for Mental Status (C0200-C0500) be conducted? was coded 1 indicating Yes. Her BIMS interview, indicating cognitive level, was not completed, and was coded as a dash -. Section Z0400 Signature of Persons Completing the Assessment or Entry/Death Reporting reflected Section C of the assessment was signed as completed on 11/11/24 by the MDS Nurse. Record review of Resident #61's electronic medical record revealed a BIMS assessment dated [DATE] with a score of 5 indicating severe cognitive impairment. During an interview and record review on 2/11/25 at 12:30 PM, the MDS Nurse reviewed Resident #61's MDS assessment dated [DATE]. She stated she had entered dashes within the BIMS section because she did not have the interview information available during the lookback period. She stated she reviewed the information for the MDS Assessment after the ARD date. When asked why she signed section C as completed on the ARD date, she stated, that's the way the system does it. She stated the facility's Social Worker typically completed the BIMS and they had a new one start on 12/1/24. She stated the facility's Speech Therapist could also complete the BIMS, but she did not notice the interview had not been completed until she reviewed the information after the ARD dates. The MDS Nurse stated there was no risk to missing a BIMS score for Resident #61 because she had regular BIMS Assessments done. Resident #34 Record review of Resident #34's Admission Record dated 2/9/25 reflected a [AGE] year-old female admitted to the facility on [DATE]. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #34's Quarterly MDS assessment dated [DATE] reflected she usually made herself understood and usually understood others. Section C0100 Should Brief Interview for Mental Status (C0200-C0500) be conducted? was coded 1 indicating Yes. Her BIMS interview, indicating cognitive level, was not completed, and was coded as a dash -. Section Z0400 Signature of Persons Completing the Assessment or Entry/Death Reporting reflected Section C of the assessment was signed as completed on 12/10/24 by the MDS Nurse. Record review of Resident #34's electronic medical record revealed her last BIMS assessment was conducted on 9/22/24. The assessment reflected a score of 14 which indicated she was cognitively intact. During an interview and record review on 2/11/25 at 12:40 PM, the MDS Nurse provided a copy of a page retrieved from the CMS RAI Manual, October 2024 Page C-2 and stated they were the instructions she followed, and she had entered dashes based on the instructions. She reviewed Resident #34's MDS assessment dated [DATE] which also included dashes entered for the BIMS assessment and reflected a Section C completion date of 12/10/24. She stated it was due to the same reason and she had reviewed the sections after the ARD date. She stated she had not noticed Resident #34 had not had a BIMS done since September 2024. During an interview on 2/11/25 at 2:14 PM, the Social Worker stated she started working for the facility on 12/1/25 and spent the first few weeks completing employee orientation courses. She stated she began completing BIMS for residents around her second or third week there. She stated she was still learning the process and may have overlooked some. She stated the facility's previous Social Worker still worked there when she started, and she did not know whether they had been doing them. She stated the BIMS were important to determine whether there were any changes in the resident's condition like a decline or progression. She stated the risk of not completing a BIMS score was they could miss a change of condition in the residents . Record review of the CMS RAI Manual, October 2024 Page C-2 reflected the following: Coding Tips: Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood . If the resident interview was not conducted within the look-back period (preferably the day before or the day of) the ARD, item C0100 must be coded 1, Yes, and the standard no information code (a dash -) entered in the resident interview items. Record review of the CMS RAI Manual, October 2024 Pages Z-4 and Z-5 reflected: Item Rationale: To obtain the signature of all persons who completed any part of the MDS. Legally, it is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response. Each person completing a section or portion of a section of the MDS is required to sign the Attestation Statement. Z0400: Signatures of Persons Completing the Assessment or Entry/Death Reporting The importance of accurately completing and submitting the MDS cannot be over- emphasized. The MDS is the basis for: -the development of an individualized care plan (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-the Medicare Prospective Payment System -Medicaid reimbursement programs -quality monitoring activities, such as the quality measure reports -the data-driven survey and certification process -the quality measures used for public reporting -research and policy development . Record review of the facility's policy, Resident Assessment and Associated Processes, dated Reviewed 12/2023 reflected: Policy It is the policy of this facility that resident's will be assessed, and the findings documented in their clinical health record. These will be comprehensive, accurate, standardized reproducible assessment of each resident and will be conducted initially and periodically as part of an ongoing process through which each resident's preferences and goals of care, functional and health status, and strengths and needs will be identified .7. Each individual who completes a portion of the assessment will electronically sign and certify the accuracy of that portion of the assessment, as well as the date the data was obtained . 35747

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on observations, interviews, and record review, the facility failed to ensure residents unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 6 residents (Residents #41) reviewed for ADL care. The facility failed to ensure Resident #41's fingernails were kept trimmed. These failures could place the residents at risk of infections or injuries. Findings included: Record review of Resident #41's Admission Record dated 2/9/25 reflected a [AGE] year-old male admitted to the facility on [DATE]. Record review of Resident #41's Quarterly MDS assessment dated [DATE] reflected he had a BIMS score of 15 indicating he was cognitively intact. He required maximum assistance for bathing and personal hygiene. He had no behaviors exhibited related to rejection of care. His diagnoses included coronary artery disease, stroke, diabetes, and hemiplegia (muscle weakness or partial paralysis) on his left side following a stroke. Record review of Resident #41's Care Plan reflected the following entries: ADL Self Care Performance Deficit r/t new environment and mobility deficit. Interventions included: Staff will provide the level of physical assistance with ADLs as needed . During an observation and interview on 2/10/25 at 11:32 AM, Resident #41 was observed in bed in his room. Resident #41's fingernails were observed to be very long on all his fingers on both hands. Some were chipped and sharp on the corners on his left hand. There was a thick build up beneath his thumb nail on his right hand. The resident stated he needed them trimmed and could not recall the last time anyone trimmed them. LVN C entered the room and stated she was his Charge Nurse that day. She stated she had not noticed his fingernails that day and was unsure when they were last trimmed. She stated sometimes the CNAs trimmed resident's nails on shower days unless they were diabetic. She stated the risk to residents was skin damage. The Activity Director's name was observed on a sign outside Resident #41's room indicating she conducted his Angel rounds (daily rounds performed by management to assess and address the resident's needs). During an interview on 2/10/25 at 11:57 AM, RN B stated she was Resident #41's Charge Nurse over the weekend and had not noticed his fingernails. She stated she thought resident's nails were taken care of on shower days by the CNAs. She stated the risk to residents was injury from scratching. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 2/10/25 at 12:00 PM, the Activity Director stated Angel Rounds were conducted daily, Monday through Friday. She stated they routinely checked things like oxygen tubing, ensuring the residents were clean and presentable, privacy bags on catheters, and tripping hazards in the rooms. The Activity Director stated she performed manicures for residents every other Monday and Resident #41 was due for one that day. She entered Resident #41's room and observed his hands. She stated she did not recall them looking that way the previous week or she would have moved up his time or reported it to nursing. She stated she had done manicures for him in the past. Resident #41 nodded, laughed, and stated he was ready. The Activity Director stated the risk to residents included bacteria growth under the nails, poking their eyes, or scratching themselves. During an interview on 2/10/25 at 1:09 PM, the DON stated she would imagine resident's nails were trimmed during shower days, three times a week. She stated she learned from the nurses that Resident #41 refused to have his nails trimmed. She stated she was not aware the Activity Director had trimmed his nails in the past. She stated the risk for untrimmed nails were residents could cut themselves or get infections. During an interview on 2/11/25 at 1:32 PM, CNA D stated he cared for Resident #41. He stated Resident #41 resisted getting out of bed at times but was compliant with showers and other tasks. He stated he had provided showers to Resident #41 the previous week but did not notice his fingernails getting too long. He stated, if residents were diabetic, he was only allowed to clean and file them. He stated the risk to residents if their fingernails were too long or rough was scratching themselves. Record review of the facility's policy, Quality of Care Subject: ADL, Services to carry out, dated Revised 07/2020, reflected: Policy: It is the policy of this facility that residents are given the appropriate treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care. Procedures: .2. If a resident is unable to carry out activities of daily living, the necessary services to maintain good nutrition, grooming, and personal oral hygiene will be provided by qualified staff.

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	676188	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millbrook Healthcare and Rehabilitation Center	1850 W Pleasant Run Rd Lancaster, TX 75146

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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. 47030 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchens reviewed for kitchen sanitation. The facility failed to ensure food was properly stored in the facility's kitchen. These failures could place residents at risk for food-borne illness. Findings Included: Observation of the facility's refrigerator on 02/09/25 beginning at 9:09 AM revealed unlabeled, undated, and uncovered food and beverage items: -3 trays of cups of dark liquid for a total of 18 cups of dark liquid; and -1 tray of cups of white liquid for a total of 11 cups of white liquid; and -3 trays with uncovered 12 slices of yellow cake on 3 trays for a total of 36 slices. Interview with the Dietary Manager on 2/10/25 at 11:30am revealed she reviews with staff ongoing about the importance of labeling and dating all food items including beverages and desserts. Dietary Manager revealed the importance of dating and labeling food to identify the food or beverage items along with to ensure the residents receive the correct food and beverages. Dietary Manager revealed she is responsible for ensuring dietary staff were storing food properly. She stated the beverages and food items were supposed to be dated and labeled. She stated improper food storage could cause harm to residents such as food borne illnesses. Interview with [NAME] A on 2/10/25 at 11:43am revealed labeling, dating, and covering beverages and food items are examples of food safety practices. [NAME] A revealed unlabeled, undated, and uncovered food could become contaminated and make the residents sick. Interview with Dietitian on 2/11/25 at 9:23am revealed unlabeled, undated, and uncovered food and beverage items could lead to food borne illness. Record review of the facility policy titled Infection Control Policy/Procedure Dietary Services, dated as revised 05/2007, revealed the policy statement, It is the policy of this facility to prevent contamination of food products and therefore prevent foodborne illness. Procedure revealed 1. Director of Food Service Responsibilities A. Provide safe food services for residents and employes. Under the Proper Food Handling section, letter K revealed Leftovers must be dated, labeled, covered, cooled and stored (within 1/2 hour) in refrigerator, not at room temperature. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Food and Drug Administration Food Code dated 2017 reflected, .3-302.12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food 3-305.11 Food Storage. (A) .food shall be protected from contamination by storing the food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination .(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on observations, interviews, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 6 (Resident #34, Resident #16 and Resident #36) residents reviewed for infection control. 1. CNA A failed to perform hand hygiene while performing incontinent care for Resident #34. 2. CNA A failed to perform hand hygiene while performing incontinent care for Resident #16. 3. CNA E failed to perform hand hygiene while performing incontinent care for Resident #36. These failures could place residents at risk for infection through cross contamination of pathogens. Findings included: 1. Record review of Resident #34's Admission Record dated 2/9/25 reflected a [AGE] year-old female admitted to the facility on [DATE]. Record review of Resident #34's Quarterly MDS assessment dated [DATE] reflected her BIMS assessment was not completed. She had functional limitation to both upper and lower extremities. She was dependent on staff for toileting, bathing, dressing, transfers, and personal hygiene. She was incontinent of bowel and bladder. Her diagnoses included kidney failure; septicemia (life-threatening infection that spread to bloodstream); acute cystitis with hematuria (bladder infection with blood in the urine); and quadriplegia (partial or complete paralysis up upper and lower limbs). She received dialysis. Record review of Resident #34's BIMS assessment dated [DATE] reflected a score of 14 which indicated she was cognitively intact. Record review of Resident #34's Care Plan reflected the following entry: Has bowel/bladder incontinence. Interventions included: Monitor/document for s/sx UTI : pain, burning, blood-tinged urine, deepening of urine color, increased pulse, increased temp . Date initiated 11/7/22. During an observation and interview on 2/9/25 at 10:05 AM, Resident #34 was awake and sitting up in bed. She stated the staff were coming soon to get her up to her chair because she slept in that morning. CNA A arrived, sanitized her hands, and gathered items needed for incontinent care. She donned gloves, lowered the resident's brief, and cleaned her perineal area appropriately. CNA A assisted Resident #34 to turn onto her side and cleaned her buttocks. The resident's skin was intact. CNA A then removed the soiled brief and placed a clean one without changing her gloves. She placed the soiled brief and wipes into the trash, removed her gloves, and sanitized her hands. She proceeded to assist Resident #34 with selecting items to wear. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #16's Admission Record dated 2/9/25 reflected a [AGE] year-old female originally admitted to the facility on [DATE]. Record review of Resident #16's Quarterly MDS assessment dated [DATE] reflected she had a BIMS score of 12 indicating moderately impaired cognition. Her diagnoses included stroke, aphasia (language disorder affecting speech); hemiparesis (muscle weakness or partial paralysis on one side); depression; gastrostomy (feeding tube); and muscle wasting and atrophy (loss of muscle mass and strength). She had limited range of motion in all limbs. She was usually understood and usually understood others. She was dependent on staff for all ADLs, was incontinent of bowel and bladder. Record review of Resident #16's Care plan reflected the following: Has bowel/bladder incontinence r/t cognitive deficit secondary to history of CVA . Interventions included: Check as required for incontinence. Wash, rinse, and dry perineum . Monitor/document for s/sx UTI: pain, burning, blood-tinged urine, deepening of urine color, increased pulse, increased temp . Date initiated 10/25/22. During an observation and interview on 2/9/25 at 12:25 PM, RN B was observed entering Resident #16's room and asked her if she needed to be changed and the resident nodded. RN B informed her she would be right back. CNA A entered the room carrying wipes. She washed her hands and donned a gown and gloves. She began incontinent care by cleaning Resident #16's perineal area from front to back. She assisted the resident to turn onto her left side and continued cleaning her. Resident #16 was observed to have had a large watery bowel movement, some of which was observed on the pad beneath her. CNA A removed the soiled brief and pad then placed a fresh brief beneath the resident without removing her gloves. Resident #16 began to have another bowel movement and CNA A told her she would give her a few minutes to let her finish. She bagged the soiled brief and pad and reached for a fresh brief while wearing the same gloves. RN B entered the room, washed her hands, donned a gown and gloves, and moved to the opposite side of the bed to assist the CNA. Resident #16 stated she thought she was finished, and CNA A began cleaning her again then replaced the soiled brief with a clean one. She placed a fresh pad beneath the resident and bagged the soiled brief and wipes, removed her gloves, sanitized her hands, and replaced her gloves. CNA A and RN B positioned Resident #16 for comfort. CNA A doffed her gown and gloves and washed her hands. CNA A stated she should change her gloves and sanitize her hands before and after providing care. When asked whether she should have changed her gloves between handling dirty and clean pads and briefs, she replied, No, I think I should have, it makes sense. She stated the risk of handling clean items with soiled gloves was the spread of infection. RN B stated they should change gloves and sanitize hands between handling dirty and clean items to prevent cross contamination. She stated she had not noticed that CNA A was using the same gloves. 3. Review of Resident #36's Face Sheet, dated 02/11/25, reflected she was a [AGE] year-old female, who initially admitted to the facility on [DATE], with diagnoses including major depressive disorder (a mental health condition that can cause persistent feelings of sadness and hopelessness) and anxiety disorder (a mental health condition that involves excessive fear, worry, or dread). Review of Resident #36's MDS Assessment, dated 12/28/24, reflected she was always incontinent of bladder and bowel. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #36's Care Plan, initiated on 01/31/24, reflected she was incontinent of bladder and bowel. Her care plan reflected she required the use of briefs and staff assistance for incontinent care. Observation from the hallway on 02/09/25 at 9:55AM revealed Resident #36's door was open as CNA E was providing incontinent care. On 02/09/25 at 9:59AM, CNA E was observed to bring a bag of used incontinence supplies out of the room and throw it away. She then went through the clean linen cart to gather fresh linens. At no point after providing incontinent care did CNA E use hand washing or hand hygiene prior to accessing the linen cart. During an interview with CNA E on 02/09/25 at 10:07AM, she stated she normally performed hand washing and/or hand hygiene after completing incontinent care. She did not think to do so with Resident #36 because she was trying to get her assigned tasks completed. She stated the risk of not performing hand washing and/or hand hygiene was that infection could spread. During an interview with the Director of Nursing on 02/09/25 at 1:38PM, she stated the expectation was for the facility staff providing incontinent care to perform hand hygiene before starting care, when changing gloves (such as when the gloves were dirty), and after care (including after discarding supplies). The Director of Nursing stated the risk of not completing proper hand hygiene/hand washing was the spread of infection. Record review of the facility policy titled, Hand Washing, dated reviewed 07/2014 reflected: Policy: It is the policy of this facility to cleanse hands to prevent transmission of possible infectious material and to provide clean, healthy environment for residents and staff. Purpose: Hand washing/ hand hygiene is generally considered the most important single procedure for preventing the transmission of infection. Antiseptics control or kill microorganisms contaminating skin and other superficial tissues and are sometimes composed of the same chemicals that are used for disinfection of inanimate objects . Except for situations where hand washing is specifically required, antimicrobial agents such as alcohol-based hand rubs are also appropriate for cleaning hands and can be used for direct care . For specific handwashing and waterless hand hygiene procedures, this facility refers to CDC's most current guidelines. Review of the CDC website on 2/11/25 reflected https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, Clinical Safety: Hand Hygiene for Healthcare Workers .Know when to wear and change gloves . When to wear gloves. When needed for Standard Precautions (when you anticipate that you will come in contact with blood or other infectious materials, mucous membranes, non-intact skin, potentially contaminated skin, or contaminated equipment) When to change gloves and clean hands . If gloves become damaged; If gloves become soiled with blood or body fluids after a task; If moving from work on a soiled body site to a clean body site on the same patient or if a clinical indication for hand hygiene occurs; If moving from care on one patient to another patient. If they look dirty or have blood or body fluids on them after completing a task; Before exiting a patient room. 35747