STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676189	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Legacy at Willow Bend	6101 Ohio Ste 500 Plano, TX 75024

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 42971 47690 48560 Based on observations, interviews, and record review the facility failed to provide the necessary services for residents who were unable to carry out activities of daily living to maintain good grooming and personal hygiene for 4 (Resident #8, Resident #3, Resident #29, and Resident #13) of 24 residents reviewed for ADLs. The facility failed to ensure: 1- Resident #8 had his fingernails cleaned and trimmed. 2- Resident #3 had his fingernails cleaned and trimmed. 3- Resident #29 had her fingernails cleaned and trimmed. 4- Personal care and skin care was provided for Resident #13 by trimming his fingernails. These failures could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections, and a decreased quality of life. Findings included: 1- Review of Resident #8's Admission MDS assessment dated [DATE] reflected Resident #8 was a [AGE] year-old male with initial admitted to the facility on [DATE]. His diagnoses included Hypertension (high blood pressure), Obstructive uropathy (urine cannot drain through the urinary tract), Diabetes mellitus (increased blood glucose levels), Hyperlipidemia (increased blood lipid levels), Cerebrovascular accident (interruption of blood flow to the brain). Resident #8 had a BIMS score of 10 which indicated Resident #8 had moderate cognitive impairment. Resident #8 required moderate assistance with personal hygiene. Review of Resident #8's Comprehensive Care Plan, revised 08/22/24, reflected the following: Focus: [Resident #8] Risk for Self-Care Deficit: Bathing, Dressing, Feeding. Goal: [Resident #8] Will Be Able to Perform Self-Care Needs. Interventions: Provide assistance with ADLs / ADLs as needed. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 09/17/24 at 09:05 AM with Resident #8 revealed nails on both hands were approximately 1.0 centimeter in length extending from the tip of his fingers and had black areas underneath the nails. Resident #8 stated he would like his nails to be cleaned and trimmed by a staff member but was not offered during his stay at the facility. In an interview on 09/17/24 at 09:17 AM with CNA H revealed that most ADL's such as hair trimming, and nail clipping was completed during shower times. She revealed that since Resident #8 was a Diabetic resident, LVNs or RNs were responsible for clipping his nails. CNA H stated that fingernail clipping should be done weekly or as needed and the risk of not cleaning/ trimming fingernails could be increased risk of infection. In an interview on 09/17/24 at 09:45 AM with RN I revealed that there were no specific days for nailcare, but it should be offered each time during showering. RN I also stated that Nurses were responsible for clipping fingernails for diabetics, after they are notified by the CNAs. He stated that he was not aware that Resident #8 needed fingernail cleaning or trimming. RN I stated that ADLs were monitored daily and the risk to the resident for failure to provide ADL including nail care was increased risk of infection. 2- A record review of Resident #3's Quarterly MDS assessment dated [DATE] reflected Resident #3 was a [AGE] year-old male originally admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including diabetes mellitus, lack of coordination, and speech and language deficits following cerebral infarction (a serious condition that occurs when blood flow to the brain is reduced or blocked, causing brain tissue to die). Resident #3 had a BIMS score of 3 which indicated Resident #3's cognition was severely impaired. He required partial assistance with personal hygiene. A record review of Resident #3's Comprehensive Care Plan, revised 05/02/24, reflected the following: Focus: [Resident#3] has an ADL self-care performance deficit related to impaired balance .Interventions: . Personal hygiene, nail care: [Resident #3] is totally dependent on 1 staff for personal hygiene and oral care. An observation and interview on 09/17/24 at 10:37 AM revealed Resident #3 was sitting in the recliner in his room. The nails on both hands were long and dirty. The fingernails on both hands were approximately 0.5 inches long and had dirt underneath the nails. The private sitter at the bed side stated since Resident #3 was diabetic she could not trim his fingernails. She stated she did not tell the facility staff about his fingernails needing to be trimmed and cleaned. In an interview with CNA A on 09/17/24 at 10:42 AM, she stated CNAs and LVNs were responsible for nail care. She stated if a resident has diabetes, only nurses were allowed to provide nailcare. She stated the risk for not performing nailcare was an increased risk of infection. She stated Resident #3 was diabetic; she would notify the nurse. 3- A record review of Resident #29's Quarterly MDS assessment dated [DATE] reflected Resident #29 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included cerebral infarction (a serious condition that occurs when blood flow to the brain is reduced or blocked, causing brain tissue to die), and hemiplegia (a condition that causes partial or complete paralysis on one side of the body) affecting left side. Resident #29 had a BIMS score of 7 which indicated Resident #29's cognition was severely impaired. She required extensive assistance of two-person physical assistance with personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #29's Comprehensive Care Plan, revised 08/02/24, reflected the following: Focus: [Resident #29] has an ADL self-care performance deficit. Interventions: . Personal hygiene: Resident is totally dependent on staff for personal hygiene. An observation and interview on 09/17/24 at 11:55 AM revealed Resident #29 was laying in her bed. The nails on the right hand were approximately 0.3 centimeter in length extending from the tip of her fingers. The nails were chipped. The nails on the left, contracted, hand were approximately 0.5 centimeter in length extending from the tip of her fingers. Resident #29 stated she did not like her fingernails that long and she stated she did not tell the nurse. In an interview with CNA C on 09/17/24 at 12:01 PM, he stated CNAs and LVNs were responsible for nail care. He stated if a resident has diabetes, only nurses were allowed to provide nailcare. He stated the risk for not performing nailcare was an increased risk of infection and risk to scratch and break the skin. He stated Resident #29 was not diabetic; he would trim her nails. In an interview with the DON on 09/19/24 at 11:37 AM revealed her expectation was that nail care should be provided as needed, especially during shower time. She stated that CNAs were responsible for doing nail care unless the resident had a diagnosis of diabetes. She also stated that as the DON, either herself or her designee were responsible to do routine rounds for monitoring. The DON stated that residents having long, and dirty fingernails could be an infection control issue and cause skin breakdown. 4.Record review of Resident #13's face sheet, dated 09/18/24, reflected Resident #13 was an [AGE] year-old male originally admitted to the facility on [DATE], and readmitted on [DATE]. Resident #13 had diagnoses of hypertension (elevated blood pressure), Diabetes mellitus, kidney transplant status, and muscle wasting and atrophy. Record review of Resident #13's MDS assessment, dated 03/31/24, reflected he had a BIMS score of 13 indicating he was cognitively intact. Resident #13 was dependent on staff to complete ADLs of bed mobility, dressing, and personal hygiene. Record review of Resident #13's Comprehensive Care Plan, dated 09/09/24, reflected the following: Focus: the resident has an ADL self-care performance deficit . Interventions: Personal Hygiene/oral care, nail care: the resident is totally dependent on (1) staff for personal hygiene In an observation/interview on 09/18/24 at 8:13 AM, the nails on both of Resident #13's hands were approximately 0.3 cm in length extending from the tip of his fingers. Resident #13 stated he liked his fingernails trimmed. In an interview/observation on 09/18/24 at 8:15 AM with LVN E revealed she looked at Resident #13's fingernails, and stated Resident #13's fingernails were long, and were supposed to be trimmed, but Resident #13 refused fingernail trimming. Resident #13 stated he liked his fingernails trimmed. LVN E replied that was new to her. LVN E stated it was the responsibility of the nurses to make sure residents' fingernails were trimmed and cleaned. LVN E stated the risk to the residents could be the development of infection and skin tears. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON on 09/19/24 at 11:37 AM revealed her expectation was that nail care should be provided as needed, especially during shower time. She stated that CNAs were responsible for doing nail care unless the resident had a diagnosis of diabetes. She also stated that as the DON, either herself or her designee were responsible to do routine rounds for monitoring. The DON stated that residents having long, and dirty fingernails could be an infection control issue and cause skin breakdown. Record review of the facility policy titled personal Care. Subject: Fingernails, care of dated 05/22/22 reflected: It is the policy of this community to establish procedures to clean the nail bed, to keep nails trimmed, and to prevent infections .1. Nails care includes daily cleaning and regular trimming

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for one of three residents (Resident #14) reviewed for catheter care. The facility failed to ensure CNA A maintained Resident #14's indwelling urinary catheter (a tube that drains urine from the bladder) drainage bag was below the bladder level during wound care on 09/17/24. This failure placed residents at risk for infection . Findings included: A record review of Resident #14's Quarterly MDS assessment dated [DATE] reflected Resident #14 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including neuromuscular dysfunction of bladder (a condition that causes bladder control issues due to damage to the brain, spinal cord, or nerves), retention of urine, and pressure ulcer of the left buttock. Resident #14 had a BIMS score of 15 which indicated Resident #14's cognition was intact. She required extensive assistance of two-person physical assistance with bed mobility and transfer. Record review of Resident #14's care plan initiated on 12/01/21 reflected, [Resident #14] has indwelling suprapubic catheter (a catheter that drains urine from the bladder by inserting a tube through the abdominal wall and into the bladder) related to neurogenic bladder . Interventions: Catheter: . Position catheter bag and tubing below the level of the bladder and away from entrance room door . Review of Resident #14's Order Summary report dated September 2024, reflected, Suprapubic catheter site: cleanse the wound with normal saline pat dry, apply silver alginate and gauze daily. with a start date of 07/11/24. Observation on 09/17/24 at 10:55 AM revealed RN B entered Resident #14's room to do wound treatment. CNA A entered Resident #14's room to assist RN B. CNA A unhooked the catheter bag from the bed rail and put it flat on the foot of the bed, above the resident's bladder. RN B provided wound care to the left buttock wound. During the procedure urine was observed flowing back toward the resident's bladder. RN B finished the treatment and then CNA A hooked the catheter bag onto the bed rail. In an interview with RN B on 09/17/24 at 11:40 AM she stated she was focused on the treatment; she did not pay attention that the CNA put the urine bag on the bed. She stated the catheter bag and tubing were supposed to be kept below the bladder. She stated failing to do this could cause the urine to back up and might cause an infection. In an interview with CNA A on 09/17/24 at 11:44 AM, she stated she was trained to always keep the catheter drainage bag below the bladder. She stated she did not know why she put the bag on the bed. She stated having it above the bladder could possibility cause the urine to run backwards, which could cause an infection. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 09/19/24 at 11:37 AM she stated any resident with a foley catheter should always have the bag and tubing below the bladder. She stated not keeping the foley catheter bag below the resident's bladder, placed them at risk of urinary tract infection and cross contamination. She stated to ensure staff were knowledgeable in the care of indwelling catheters the facility does skills competency checks and she stated the ADON , and Charge Nurses made daily rounds and watched care. She stated when staff needed to be re-trained, she provided the in-service training. Record review of CNA A's competency check off for catheter care revealed she was proficient in care as of 07/03/24. Review of the facility's policy titled, Urinary Catheter Care reflected, . The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48560 Based on observation, interview, and record review the facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 1 of 3 Residents (Resident #210) reviewed for respiratory care. The facility failed to ensure Oxygen (O2) in use signage was on Resident #210's doorway. This failure could place residents at risk of not receiving appropriate respiratory care. The finding were: Review of Resident #210's face sheet dated 9/17/2024 revealed he was an [AGE] year-old-male admitted to the facility on [DATE]. His diagnoses included: Congestive heart failure (heart cannot pump enough blood to meet body's needs), acute respiratory failure (disease that affects breathing), chronic kidney disease (kidneys are damaged and cannot filter blood adequately), Obstructive and reflux uropathy (urine cannot drain through the urinary tract). Record review of Resident #210's Physician Orders dated 9/11/2024 reflected, Oxygen at 2 Liter per minute via nasal cannula as needed to keep O2 Saturation more than 92%. Record review of Resident #210's Baseline care plan dated 09/11/24, reflected Oxygen therapy - while a resident. In an observation and interview on 09/17/24 at 11:06 AM with resident #210 revealed Resident #210 was on Oxygen via nasal cannula. Resident #210 stated he had been on Oxygen since admit to the facility for breathing difficulty. Observed Resident #210's room did not have signage for Oxygen in use outside the door. In an interview on 09/17/24 at 01:10 PM with LVN K revealed that it was her first day working with Resident #210 since he was a new admit to the facility. She stated that he had orders for Oxygen in the electronic health record. She stated that Resident #210 was on Oxygen therapy since admit that was 9/11/24 and there should be a signage on the door for oxygen in use to alert other staff members. She stated that nurses were responsible for putting up the signage. She stated that the risk of not having signage outside Resident's room was decreased quality of care by not meeting resident's care needs. In an interview on 09/19/24 at 11:01 AM with the DON, she stated her expectation was if the resident is on Oxygen therapy, then signage for Oxygen in use should be on the door. She stated floor nurses were responsible for putting the signage on the door. She stated that the facility was a nonsmoking facility. She stated the risk of not having appropriate signage on the door was during emergency or evacuation , the staff may not be aware that resident was dependent on Oxygen therapy and portable oxygen needed to be arranged. She added the risk of inadequate signage was Resident will not receive the care they need, and quality of care will be compromised. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility policy titled Oxygen Storage dated 05/13/2022 reflected, . 3. Signage will be placed on the doorway of each resident room housing oxygen to notify that oxygen is in use.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 42971 Based on observation, interview and record review the facility failed to provide pharmaceutical services to ensure the accurate acquiring, receiving, dispensing, and administering of medications for one of one Resident (Resident #9) and one (Nurses Cart Hall 500) of 3 medication carts reviewed for pharmacy services in that: The facility failed to ensure RN B, responsible for Nurses Cart Hall 500, removed Resident #9's medications in unsecure containers from the Nurses Cart. This failure could place residents at risk of not having the medication available due to possible drug diversion and at risk of not receiving the intended therapeutic benefit of the medication because of possible diminished effectiveness. The findings include: Observation on 09/17/24 at 10:14 AM of Nurses Cart Hall 500, with RN B revealed the blister pack for Resident #9's diazepam 5 mg tablet (controlled medication used for anxiety) had 6 blister seals broken and the pills still inside the broken blisters were taped over. Interview on 09/17/24 at 10:28 AM, RN B stated the narcotic count was done at shift change and the count was correct. She stated she did not check the blister packs during the count . She stated she was unaware when the blister pack seals were broken, and she was not aware of who might have damaged the blisters and taped them over. She stated the risk would be a potential for drug diversion and we did not know the pills in the taped-over blisters were actually diazepam. She stated the nurses and medication aides were responsible to check the medication blister packs for broken seals during the count of narcotics during the change of the shift. She stated when a broken seal was observed, she would report it to the DON and would discard the pill with another nurse. Interview on 09/19/24 at 11:37 AM, the DON stated she expected if a blister pack medication seal was broken the pill should be discarded. The DON stated it would not be acceptable to keep a pill in a blister pack that was opened. The DON stated the risk would be potential for drug diversion and infection control issue. She stated nurses were responsible for checking the medication blister packs for broken seals during the count on the change of shifts. The DON stated the ADON, and the DON were supposed to check the carts weekly for monitoring. Record review of the facility's policy titled Storage of Medication, dated 1/27/24, revealed in part .4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48560 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 for the facility's only kitchen in that: 1. The facility failed to ensure food items in the facility freezer were labeled and had use-by dates. 2. The facility failed to ensure Dietary Server G used appropriate hair restraint in the kitchen. These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness, and food contamination. Findings included: Observation on 09/17/24 at 08:02 AM in the facility's walk-in freezer revealed some kind of meat in a gallon size clear plastic storage bag was not labeled or dated. Observation on 09/17/24 at 08:03 AM in the facility's walk-in freezer revealed Brussel sprouts in a gallon sized clear plastic storage bag were not dated. Observation on 09/17/24 at 08:06 AM in the facility's walk-in freezer revealed frozen potato fries in a gallon sized clear plastic storage bag were not dated or labeled. Observation on 09/17/24 at 08:07 AM in the facility's walk-in freezer revealed sweet potato fries in a gallon-sized clear plastc storage bag that was half filled and did not had a use-by date. Observation on 09/17/24 at 08:12 AM revealed Dietary Server G, who was serving breakfast to the residents, was frequently visiting the kitchen prep area and the dining hall did not wear effective hair restraint. Observed Dietary Server G had her bangs outside of the hair restraint and her hair at the back of the head were not secured under the hair restraint. In an interview on 09/17/24 at 08:09 AM with [NAME] F revealed that she did not work the day before, so she was not sure why the food products in the facility freezer were not dated or labeled. She stated that everyone in the kitchen including cooks, dietary aides and Food Service Manager was responsible for dating and labeling all food items in the kitchen. She stated that the risk for residents for not dating and labeling food items was residents could get sick or food borne illness. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview 09/18/24 at 01:34 PM with the Dietary Manager stated it was his expectations that all the food items in the kitchen should be dated or labeled. He stated that everyone in the kitchen including the cooks, dietary aides and himself was responsible for labeling and dating food items with Use-by dates. He also stated that it was also his expectation that all dietary staff entering the kitchen area should always wear a hair restraint in a manner that all the hair is restrained appropriately. He stated that he had provided in-services for all kitchen staff in the past that included wearing appropriate hair restraints and dating/labeling food items. He stated that not labeling/dating food items or not wearing adequate hair restraints could cause food borne illness in residents. In an interview on 09/19/24 at 09:08 AM with Dietary Server G revealed that she had worked in the facility for one year as a dietary server. She stated she knew that she had to wear hair restraint such that it covers all the hair before entering the kitchen area. She stated that hair net may have moved and hence her bangs and back of the hair was exposed outside of the hairnet. She stated that the risk to residents if effective hair restraint was not worn would be residents getting hair in their food that could make them sick. Record review of the facility policy titled, Good Hygienic practices for food service employees revised 3/11 revealed, .Hair Restraints: Nutrition Service employees will wear hair restrains such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively control and keep their hair from contacting exposed food, clean equipment, utensils, and linens; and unwrapped single-service and single use articles . Record review of the facility policy titled, Stock Dating revised 3/11, reflected, POLICY STATEMENT: Stock will be routinely dated when received in the facility for the purpose of assuring proper stock rotation Date stock with date of delivery (per facility policy and state regulations). Review of the Food and Drug Administration Food Code, dated 2022, reflected, 2-402.11 Effectiveness. (Hair Restraints) .1. Code of Federal Regulations, Title 21, Sections 110.10 Personnel (6) Wearing, where appropriate, in an effective manner, hair nets, head bands, caps, beard covers, or other effective hair restraints. Review of the Food and Drug Administration Food Code, dated 2022, 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.(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676189	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Legacy at Willow Bend	6101 Ohio Ste 500 Plano, TX 75024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47690 Based on observation, interview and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for two of 12 residents (Resident #23 and Resident #210) observed for infection control. 1. CNA D failed to perform hand hygiene while providing incontinence care to Resident #23. 2. The facility failed to ensure CNA A wore appropriate PPE while providing care to Resident #210 who was on Enhanced Barrier Precaution. These failures placed residents at risk for spread of infection through cross-contamination. Findings include: 1.Record review of Resident #23's face sheet dated 9/18/24 reflected he was an [AGE] year old male. He was originally admitted to the facility on [DATE] and readmitted on [DATE]. He was admitted with diagnoses of hypertension (high blood pressure), dementia (loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), and depression. Review of Resident #23's care plan initiated 12/09/22 reflected the resident had an ADL self-care performance deficit related to impaired balance and the intervention was the resident required maximum assistance by (1) staff for toileting. Observation on 09/18/24 at 10:36 AM revealed CNA D entered Resident #23's room to provide incontinent care for the resident. CNA D washed his hands in the bathroom, and donned gloves. CNA A cleaned the resident and removed the dirty brief. CNA D then placed the dirty brief in the trash can and cleaned the resident's bottom. After cleaning the resident, without any form of hand hygiene or change of gloves, CNA D put the clean brief underneath the resident, and applied the barrier cream to Resident #23's bottom. CNA D changed gloves without any form of hand hygiene, fastened the resident's brief, and assisted the resident to position in bed. After care, CNA D completed hand hygiene. In an interview on 09/18/24 at 10:45 AM with CNA D, he stated he was supposed to complete hand hygiene before and after caring for a resident. CNA D stated after cleaning the resident he was supposed to clean his hands and change gloves before applying the clean brief. CNA D stated he was supposed to complete hand hygiene to prevent the spread of infection. CNA D stated he had completed a hand hygiene and infection control in-service about two months ago. In an interview on 09/19/24 at 11:00 AM with the DON, she stated infection control was important during care. The DON stated during care the staff were to use the hand sanitizer or wash hands if they were physically soiled. The DON stated the staff were expected to complete hand hygiene before care and after care, she also stated during incontinent care the staff were supposed to change gloves and use hand sanitizer when taking off the dirty brief before applying the clean one. The DON stated hand hygiene was to be completed for infection control. DON said she was the infection preventionist and in-service on infection control was completed within a month ago. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of inservices reflected the facility completed an in-service on 07/05/24 for hand hygiene for CNA D. 2. Resident #210 Review of Resident #210's face sheet dated 9/19/2024 revealed he was an [AGE] year-old-male admitted to the facility on [DATE]. His diagnoses included: Congestive heart failure (heart cannot pump enough blood to meet body's needs), acute respiratory failure (disease that affects breathing), chronic kidney disease (kidneys are damaged and cannot filter blood adequately), Obstructive and reflux uropathy (urine cannot drain through the urinary tract). Record review of Resident #210's Physician Orders dated 9/13/24 reflected, Continue FOLEY CATHETER, size 20 French every day and night shift. Record review of Resident #210's care plan dated 9/18/2024 reflected, Focus: [Resident #210] have a condition that requires Enhanced Barrier Precautions as related to Foley Catheter and Oxygen. Goal: Infection control intervention to reduce the transmission of Multidrug- resistant organisms. Intervention: Follow Enhanced Barrier Precaution guidelines when providing care and coming in direct contact with potentially infected material or devices that put [Resident #210] at risk. Direct care activities including dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting and incontinence care, Device use, Catheter, Trach/Vent, central lines, feeding tubes, wound care and/or skin opening requiring a dressing. Set up isolation per facility protocol. Follow the enhanced barrier guidelines. Observation on 09/18/24 at 10:36 AM revealed Resident #210's room had enhanced barrier precaution (EBP) signage on the door of the room. Resident #210 was on the bed with Oxygen running via Nasal cannula and had a foley catheter. CNA A entered the room, performed hand hygiene, donned gloves, but did not don a gown. CNA A, along with the other CNA present in the room (who had already donned gloves and gown) helped Resident #210 to sit up at the edge of the bed. CNA A then proceeded to attach a gait belt on Resident #210 and checked to see if the gait belt was secured. CNA A and other CNA then helped the resident to slide over from the bed to the weighing scale and then from the weighing scale to the wheelchair in the room while holding on to Resident #210's gait belt. CNA A then proceeded to remove her gloves and performed hand hygiene. In an interview on 09/18/24 at 11:15 AM with CNA A revealed she does not work on Resident #210's hall. She was only tasked to weigh the resident that morning. She stated that she saw the EBP sign on the door but was not familiar with the resident's care. She stated that an Enhanced barrier precaution sign was for residents who had wounds, G-tubes or Foley catheters and PPE including gloves and gowns should be worn during direct care contact with the resident. She stated that since she helped the resident with attaching the gait belt and helped him slide over from the bed, that would be considered as direct contact and she should have donned the gown. She stated that the risk for not wearing adequate PPE that included gown was lapses in infection control and contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/19/24 at 11:04 AM with the DON stated her expectation was nursing staff should wear adequate PPE while providing direct care activities to a resident who has Enhanced Barrier precautions. She stated direct care activities included: bathing, changing, transferring, weighing with assistance, etc. She stated the risk of not donning adequate PPE for EBP residents was increased spread of infections. She stated that as the DON and the Infection preventionist in the facility, she provided education to all nursing staff about adequate PPE, conducted random observation rounds and talked to the residents if they had seen any lapses in infection control to ensure adequate quality of care within the facility. She stated that CNA A had received her latest skill check on 07/03/24 for transfers and PPE. Record review of CNA A Skill checks dated 07/03/24 revealed, CNA A successfully completed annual competency evaluation for PPE and Transfers from bed to chair. Record review of the facility policy titled Infection Control- Subject: Enhanced Barrier Precaution dated 6/24/24 reflected, .A. Used for the following . 2. Indwelling medical devices regardless of MDRO status (Examples: Central line/PICC line, urinary catheter, feeding tube, tracheostomy etc.) . C. Enhanced Barrier Precautions are used when specific, high contact resident care activities are performed (Examples: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care or use, and wound care etc.) . F. Use of PPE (Personal Protective Equipment) 1. Perform hand hygiene per policy . prior to donning PPE 2. [NAME] gown prior to performing the above listed high-contact resident care activities . Record review of US Center for Disease Control and prevention reflected, . Enhanced Barrier Precautions: Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html. Review of the facility policy dated 10/15/23 and titled Hand washing/Hand Hygiene reflected, 1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infection.9. The use of gloves does not replace hand washing/ hand hygiene. Integration of gloves use along with routine hand hygiene is recognized as the best practice of preventing healthcare-associated infections. 48560