STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676215	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation & Wellness Centre of Dallas LLC	4200 Live Oak St Dallas, TX 75204

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50222 Based on observation, interview, and record review, the facility failed to ensure each resident was treated with respect and dignity for 5 (Residents #16, #13, #26, #18 and #45) of 10 residents observed in the dining room for dignity. A. Activity Coordinator A was observed standing next to seated Resident #16 and Resident #13 while providing assistance with eating. B. ADON A was observed using a cell phone while sitting at the table with Resident #13 and Resident #26 that required assistance with eating. C. Resident #45 had exposed tubing from her wound vacuum-assisted closure device draped from her ankle, across the side of her wheelchair, to the machine on the back of the wheelchair while sitting at the table in the dining room during lunch. D. Resident #18 was eating their meal for over six minutes before Resident #13, who was sitting at the same table, was provided a tray. This failure placed residents at risk of experiencing diminished quality of life, loss of dignity, and could negatively affect their psychosocial well-being. Findings included: Record review of Resident #16's Face Sheet dated 05/31/24 revealed Resident #16 was [AGE] years old with diagnoses of Parkinson's disease, cognitive communication deficit, and dysphagia (difficulty swallowing). Record review of Resident #16's MDS dated [DATE] revealed Resident #16 required partial or moderate assistance (helper does less than half the effort) eating. Record review of Resident #16's Care Plan dated 04/16/24 stated Resident #16 should be offered tray set-up and verbal cueing while eating. Record review of Resident #13's Face Sheet dated 05/30/24 revealed Resident #13 was [AGE] years old with diagnoses of Alzheimer's disease and dysphagia (difficulty swallowing). (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #13's MDS dated ,d+[DATE]/ 24 revealed Resident #13 requires one-person physical assistance while eating. Record review of Resident #13's Care Plan dated 02/27/24 revealed Resident #13 should be monitored for chewing and swallowing problems. Record review of Resident #26's Face Sheet dated 05/30/24 revealed Resident #26 was [AGE] years old with a diagnoses of dehydration, dysphagia (difficulty swallowing), and dementia (impaired memory). Record review of Resident #26's MDS dated [DATE] revealed Resident #26 required supervision with one-person physical assistance while eating. Record review of Resident #26's Care Plan dated 02/27/24 stated to provide hands on assistance during meals. Record review of Resident #45's Face Sheet dated 05/30/24 revealed Resident #45 was [AGE] years old with a diagnoses of anxiety, schizoaffective disorder (mental health disorder), and cognitive communication deficit. Record review of Resident #45's Care Plan dated 04/16/24 revealed the Resident #45 required treatment and interventions for the treatment of anxiety, depression, mood disorder, behavior management, schizophrenia. Observation on 5/28/24 at 12:10 p.m., Activity Coordinator A was standing between Resident #16 and #13 while assisting with eating their lunch. Observation on 5/29/24 at 12:24 p.m., ADON A was observed sitting at a table with Resident #26 and Resident #13. Resident #13 and Resident #26 stared at their plates and did not eat while ADON A looked down at a cell phone. ADON A swiped the cell phone screen with her thumbs for over two minutes before ADON A looked up and sat the cell phone in her lap. ADON A then assisted Resident # 26 by placing silverware in the resident's hand and cued Resident #13 to take a bite of food. Observation on 5/29/24 at 12:42 p.m., ADON A was observed sitting at a table with Resident #26 and Resident #13. Resident #13 and Resident #26 stared at their plates and did not eat while ADON A looked down at a cell phone. Observation on 5/30/24 at 12:12 p.m., Resident #45 was observed sitting at a dining room table and had exposed tubing from her wound vacuum-assisted closure device draped from her ankle, across the side of her wheelchair, to the machine on the back of the wheelchair. Fluids were visible going through tubing to the machine. Observation on 5/30/24 at 12:12 p.m., Resident #18 was observed eating for over six minutes before Resident #13 was provided a tray. Observation on 5/30/24 at 12:18 p.m., Activity Coordinator A was observed standing next to seated Resident #13 while assisting Resident #13 with eating. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 5/30/24 at 12:15 p.m., Activity Coordinator A reported Resident #13's tray was on another warming cart and would be brought to the resident when the cart arrives. In an interview on 5/30/24 at 12:32 p.m., Activity Coordinator A stated everybody at a table should be served at the same time. Activity Coordinator A stated she was unsure if she should have waited until Resident #13's tray arrived to serve Resident #18. Activity Coordinator A stated she was unsure if Resident #45 always had wound VAC tubing exposed or if it should be covered but would ask the nurse. In an interview on 5/30/24 at 12:34 p.m., ADON A stated they should try to keep wound VAC tubing as private as possible and use a privacy bag for the machine. ADON A stated the wound VAC machine did not fit in the current privacy bag and would get a different one. In an interview on 5/30/24 at 12:53 p.m., the DON stated he expected staff to be attentive during dining and that when he was a CNA he sat with his residents to promote a home-like environment. The DON stated he encouraged staff to sit with residents while feeding. The DON stated the greatest concern if wound VAC tubing is exposed is dignity and the least amount of tubing possible should be visible. Record review of the facility's policy titled Abuse/Reportable Events with an effective date of 12-1-2018, stated This facility establishes an environment that is as homelike as possible and includes a culture and environment that treats each resident with respect and dignity. It also states, Treating a nursing home resident in any manner that does not uphold a resident's sense of self-worth and individuality dehumanizes the resident.

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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** 44021 Based on observation, interview, 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 5 of 8 residents (Resident #'s 45, 18, 17, 9, and 67) reviewed for accommodation of needs, in that: The facility failed to ensure: Residents #'s 45, 18, 17, 9, and 67 had either unwanted facial hairs (Resident #'s 45, 18, and 17 female residents) and or long, dirty, or untrimmed nails (residents #'s 9 and 67). This failure placed residents at risk of not receiving services/care with reasonable accommodation of their needs and preferences, feelings of not being listened to, and depression. Findings include: Record review of Resident # 45's Face Sheet revealed the resident had an original admitted [DATE] with diagnoses which included Cellulitis of right lower limb (Primary, Admission), Cough, unspecified, Acute respiratory failure with hypercapnia (elevated levels of Carbon Dioxide in the blood), Unspecified diastolic (congestive) heart failure. Record review of Resident # 45's MDS dated [DATE] reflected a BIMS score of 15 out of 15, which suggested no cognitive impairment (no difficulty making decisions that affected everyday life and care). Continued review showed substantial/maximal staff assistance for daily care, including personal hygiene. Record review of Resident 45's Care Plan dated 4/16/24 read, in part, [Resident #45] has an ADL self-care performance deficit and requires assistance by staff in all Activities of Daily Living (ADL's), 2 staff members for bed mobility and toileting, 1 staff member for transfers, bathing, dressing, grooming, personal hygiene. Eating with set up tray assist. During an observation in the dining room on 5/29/24 at 12:03 PM, Resident # 45 was sitting up in motorized wheelchair at the dining table. Resident #45's wheelchair was observed to have a frayed right armrest, the resident appeared to have facial hair on and below her chin. She stated that she had noticed that it was frayed and that she would like it to be repaired but did not know who to tell about it. She stated that it did not seem to bother her skin yet. She stated that she had not been told about having facial hair but would very much like it to be shaved off. Record review of Resident # 18's Face sheet revealed the resident had an original admitted [DATE] with diagnosis of Encephalopathy (disorder that affects structure or function of brain), unspecified (Primary, Admission), Cauda equina syndrome (compression of nerves at base of spine), Muscle wasting and atrophy, not elsewhere classified, unspecified site, Muscle weakness (generalized), Cognitive communication deficit. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident # 18's MDS dated [DATE] reflected a BIMS score of 12 out of 15, which suggested moderate cognitive impairment. Continued review showed substantial/maximal staff assistance for daily care, including personal hygiene. Record review of Resident # 18's Care Plan dated 5/21/24 read in part, that [Resident #18] has an ADL self-care performance deficit and requires assistance by staff in all Activities of Daily Living (ADL's), 2 staff members for bed mobility and toileting, 1 staff member for transfers, bathing, dressing, grooming, personal hygiene. Eating with set up tray assist. During an observation and interview on 5/28/24 at 10:56 AM, Resident # 18 was observed to be sitting comfortably in a wheelchair, the left armrest on the wheelchair appeared to have cracked and half of the armrest cushion appeared to be missing entirely. The resident's nails appeared to be long and tinged yellow with some dirt under them. The resident stated that he did not like to have long nails and that he wished someone would trim them more often for him. Record review of Resident # 17's Face Sheet revealed the resident had an original admitted [DATE] with diagnoses which included Interstitial pulmonary disease (progressive scarring of the lung tissue), unspecified (Primary, Admission), Urinary tract infection, other speech and language deficits following cerebral infarction, Pneumonia, Acute upper respiratory infection. Record review of Resident # 17's MDS dated [DATE] reflected a BIMS score of 00 out of 15, which suggested severe cognitive impairment. Continued review showed total/maximal staff assistance for daily care, including personal hygiene. Record review of Resident 17's Care Plan dated 5/07/24 read, in part, [Resident #17] has an ADL self-care performance deficit and requires assistance by staff in all Activities of Daily Living (ADL's), 2 staff members for bed mobility and toileting, 2 staff member for transfers, bathing, dressing, grooming, personal hygiene. During an observation and interview of on 5/28/24 at 11:13 AM, Resident #17 was observed to have untrimmed, long nails on both hands, the nails appeared to have some dirt accumulation under them. The resident was unable to respond to questions. During the observation of Resident # 17, CNA H entered the room and stated that Resident #17's nails should have been trimmed, she stated that she had seen Resident # 17's nails longer. She denied that the resident or his family had any objection or instructions to keep Resident #17's nails long or untrimmed. She stated that she would trim Resident # 17's nails later that evening when she would administer a bed bath for the resident. Record review of Resident # 9's Face sheet revealed the resident had an original admitted [DATE] with diagnoses of Cerebral palsy, unspecified (Primary, Admission), Diarrhea, Urinary tract infection, site not specified, Depression, Anxiety disorder due to known physiological condition. Record review of Resident # 9's MDS dated [DATE] reflected a BIMS score of 07 out of 15, which suggested severe cognitive impairment. Continued review showed total/maximal staff assistance for daily care, including personal hygiene. Record review of Resident # 9's Care Plan dated 5/07/24 read, in part, [Resident #9] Requires extensive assist of 1 staff member for all ADL functions except eating with set up tray assist. Set-up, assist, give shower, shave, oral, hair, nail care per schedule and PRN. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 5/29/24 at 12:40 PM, Resident # 9 was observed to have facial hair on her chin, she stated that it would be nice if someone would help her with her chin hairs because she would never want to have them. She stated that none of the staff had mentioned that she had any chin hairs. Record review of Resident # 67's Face sheet revealed the resident had an original admitted [DATE] with diagnoses of Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (Primary), Depression, unspecified, Gastro-esophageal reflux disease without esophagitis (chronic heart burn). Record review of Resident # 67's MDS dated [DATE] reflected a BIMS score of 08 out of 15, which suggested moderate cognitive impairment. Continued review showed minimal staff assistance for daily care, including personal hygiene. Record review of Resident # 67's Care Plan dated 4/24/24 read, in part, [Resident #67] Requires minimal assist of 1 staff member for all ADL functions. ADLs Functional Status/Rehabilitation Potential Residents ADL Functions: Bed Mobility: assist x 1, Transfers: assist x 1, Dressing: assist x 1, Eating: assist x 1, Toileting: assist x 1, Personal Hygiene: assist x 1, Bathing: assist x 1. Assist, give-- shower, shave, oral, hair, nail care per schedule and as needed. During an observation and interview on 5/28/24 at 3:01 PM, Resident #67 was observed to have very long toenails and facial hair consisting of several long hairs on and below her chin. She stated that she thinks a podiatrist came around last month but she was not entirely sure, she stated that she didn't know who to ask to shave off her facial hair but that she did not want facial hair and hoped a staff member could help her with getting rid of the chin hairs. In an interview on 5/30/24 at 3:20 PM with the DON, he stated that residents should have their nails trimmed and female residents should always be offered to have any unwanted facial hair shaved off for them. Long nails could cause injury to residents and male residents may find it embarrassing to have long nails. Female residents should have unwanted facial hair attended too, as having unwanted facial hair could cause the residents emotional harm or embarrassment. Record review of the facility's policy titled Activities of Daily Living dated December 2018, reflected in part .it is the policy of this home to assure residents have their activities of daily living met .Grooming: Encourage residents with nail trimming and grooming .assist residents with shaving .makeup application.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44021 Based on observations, interviews, and record review, the facility failed to ensure all assistive devices and overbed tables were maintained and free of hazards for three (Residents #9, #18, and #45) of eight residents reviewed for essential equipment. The facility failed to properly maintain wheelchairs for Residents #9, #18, and #45. These failures could place residents at risk for equipment that was in unsafe operating condition, which could cause injury. Findings included: Record review of Resident # 9's Face sheet revealed the resident had an original admitted [DATE] with diagnosis of Cerebral palsy, unspecified (Primary, Admission), Diarrhea, Urinary tract infection, site not specified, Depression, Anxiety disorder due to known physiological condition. Record review of Resident # 9's MDS dated [DATE] reflected a BIMS score of 07 out of 15, which suggested severe cognitive impairment. Continued review showed total/maximal staff assistance for daily care, including use of a wheelchair. Record review of Resident # 9's Care Plan dated 5/07/24 read, in part, [Resident #9] Requires extensive assist of 1 staff member for all ADL functions. Resident requires a wheelchair, Resident sleeps in the wheelchair with bedside table in front of her with a pillow on top. During an observation and interview on 5/29/24 at 12:40 PM, Resident # 9 was observed to have a frayed and cracked armrest on the right side of her wheelchair. Resident #9 stated that she sleeps in her wheelchair and is in it nearly all day and that it would be nice to have a new arm rest to replace the broken one. Record review of Resident # 18's Face sheet revealed the resident had an original admitted [DATE] with diagnoses of Encephalopathy (disorder that affects structure or function of brain), unspecified (Primary, Admission), Cauda equina syndrome (compression of nerves at base of spine), Muscle wasting and atrophy, not elsewhere classified, unspecified site, Muscle weakness (generalized), Cognitive communication deficit. Record review of Resident # 18's MDS 5/09/24 reflected a BIMS score of 12 out of 15, which suggested moderate cognitive impairment. Continued review showed substantial/maximal staff assistance for daily care, including use of a wheelchair. Record review of Resident # 18's Care Plan dated 5/21/24 read in part, that [Resident #18] has an ADL self-care performance deficit and requires assistance by staff in all Activities of Daily Living (ADL's), 2 staff members for bed mobility and toileting, 1 staff member for transfers, bathing, dressing, grooming, personal hygiene. Transfers to and from wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 5/28/24 at 10:56 AM, Resident # 18 was observed to be sitting comfortably in a wheelchair, the left armrest on the wheelchair appeared to have cracked and half of the armrest cushion appeared to be missing entirely. Resident #18 stated that he didn't think that he had not suffered any scratches from the missing part of the armrest on his wheelchair, but that it may be more comfortable if it was replaced. Record review of Resident # 45's Face Sheet revealed the resident had an original admitted [DATE] with diagnoses which included Cellulitis of right lower limb (Primary, Admission), Cough, unspecified, Acute respiratory failure with hypercapnia (elevated levels of Carbon Dioxide in the blood), Unspecified diastolic (congestive) heart failure. Record review of Resident # 45's MDS dated [DATE] reflected a BIMS score of 15 out of 15, which suggested no cognitive impairment (no difficulty making decisions that affected everyday life and care). Continued review showed substantial/maximal staff assistance for daily care, including personal hygiene. Record review of Resident 45's Care Plan dated 4/16/24 read, in part, [Resident #45] has an ADL self-care performance deficit and requires assistance by staff in all Activities of Daily Living (ADL's), 2 staff members for bed mobility and toileting, 1 staff member for transfers, bathing, dressing, grooming, personal hygiene. Eating with set up tray assist. During an observation in Resident # 45 in the dining room on 5/29/24 at 12:03 PM, Resident # 45 was sitting up in motorized wheelchair at the dining table. Resident 45's wheelchair was observed to have a frayed right armrest. She stated that she really hadn't noticed but that it would be nice to have a new armrest for her chair. In an interview on 5/30/24 at 3:05 PM, the Maintenance Supervisor stated that he was responsible for the repair of wheelchairs and if the residents needed other equipment replaced. He stated he kept a maintenance logbook at the nurse's station, but the staff tell him, they do not use the book. The Maintenance Supervisor stated he had not had any staff members tell him about any wheelchairs needing repair. The Maintenance Supervisor stated that if the equipment was not in working ordered it could cause injuries. In an interview 05/30/24 3:20 PM, the DON stated that armrests on wheelchairs that were damaged or missing could cause skin degradation for the resident and that wheelchair armrests should be repaired at all times for the comfort and safety of the residents. Record review of the Maintenance log dated 1/01/2024 through 5/30/2024 at the nurse's station, reflected no entries for wheelchair armrest repair. A review of the facility's policy and procedure Adaptive Devices and Equipment dated December 2022 reflected Policy Statement Our facility maintains and supervises the use of assistive devices and equipment for residents . 6. The following factors and addressed to the extent possible to decrease the risk of available accidents associated with devices and equipment . c. Devices condition-devices and equipment are maintained on schedule and according to manufacturer's instructions. Defective or worn devices are discarded or repaired

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 44021 Based on observation, interview, and record review the facility failed to post the following information on a daily basis: (1) Current date. (2) The total number and the actual hours worked by Register Nurses, Licensed Vocational Nurses, Certified nurse's aides, and Resident census at the beginning of each shift in a prominent place readily accessible to residents and visitors. The facility did not post and maintain the required staffing information from May 23, 2024, to May 28, 2024. This failure could place residents and visitors at risk of not knowing how many nursing staff were on duty and the actual hours worked per shift daily. Findings include: During an observation on 05/28/24 at 9:49 AM, Nursing Staffing Information dated 05/23/24 was posted up in the facility main entrance visible to all residents and visitors. In an interview on 05/28/24 at 9:50 AM, the ADM stated that hours should be posted so that both family members and residents are aware of how many staff might be in the building during each shift. Without that information, residents and visitors may feel that there are not enough staff to sufficiently care for their loved ones . Policy review of a document dated 12/2017 entitled Nursing Policy and Procedure, Posting Nurse Staff Information and Report revealed that It is the policy of this home to post staff information daily.the nurse staffing data must be posted at the beginning of each shift.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070 Based on observation, interview and record review, the facility failed to ensure it was free of a medication error rate of five percent (5%) or greater for 10 of 80 opportunities during medication pass resulting in an 12 percent (12%) error rate for 5 (Residents #130, #32, #3, #13, and #43) of 8 residents observed for medication pass . 1. MA E failed to administer Resident #130's Potassium 20 meq (potassium supplement) and Eliquis 2.5mg (blood thinner) in a timely manner. 3. MA E failed to administer Resident #32's Eliquis 5mg (blood thinner) in a timely manner. 4. MA E failed to administer Resident #3's Eliquis 5mg (blood thinner) and Prostat 30ml (protein supplement for wound healing) in a timely manner. 6. MA F failed to administer Resident #13's Carbi/dopa [NAME] doppa 10mg/100mg (for Parkinson diseases) and Ropinirole 0.25mg (restless) in a timely manner. 8. MA F failed to administer Resident #43's Baclofen 5mg (muscle relaxer), Eliquis 5mg (blood thinner), and Lyrica 150mg in a timely manner. These failures could place residents at risk for not receiving therapeutic dosages of their medications as ordered by the physician and a decreased health status. Findings included : Observation on 05/28/24 at 10:20 a.m., revealed MA E administered the following medication to Resident #130 Potassium 20 meq and Eliquis 2.5mg. Review of Resident #130's Physician's Order dated 09/27/18 and updated 05/08/24 reflected, Potassium 20 meq one three times a day at 9:00 a.m.,1:00 p.m. and 5:00 pm. Observation on 05/28/24 at 10:34 a.m., revealed MA E administered the following medication to Resident #32 Eliquis 5 mg. Review of Resident #32's physician's order dated 05/28/24 reflected Eliquis 5 mg 1 PO QD at 9:00 a.m. Observation on 05/28/24 at 10:51 a.m., revealed MA E administered the following medications to Resident #3, Eliquis 5mg and prostat liquid 30 mg . Review of Resident #3's physician's order dated 05/01/24 reflected the following: Eliquis 5mg 1 tab PO at 9:00 a.m. and 5:00 p.m. and prostat liquid protein 30 ml BID at 9:00 a.m. and 5:00 p.m. Observation on 05/28/24 at 11:00 a.m., revealed MA F administered the following medications to Resident #13, Carbidopa levodopa 10mg/100mg and Ropinirole 0.25mg. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #13's physician orders dated 05/01/24 reflected the following: Carbidopa levodopa 10mg/100mg BID at 8:00 a.m. and 4:00 p.m. and Ropinirole 0.25mg TID at 8:00 a.m., 12 :00 p.m., and 4:00 p.m. Observation on 05/28/24 at 11:38 a.m., revealed MA F administered the following medications to Resident #43, Baclofen 5mg and Lyrica 150 mg and Eliquis 5mg. Resident #43's physician orders dated 05/01/24 reflected the following: Baclofen 5mg TID at these times 9:00 a.m.,1:00 p.m., and 5:00 pm and Lyrica 150mg TID at 9:00 a.m., 1:00 p.m., and 5:00 p.m. In an interview on 05/30/24 at 2:00 p.m., the DON revealed the staff have an hour before and after the administration time if given later it is considered late. The DON stated the staff should be giving the medications at the time they are ordered, if the staff is unable to give the medications timely, they are not communicating with me about it. The DON stated, the medication aides, and the nurses have plenty of time to let me know these things. In an interview at 05/28/24 at 11:15 a.m., MA E revealed she knew she had an hour before and after the ordered administration time, it was impossible sometimes to get them all their medications within the two-hour time frame. MA E stated sometimes I have to come back because the therapist is there working with them in the room, or the resident does not want the medication at that time. MA E stated she had not reported that she had problems sometimes giving the medications timely. In an interview on 05/28/24 at 11:45 a.m., MA F revealed she knew what the time frame was for the medications that had been ordered, but sometimes it was impossible to give them during that time frame because the resident did not want at that time, they were in the shower, they were in therapy, so they get their medications when they want them. MA F stated she had not communicated this to the charge nurse, or the DON . Review of the facility policy and procedure Medication Administration dated December 2018 reflected, It is the policy of this home that medications will be administered and documented as ordered by the physician and in accordance with state regulations 8. Medications are administered within 60 minutes of scheduled time, unless otherwise specified by the physician

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The Rehabilitation & Wellness Centre of Dallas LLC	4200 Live Oak St Dallas, TX 75204

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070 Based on interview and record review, the facility failed to ensure residents were free of significant medication errors for four (Resident #130, #32, #3, and #43) of eight residents administered medications by MA E and MA F reviewed for significant medication errors . MA E failed to administer Eliquis (blood thinner) on 05/28/24 as ordered by the physician for Resident's #130, #32, and #3. MA F failed to administer Resident #43's Eliquis 5mg on 05/28/24 as ordered by the physician. This failure placed residents who were ordered to receive blood thinner at risk of not receiving their medications as ordered by the physician, resulting in blood clot and clinical complications. Findings included: Record review of Resident #130's admission MDS assessment, dated 05/26/24, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #130 had diagnoses which included: chronic pain (constant pain), chronic heart failure (heart's inability to pump blood through), and anxiety (nervousness). Resident #130 was cognitive and able to make decisions and required assistance of one staff for activities of daily living. Observation on 05/28/24 at 10:20 a.m., revealed MA E administered the following medication to Resident #130 including Eliquis 2.5mg. Record review of Resident #130's physician orders dated 05/20/24 reflected, Eliquis (blood thinner) 2.5mg give one tab by mouth BID (two times a day at 9:00 a.m. and 5:00 p.m .) Interview with Resident #130 on 5/28/24 at 1:29 p.m., revealed Resident #130 stated she received her Eliquis medication at different times of the day, sometimes it was early in the morning and sometimes it was later in the morning like today and she was concerned about blood clotting . Resident #130 stated she had not told anyone. Interview on 05/28/24 at 1:32 p.m., MA E stated she told Resident #130 that she was running behind this morning, because of the weather, and that her Eliquis medication was given with the other medications, that she was supposed to give it around 9:00 a.m. MA E stated Eliquis was for preventing clots, almost everyone here is on some kind of blood thinner. MA E stated she was unaware of anything concerning a medication error report concerning time . Review of Resident #130's MAR dated 05/01/24 reflected the following: On 05/28/24 at 10:20 a.m., Resident #130's Eliquis 2.5mg (blood thinner) was administered late, and its scheduled time was 9:00 a.m. (Resident #130 received her medications at 10:20 a.m.) The MAR had it documented under the option of other, indicating the documentation was late. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #32's admission MDS assessment, dated 05/20/24, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #32 had diagnoses which included: hypertension (elevated blood pressure), chronic heart failure (heart's inability to pump blood through), and diabetes (high blood sugar). Resident #32 was cognitive and able to make decisions and required assistance of one staff for activities of daily living. Observation on 05/28/24 at 10:34 a.m., revealed MA E administered the following medication to Resident #32 including Eliquis 5 mg. Record review of Resident #32's physician orders dated 05/15/24 reflected, Eliquis (blood thinner) 5 mg give one tab by mouth BID (two times a day) at 9:00 a.m. and 5:00 p.m. Review of Resident #32's MAR dated 05/01/24 reflected the following: On 05/28/24 at 10:32 a.m., Resident #32's Eliquis 5mg (blood thinner) was administered late, and its scheduled time was 9:00 a.m. Further documentation of the MAR reflected the late documentation was under other indicating the documentation was late. Record review of Resident #3's other payor source MDS assessment, dated 04/26/24, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included: hypertension (elevated blood pressure), chronic heart failure (heart's inability to pump blood through), and diabetes (high blood sugar). Resident #3 was cognitive and able to make decisions and required assistance of one staff for activities of daily living. Observation on 05/28/24 at 10:51 a.m., revealed MA E administered the following medication to Resident #3 including Eliquis 5mg . Record review of Resident #3's physician orders dated 05/10/24 reflected, Eliquis (blood thinner) 5mg give one tab by mouth BID (two times a day), at 9:00 a.m. and 5:00 p.m. Review of Resident #3's MAR dated 05/01/23 reflected the following on 05/28/24 at 10:51 a.m., Resident #3's Eliquis (blood thinner) was administered late, and its scheduled time was 9:00 a.m. (Resident #3 received her medication at 10:51 a.m.). Record review of Resident #43's quarterly MDS assessment, dated 04/06/24, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #43 had diagnoses which included: multiple sclerosis (nerve and muscle disease), and essential hypertension (high blood pressure). Resident #43 was cognitive and able to make decisions and required assistance of one staff for activities of daily living. Observation on 05/28/24 at 11:38 a.m., revealed MA F administered the following medication to Resident #43 including Eliquis 5mg. Record review of Resident #43's physician orders dated 05/10/24 reflected, Eliquis (blood thinner) 5mg one tab by mouth BID (two times a day) at 9:00 a.m. and 5:00 p.m. Review of Resident #43's MAR dated 05/01/24 reflected the following: On 05/28/24 at 11:38 a.m., Resident #43 Eliquis (blood thinner) 5mg was administered late, and its scheduled time was 9:00 a.m. (Resident #43 received her medications at 11:38 a.m.). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident #43 on 5/28/24 at 1:39 p.m., revealed Resident #43 stated she received her Eliquis medication at different times of the day, it is usually almost lunch time on most days like today and she was concerned about blood clotting . Resident # 43 stated that she had not reported to any one, she just took the medications when they brought them to her. In an interview on 05/28/24 at 1:45 p.m., MA F revealed she knew what the time frame was for the medications that had been ordered, but sometimes it was impossible to give them during that time frame because the resident did not want at that time, they were in the shower, they were in therapy, so they get their medications when they want them. MA F stated she had not communicated this to the charge nurse, or the DON. MA F stated Eliquis was for preventing blood clots. MA F stated if you give medications wrong you are supposed to report to the charge nurse. She said she had not done that she was giving the medications when she could. Interview with the DON on 05/30/24 at 2:50 p.m., revealed he had worked at the facility for six months. The DON stated he expected to be notified from all med aides and nurses if medication was given late. The DON stated all medications to the resident per physician order was to prevent the residents from complications including prevent blood clot from missing Eliquis. The DON stated there is policy medications that are given late, they should be reported as a medication error to me. The DON stated he would be in-serving on the appropriate way to perform a medication pass and when to communicate with him concerning, problems related to the medication pass. Review of the facility's policy on Medications-Unusual Occurrences, dated December 2018, revealed, It is the policy of this home to administer medications within the standards of practice . A medications error occurs when a medication is administered in any manner that is inconsistent with the physician's order for the medication. Medication errors include , but not limited to administering the wrong medication, administering at the wrong time

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 27070 Based on observation, interviews, and record review the facility failed to ensure that medications were secure and inaccessible to unauthorized staff and residents for 8 (eight doses IV medication) of eight left at the nurse's station, for Floor 200 unsupervised. The facility failed to ensure IV antibiotics were stored in locked compartments and not left at the nurse's station unsupervised. This failure could result in residents having access and ingestion of medications leading to a risk for harm and possible drug diversion. Findings included: In an observation and interview on 05/28/24 at 9:40 a.m., approximately 8 antibiotic IV bags of Nafcillin 2g/50ml in 100mL NS to be administered via PICC line Q4 hours. was at the nurse's station unsupervised with no staff around. This Surveyor continued to observe for approximately 10 minutes the unsupervised drugs. LVN G came out of the medication room and stated she was responsible for the medications. LVN G got an overbed table and placed all the IV antibiotic bags on it, then walked back into the medication room, leaving the medications unsupervised for another 5 minutes. The DON came to the nurse's station, as LVN G came out of the medication room, communicated to LVN G about the medication, at which time LVN G picked up all the IV bags, and placed them in the locked medication room. LVN G returned with one IV bag she said she was going to administer to Resident #129. In an observation on 05/28/24 at 9:45 a.m., with LVN G of the medication left at the nurse's station revealed: for Resident #129 Nafcillin (antibiotic) 2g/50ml in 100mL NS to be administered via PICC line Q4 hours. Rate of administration: 100mL/hr through the triple lumen that is in the upper left arm. Resident #129's PICC line area was checked by LVN G for redness through the occlusive dressing and was good no redness or swelling noted . The IV is delivered over the hour, then flushed again with the N/S 10 mls -as MD ordered. LVN G stated Resident #129 an interview on 05/28/24 at 9:50 a.m. with LVN G revealed she knew the IV bags were supposed to be locked up in the medication room, but with all the bad storms and staff being late to work, she had gotten disorganized. LVN G stated that the medications left unattended anyone could pick those up and that would not be safe, it could harm them. In an interview on 05/30/24 at 2:00 p.m., the DON stated it was his expectation that the IV antibiotics that was at the nurse's station be secured, if they were not being given by the nursing staff. The DON stated that the nurses were responsible to keep the medications locked either in the medication carts or in the medication room, when not in use. He stated if the medications were not locked up, residents and unauthorized staff could get the medications and there would be opportunities for harm and medication diversion. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Policy and Procedure Medication Storage dated December 2018, reflected, It is the policy of this home that medications will be stored appropriately as to be secure from tampering, exposure or misuse . 2. Only licensed nurses, . and those lawfully authorized to administer medications are allowed access to medications . medications and supplies are locked or attended by person with authorized access .

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 44021 Based on interview and record reviews the facility failed to maintain documentation and demonstrate evidence of its ongoing QAPI program for 1 of 1 facility reviewed for QAPI. The facility failed to maintain documentation of QAPI meetings prior to June of 2024. This failure placed residents at risk of maintaining and improving safety and quality of life. Findings included: Record review of QAPI meetings revealed: Facility had maintained QAPI meeting minutes from 08/2023 to 02/2024. No signed QAPI team signature sheets were found from 03/2024 to 05/2024. During an interview on 05/29/24 at 1:30 PM, the ADM stated he and the staff had been scouring the ADM office for evidence of previous QAPI meetings with no success. He said he became the temporary ADM in May of 2024, and his staff was unable to locate where the former ADM had placed the meeting minutes or signature sheets. During an interview on 05/30/24 at 1:24 PM, the ADM said that he and the staff was unable to locate any other QAPI documented meetings after Feb of 24 and that he did not have any proof that meetings occurred or were fully attended for the last three months. He stated that without monthly meetings the facility would not be alert to problems and not be able to create resolutions or assess problems and the effectiveness of solutions . Record review of QAPI policy dated 1/12/2027 revealed: The facility will conduct monthly meetings to monitor and evaluate all areas of facility services and practices . Establish systems and processes to maintain documentation relative to the QAPI program, as a basis for demonstrating that there is an effective ongoing program .All attending team members will sign in on the attached sheet at each meeting.

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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** 27070 Based on observation, interview, 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 6 of 7 (CNA A, CNA B, LVN C, CNA D, MA E, and MA F) staff members and 14 of 15 residents (Resident #3, #13, #22, #32, #43, #44, #46, #50, #64, #129, #130, #131, #132, & #150) reviewed for infection control procedures. CNA A, CNA B, LVN C, and CNA D failed to perform hand hygiene after direct contact with Residents #50, #22, #46, #132, #44, and #64 while serving meals on the hallways. MA E failed to disinfect the blood pressure cuff (machine used for checking blood pressure) in between blood pressure checks for Residents #130, #3, and #32. MA F failed to disinfect the blood pressure cuff in between blood pressure checks for Residents #13 and #43. LVN C failed to wash her hands or use hand sanitizer after removing her gloves when using the glucometer machine (an instrument for measuring the concentration of glucose in the blood) between resident use, for Residents #131 and #132. This failure could place residents at risk for cross contamination and infections. Findings included : Record review of Resident #50's quarterly MDS assessment, dated 05/26/24, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #50 had diagnoses which included: chronic kidney disease (kidney work slow), hypertension (high blood pressure), and diabetes (high blood sugar). Resident #50 was cognitive and able to make decisions and required assistance of one staff for activities of daily living. Record review of Resident #22's other payment MDS Assessment, dated 03/19/24, revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #22 had diagnoses which included: spinal stenosis (pain in the spine), hypertension (increased blood pressure), and osteoporosis (bone is deteriorating). Resident #22's, severely impaired for cognition and required one staff for assistance with activities of daily living. Record review of Resident #46's admission MDS Assessment, dated 05/01/24, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #46 had diagnoses which included: Diabetes (increased sugar levels). Resident #46 was cognitively able to make decisions and required one staff for assistance with activities of daily living. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #132's admission MDS Assessment, dated 03/15/24, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #132 had diagnoses which included: Diabetes (high blood sugar), Osteomyelitis (infection of the bone), and diastolic heart failure (the heart unable to pump blood correctly). Resident #132 was cognitively able to make decisions and required assistance of one staff for activities of daily living. Record review of Resident #44's other payment MDS Assessment, dated 04/09/24, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #44 had diagnoses which included: Diabetes (high blood sugar), and respiratory failure (lungs not able to work properly). Resident #44 was severely impaired for cognition cognitively and required assistance of two staff for activities of daily living. Record review of Resident #64's admission MDS Assessment, dated 05/21/24, revealed a [AGE] year-old female who admitted to the facility on [DATE]. Resident #64 had diagnoses which included: multiple rib fractures left side (broken ribs left side), lack of coordination (unable to mobilize safely), and unsteadiness on feet (not safe walking). Resident #64 was cognitively able to make decisions and required assistance of one staff for activities of daily living. Record review of Resident #130's admission MDS assessment, dated 05/26/24, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #130 had diagnoses which included: chronic pain (constant pain), chronic heart failure (heart's inability to pump blood through), and anxiety (nervousness). Resident #130 was cognitive and able to make decisions and required assistance of one staff for activities of daily living. Record review of Resident #130's physician orders dated 05/20/24 reflected, Digoxin (heart failure) 1.25mg give one tab by mouth one time a day, Furosemide (for fluid buildup) 40mg give one tab by mouth one time a day, Lidocaine patch (for pain) 5% apply to back one time a day and to obtain blood pressure one time a day on each shift. Record review of Resident #3's other payor source MDS assessment, dated 04/26/24, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included: hypertension (elevated blood pressure), chronic heart failure (heart's inability to pump blood through), and diabetes (high blood sugar). Resident #3 was cognitive and able to make decisions and required assistance of one staff for activities of daily living. Record review of Resident #3's physician orders dated 05/10/24 reflected, Amiodarone (irregular heartbeat) 200 mg give one tab by mouth one time a day, Lasix (for fluid buildup) 40mg give one tab by mouth one time a day, and to obtain blood pressure one time a day on each shift. Record review of Resident #32's admission MDS assessment, dated 05/20/24, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #32 had diagnoses which included: hypertension (elevated blood pressure), chronic heart failure (heart's inability to pump blood through), and diabetes (high blood sugar). Resident #32 was cognitive and able to make decisions and required assistance of one staff for activities of daily living. Record review of Resident #32's physician orders dated 05/15/24 reflected, Amiodarone (irregular heartbeat) 200 mg give one tab by mouth one time a day, Metoprolol (high blood pressure) 25 mg give one tab by mouth one time a day, and to obtain blood pressure one time a day on each shift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #13's annual MDS assessment, dated 05/24/24, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #13 had diagnoses which included: essential hypertension (elevated blood pressure), tachycardia (fast, irregular heart rate), and diabetes (high blood sugar). Resident #13 was unable to make decisions and required assistance of one staff for activities of daily living. Record review of Resident #13's physician orders dated 05/10/24 reflected, Diltiazem (high blood pressure) 120 mg give one tab by mouth one time a day, and to obtain blood pressure one time a day on each shift. Record review of Resident #43's quarterly MDS assessment, dated 04/06/24, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #43 had diagnoses which included: multiple sclerosis (nerve and muscle disease), and essential hypertension (high blood pressure). Resident #43 was cognitive and able to make decisions and required assistance of one staff for activities of daily living. Record review of Resident #43's physician orders dated 05/10/24 reflected, Metoprolol (for high blood pressure) 25mg one tab by mouth one time a day, and to obtain blood pressure one time a day on each shift. Record review of Resident #131's admission MDS Assessment, dated 05/25/24, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #131 had diagnoses which included: Diabetes (high blood sugar), malignant neoplasm of bone (cancer of the bone), and pneumonia (infection of the lungs). Resident #131 was cognitively able to make decisions and required assistance of one staff for activities of daily living. Record review of Resident #131's physician orders dated 05/25/24 reflected, Humalog Kwik Pen subcutaneous solution pen-injector100 unit/ml (insulin) as sliding scale, before meals and at bedtime. Record review of Resident #132's admission MDS Assessment, dated 03/15/24, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #132 had diagnoses which included: Diabetes (high blood sugar), Osteomyelitis (infection of the bone), and diastolic heart failure (the heart unable to pump blood correctly). Resident #132 was cognitively able to make decisions and required assistance of one staff for activities of daily living. Record review of Resident #132's physician orders dated 05/05/24 reflected, insulin lispro insulin pen-injector100 unit/ml (insulin) as sliding scale, before meals and at bedtime. Observation on 05/28/24 at 10:20 a.m., revealed MA E performing morning medication pass, during which time she checked the blood pressure on Resident #130. MA E failed to sanitize the blood pressure cuff before or after using it on Resident #130. Observation on 05/28/24 at 10:34 a.m., revealed MA E performing morning medication pass, during which time she checked the blood pressure on Resident #32. MA E failed to sanitize the blood pressure cuff before or after using it on Resident #32. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/28/24 at 10:51 a.m., revealed MA E performing morning medication pass, during which time she checked the blood pressure on Resident #3. MA E failed to sanitize the blood pressure cuff before or after using it on Resident #3. Observation on 05/28/24 at 11:00 a.m., revealed MA F performing morning medication pass, during which time she checked the blood pressure on Resident #13. MA F failed to sanitize the blood pressure cuff before or after using it on Resident #13. Observation on 05/28/24 at 11:38 a.m., revealed MA F performing morning medication pass, during which time she checked the blood pressure on Resident #43. MA F failed to sanitize the blood pressure cuff before or after using it on Resident #43. Observation on 05/28/24 at 12:03 p.m., revealed LVN C performed a blood sugar test on Resident #131. LVN C sanitized the glucometer machine (an instrument for measuring the concentration of glucose in the blood) and then entered the room wearing gloves. LVN C did not wash her hands or use hand sanitizer after removing gloves. Observation on 05/28/24 at 12:05 p.m., revealed LVN C performed a blood sugar test on Resident #132. LVN C sanitized the glucometer machine (an instrument for measuring the concentration of glucose in the blood) and then entered the room wearing gloves. LVN C did not wash her hands or use hand sanitizer after removing gloves. Observation on 05/28/24 beginning at 12:30 p.m., revealed CNA A, CNA B, LVN C, and CNA D had walked down the hallway, did not use hand sanitizer, and served a lunch tray to Residents #11, touched, and moved the overbed table in the resident's room, touched the hand and shoulder of Resident #50, , Resident #22, Resident #46, Resident #132, Resident #44, and Resident #64. Each staff member prepared the meal tray for the resident to eat their lunch. The CNAs and LVN did not have on gloves. The CNAs was observed to not wash their hands or use hand sanitizer, available in the hallway. Observation on 05/28/24 beginning at 12:40 p.m., CNA A, CNA B and CNA D was observed to enter the east end of Floor 200 to serve lunch trays. The CNAs opened the tray service cart and started to pull trays without washing hands or using hand sanitizer. The DON approached the staff and instructed them to all use hand sanitizer prior to and between meal service. An interview on 05/28/24 at 10:55 a.m., MA E stated she did not think about cleaning the blood pressure cuff between usage. MA E stated she wore gloves between each usage when she took the blood pressure and used hand sanitizer, but she did not think the cuff needed to be cleaned. MA E stated if the cuff was on the residents and then not cleaned it could spread germs to others. An interview on 05/28/24 at 11:45 a.m., MA F stated she did not think about cleaning the blood pressure cuff between usage. MA F stated she knew she was supposed to use the sanitizing wipes between each usage when she took the blood pressure, but she did not think about it. MA F stated if the cuff was not cleaned appropriately, it could spread germs to others. (continued on next page)

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	676215	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation & Wellness Centre of Dallas LLC	4200 Live Oak St Dallas, TX 75204

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 05/28/24 at 1:45 p.m., CNA A stated he did not complete hand hygiene after having direct contact with residents. CNA A stated he was supposed to use the hand sanitizer in between serving each tray and wash hands with soap and water after the third tray from the hall cart. CNA A said he had been educated on completing hand hygiene. CNA A stated he did not sanitize his hands, because he was nervous and trying to get the lunch trays served before the food got cold. An interview on 05/28/24 at 2:45 p.m., LVN C revealed the nurses checked the meal tickets to make sure they are the correct diet being served to the resident. LVN C stated she was trying to help serve the trays so that food did not get cold, and she did not think about the hand sanitizer, since it was not direct resident care, it was just moving the overbed table and setting up the tray for them. Further interview with LVN C revealed she thought if she wore gloves for all her blood sugar checks she was protecting herself and the residents from spreading any germs because she was changing her gloves every time, between each blood sugar check and when she cleaned her glucometer. An interview with the DON on 05/30/24 at 2:00 p.m., revealed that all staff must complete hand hygiene after having contact with residents. He stated CNAs and LVNs were trained to wash their hands with soap and water prior to tray service, then use hand sanitizer between each tray and on the third tray they are to use soap and water and wash their hands. The DON stated if the CNAs do not use appropriate hygiene, they can spread germs to the residents and themselves. Record review of an undated in-service log revealed CNA A, CNA B, LVN C, and CNA D received handwashing and hand sanitizing training, to prevent the spread of infection. Further review of in-service logs revealed an in-service conducted on 05/15/24 reflected: when passing trays in the hallways, sanitize after going in every room. Remember to wash your hands after every third use of hand sanitizer. Record review of the Facility's Policy titled Infection control dated December 2018 reflected: 1. all personnel shall be trained be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections 2. all personnel shall follow the handwashing/hand hygiene procedure to help prevent the spread of infections to, other personnel, residents, and visitors 5. Employees must wash their hands c. before and after direct resident contact g. before and after assisting a resident with meals Record review of the Facility's Policy titled Infection control-Cleaning and Disinfecting Resident Care items and Equipment dated December 2018 reflected: It is the policy of this home to clean and disinfect resident-care equipment, including reusable items and durable medical equipment . non critical items are those that come in contact with intact skin but not mucous membranes . non-critical resident-care items include bedpans, blood pressure, cuffs

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070 Based on observation, interview and record review, the facility failed to maintain an effective pest control program for 1 of 1 facility reviewed for pests in that: Gnats were observed in multiple areas of the facility. This failure could affect residents by placing them at an increased risk of exposure to pests and vector-borne diseases and infections. Findings included: Observation on 05/28/24 at 9:17 a.m., revealed three gnats in the conference room crawling on the table. Observation on 05/28/24 at 9:39 a.m., revealed three gnats in the conference room flying round the surveyor. Observation on 05/28/24 at 9:40 a.m., revealed a gnat crawling across the nurse's station. Observation on 05/28/24 at 9:45 a.m., revealed a group of gnats flying down Hall 200. Observation and interview on 05/28/24 at 9:55 a.m., revealed a gnat crawling on the medication cart on Floor 200. Interview with LVN C revealed that this time of the year was bad for gnats. LVN C stated she did not see the pest control man at the facility. LVN C stated that the Administrator handles all of that, and that she had not reported the gnats to anyone. Observation and interview on 05/28/24 at 10:00 a.m., revealed a gnat crawling on the table, in the dining room on Floor 300. Observation on 05/29/24 at 10:05 a.m., revealed a gnat crawling on the table in the conference room. In an interview on 05/29/24 at 10:10 a.m., with Resident #129 revealed he see gnats every day when he goes to therapy, he stated he was new hear so he did not know really who to tell. Observation on 05/29/24 at 10:20 a.m., revealed a swarm of five gnats flying down the Hall 300. Observation on 05/29/24 at 10:22 a.m., revealed four gnats in room [ROOM NUMBER]B crawling on the bed linens. There were no residents in the room at this time. The residents were out in the hallway, neither of them stated they had seen any gnats. In an interview on 05/30/24 at 10:51 a.m., with Resident #43 revealed she had seen little black flying bugs and sometimes, in her room and on the hallways. The resident said she had not reported to anyone, and she did not recall seeing the pest man here. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 05/30/24 at 10:53 a.m., with Resident #3 revealed two gnats in the room and a gnat landed on the overbed table during the interview . Resident #3 said she had seen gnats around the facility every day, and she had lived there for about two months. She said she had not mentioned the gnats to anyone. Observation on 05/30/24 at 12:30 p.m., revealed a swarm of gnats (7) around a tray of food cart at the nurse's station on Floor 300. Observation and interview on 05/30/24 at 11:43 a.m., with Resident #32 revealed that he had seen more small black flies, he said he had not told anyone about the pest, he had just admitted this month, but he thought he had seen the pest control man there. During this interview two gnats were observed on the privacy curtain in the room. Observation on 05/30/24 at 12:07 p.m., revealed in room [ROOM NUMBER]B a fly crawling on the sheets while the resident was asleep in the bed. Observation on 05/30/24 at 12:17 p.m., revealed a gnat crawling on the upper arm of a resident, in Floor 300 dining room. The resident swatted at the gnat, the gnat began to crawl on the table, the resident did not notice the two gnats. The resident could not comment when ask about the gnats. Further observation revealed gnats on three different tables while food was being served in the Floor 300 dining room. Observation on 05/30/24 at 1:10 p.m., revealed a gnat crawling on the medication cart at the nurse's station. on Floor 200. Observation and interview on 05/30/24 at 1:12 p.m. revealed a pest control logbook at the nurse's station on Floor 200 and Floor 300. Observation and interview on 05/30/24 at 1:45 p.m. revealed LVN C on Floor 200 stated she was aware of the pest control logbook, she had never used the book, if she saw pest, she would tell the Maintenance man. Observation on 05/30/24 at 2:20 p.m., revealed a group of three gnats flying down Floor 200, one of the gnats landed on the door frame of a resident's room. Observation on 05/30/24 at 2:35 p.m., revealed a gnat crawling on the water container on the medication cart Floor 200. An interview on 05/30/24 at 3:05 p.m., with the Maintenance Supervisor revealed that he had worked at the facility for over three weeks. The Maintenance Supervisor stated he had seen gnats around the facility, and he tried to take care of them, but did not specify how. He stated the staff tells him when they see pest, but the staff does not use the pest control log at the nurse's stations. The Maintenance Supervisor stated he does not check the pest control logs at either one of the nurse's stations. He stated he had the ability to contact the pest control company that came one time a month for additional visits. The Maintenance Supervisor stated it could be upsetting to the residents to see gnats in their rooms and it could be annoying to the residents. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Pest control logs at the nurse's station on Floor 200 and Floor 300 dated 04/22 through 10/23 revealed no mention of gnats. There was no further documentation to review . Record review of facility provided pest control log revealed, in part, dates and treatments as follows: Treatment dates and services performed: 03-06-2024-after inspection verified active In the kitchen, we found numerous sanitation factors contributing to gnats and drain fly proliferation. An insecticide and insect growth regulator was utilized to knock down current populations. Drains were also targeted to help reduce further issues. It's recommended that the kitchen performs some type of heavy deep cleaning. On the exterior of the facility, an insect bait was utilized around the perimeter to form a barrier from common pests Will return as needed or in April. Thank you. 04-17-2024- today arrived to complete your April service. Upon arrival . checked in with the front desk and located the logbook. There were no new entry's for service in guest or common areas of the facility . then inspected the kitchen for gnats and found no new activity at this time . 05-02-2024 Today May service. Upon arrival . checked in with the front desk and located the logbook. There were no new entries for service in guest or common areas of the facility. I met with the new dietitian and part MD . gnats were reported . inspected the interior kitchen and found and small fly issue due to conducive conditions in dish pit area. Dietitian stated they will be doing a full deep clean this weekend spoke to admin about these issues, and we agreed to come out Tuesday for a small fly wipe down for kitchen area and adjacent hallway after breakfast. I did treat the affected areas and knocked down the population Record review of the facility's policy Pest Control Service Agreement dated December 2016 reflected, 1. SERVICES TO BE PERFORMED. Client hereby . provide the following services: a) Perform monthly pest control . Including: coordinating . staff to Implement an Integrated Pest Management Plan, monitor end track pest Issues inside and outside . addressing . Issues both reported and observed, recording actions taken and observations to staff to be kept on record. Pest control each month consists of; b) Inspecting and treating exterior pest Issues including [NAME] exits, potential entry points, and grounds. c) inspecting and treating Interior pest Issues Including kitchen, laundry, exits, closets. d) Monitoring and maintaining any equipment used to bait and/or eliminate pests inside and outside (I.e. fly fights and rodent bait stations). e) When requested, treat specific areas that are experiencing a particular problem, which may include the removal of persons In effected area for varying time periods, shall adequately suppress end/or treat the following as needed, . 4.1 Roaches (German/American/Brown-Banded) (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4.2 Bed Bugs 4.3 Spiders/Scorpions 4.4 Crickets/Silverfish 4.5 Rodents 4.6 Flies/Goals/Fruit Flies 4.7 Wasps/Bees 4.8 Ants (Flre/carpenter/Black/Pharaoh/Odorous,etc) 4.9Tennttes .