STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676217	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royse City Medical Lodge	901 W Interstate 30 Royse City, TX 75189

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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** 47690 49837 Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 5 (Resident#34, Resident #36, Resident #39, Resident#55, and Resident #76) of 8 residents reviewed for ADLs. The facility failed to ensure Resident#34, Resident #36's, Resident #39's, Resident#55, and Resident #76's nails were cleaned and trimmed. This failure 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 include: 1. Record review of Resident # 39's Face Sheet dated, 10/17/24, reflected an [AGE] year-old woman admitted on [DATE] with diagnoses of vascular dementia (brain damage caused by multiple strokes), psychotic disturbance (a severe mental disorder that causes a person to lose touch with reality and have abnormal perceptions and thoughts), mood disturbance (a range of psychiatric conditions that affect a person's emotional state), and anxiety. Record review of Resident #39's Quarterly MDS assessment dated [DATE], reflected Resident #39 had a BIMS 6 indicated Resident #39's cognition was severely impaired. Further review of MDS assessment for Resident#39's self-care revealed she was partial to moderate assistance. Record review of Resident #39's Comprehensive Care Plan, revised 02/23/24, reflected the following: Focus: [Resident #39] has an ADL self-care performance and require staff assistance for all ADLs related to hemiplegia (partial or complete paralysis of one side of the body, usually affecting the arm, leg and face). Interventions: Staff to assist with all ADLs as required. Bathing/Showering: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. In an observation and interview on 10/15/2024 at 10:23 AM with Resident #39 revealed her nails on both hands were approximately 0.5 - 0.7 centimeter in length extending from the tip of his fingers. Resident #39 stated she had not had her nails cut in a long time. Resident #39 could not remember the last times her nails were cut. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident # 36's Face Sheet dated, 10/17/2024, reflected a [AGE] year-old male admitted on [DATE] with diagnoses of muscle wasting and atrophy (the decrease in size and wasting of the muscle tissue), other lack of coordination (poor muscle control that causes clumsy movements), and need for assistance with personal care. Record review of Resident #36's Quarterly MDS assessment dated [DATE] reflected Resident #36 had a BIMS of 3 which indicated Resident #36's cognition was severely impaired. Further review of MDS assessment for Resident#36's self-care revealed he was substantial to maximal assistance. Record review of Resident #36's Comprehensive Care Plan, revised 02/05/24, reflected the following: Focus: [Resident #36] has an ADL self-care performance deficit related to limited mobility. Interventions: Personal Hygiene: Resident is totally dependent in personal hygiene. An observation on 10/15/24 at 2:30 PM revealed Resident #36 was laying in his bed asleep. Resident #36 woke up upon surveyor's entry. While in the middle of speaking with Resident #36, Resident #36 closed his eyes and slept. The nails on both of his hands were approximately 0.5 - 0.7 centimeter in length extending from the tip of his fingers. The nails on the right hand had a dark brown colored residue underneath them. The nails on the left hand were clean. In an interview with CNA H on 10/15/24 at 2:35 PM, she stated CNAs and nurses were responsible for nail care. She stated if a resident was a diabetic, only nurses were allowed to cut the residents nails. CNA H stated she was not trained to trim Resident #36's nails. She stated she had not noticed Resident #36's nails. She stated the risk of not providing nailcare was the risk of infection to Resident #36. 3. Review of Resident # 76's Face Sheet dated, 10/17/24, reflected a [AGE] year-old male admitted on [DATE] with diagnoses of unspecified dementia (a clinical syndrome that occurs when a person has dementia but it does not have a specific diagnosis), muscle weakness (a decrease in muscle strength that affects most areas of the body), psychotic disturbance (a severe mental disorder that causes a person to lose touch with reality and have abnormal perceptions and thoughts), mood disturbance (a range of psychiatric conditions that affect a person's emotional state), and anxiety. Record review of Resident #76's Quarterly MDS assessment dated [DATE], reflected Resident #76 had a BIMS of 15 which indicated Resident #76's cognition was intact. Further review of MDS assessment for Resident#76's self-care revealed he was substantial to maximal assistance. Record review of Resident #76's Comprehensive Care Plan, undated, reflected the following: Focus: [Resident #76] has an ADL self-care performance deficit related to weakness on left side. Resident has limited physical mobility related to sequelae of a cerebrovascular accident (CVA). Interventions: Staff to assist with all ADL's as required. In an observation and interview on 10/16/2024 at 10:35 AM with Resident #76 revealed nails on his left hand long and dirty. His nails on his left hand were approximately 0.5 -0.7 centimeter in length extending from the tip of his fingers. The nails on the left hand had a dark brown colored residue underneath them. Resident #76 stated his nails had never been cut. He stated a man (name unknown) came every few months to cut his toenails. (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 observation and interview on 10/16/24 at 10:52 A.M. CNA I stated she provided patient care to Resident #76 but did not pay attention to his nails. She stated the expectation was to tell the charge nurse that Resident #76's nails needed to be cleaned and trimmed. She stated the risk to the resident was infection. In an interview on 10/16/24 at 1:54 PM RN B he stated he had worked at the facility for 5 years. RN B stated nurses were responsible for cutting fingernails for diabetics, after they were notified by the CNAs. He stated the nurses were responsible for cleaning and cutting resident's nails who are diabetics. He stated it was the nurse's responsibility to ensure the CNAs were cleaning and cutting the residents nails. He stated the risk was infection and would cause abrasions to the residents. In an interview on 10/16/24 at 2:08 PM CNA K she stated she had worked at the facility for 2 years. She stated cleaning and cutting nails are everyone's responsible unless the resident w ere a diabetic. The nurses are then responsible for cutting resident's nails who are diabetics. CNA K stated she provided patient care last night for Resident #76. She stated she asked Resident #76 to clean and cut his nails, but he declined. She stated Resident #76 said he did not want to be bothered or even changed. She stated she reported the refusal to LVN J, when LVN J was on the phone. She stated she was not sure if she was acknowledged by LVN J. 4. Review of Resident #34's MDS, dated [DATE], revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. His BIMS score was 13 out of 15 which indicated he was cognitively intact. His diagnoses included diabetes mellitus (high sugar level in the blood), Schizophrenia (serious mental health condition that affects how people think, feel and behave. It may result in a mix of hallucination .), muscle weakness, and lack of coordination. Further review of MDS assessment for Resident#34's self-care revealed he was substantial to maximal assistance. Review of Resident #34's Care Plan, dated 10/14/24, revealed Focus: The resident has an ADL self-care performance deficit r/t impaired balance. Goal: The resident will maintain current level of function in ADLs Interventions: . BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Further review revealed there was no documentation of nail care refusal. An observation/Interview on 10/15/24 at 09:45 am revealed Resident#34 setting up in the wheelchair in his room, wearing day attire, both hands fingernails approximately 0.5 centimeter in length extending from the tip of his fingers with dry matter under-net couple of them. Resident#34 stated he would like his fingernails cleaned. 5.Review of Resident #55's quarterly MDS, dated [DATE], revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her BIMS score was 13 out of 15 which indicated cognitively intact. Her diagnoses included hypertension (high blood pressure), diabetes mellitus (high sugar level in the blood), cerebrovascular accident(type of ischemic stroke resulting from a blockage in the blood vessels supplying blood to the brain) with left side hemiplegia (paralysis of one side of the body), and Non-Alzheimer's 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). Further review of MDS assessment for Resident#55's self-care revealed she was substantial to maximal assistance. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #55's Care Plan, dated 10/01/24, revealed Focus: The resident has an ADL self-care performance deficit r/t CVA with left Hemiplegia. Goal: The resident will maintain current level of function through the review date Interventions: . BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse Further review revealed there was no documentation of nail care refusal. An observation/Interview on 10/15/23 at 10:16 am revealed Resident #55 was laying in her bed wearing T-shirt and covered with a blanket. Right hand fingernails approximately 0.4 centimeter in length extending from the tip of her fingers with brown matter under-net. left hand severely contracted, the first, second and 3rd fingernail approximately 0.4 centimeter in length extending from the tip of her fingers, with dirty matter under net the 1st, 2nd, and the 3rd fingernail. Resident#55's 4th, and 5th finger hiding inside the contacted hand , no indentation observed on her skin, and Resident#55 did not complain of pain. Resident#55 stated she would like her fingernails trimmed and cleaned. Interview on 10/15/2024 at 11:19 am CNA N checked Resident#34 and stated the residents' nails were not trimmed, and under-net fingernails there was brown matter. CNA F checked Resident#55 and stated they needed to be trimmed and cleaned. CNA N stated residents' fingernails care was the responsibility of the CNAs to clean them during residents' shower days and let the charge nurse know if resident's fingernail needed trimming. She stated it was the responsibility of charge nurse to trim residents' fingernails. CNA N stated the risk to residents if their fingernails care were not done development of infection and scratching their skin. Interview on 10/15/24 at 12:58 pm LVN M stated Resident#34, and Resident#55 refused nail care, and it was care planed. LVN M further stated the Resident#34, and Resident#55 fingernails had been cleaned and trimmed today. LVN M stated the nails care for the resident was done by the nurses and the CNAs when it was noticed, and the risk to residents' development of infection. In an interview on 10/15/24 at 2:53 PM LVN J stated she had worked in the facility for about 4 months. She stated the CNAs were responsible for cleaning and clipping fingernails for except for residents who are diabetics. LVN J stated it was the nurses or anyone's responsibilities to cut the residents nails. She stated it was the facility's responsibly and expectation for the nurses to ensure the residents nails are cleaned and trimmed nails. She stated the risk to the residents was infection. Interview on 10/16/24 at 09:00 a.m. the DON stated residents' fingernail care should be done with shower and as needed unless the resident refuse. The DON stated it was the responsibility of the Hall charge nurse, DON and the ADON to make sure residents nails were kept cleaned and trimmed. The DON stated the risk to residents' development of infection. Review of the facility policy Titled Care of Fingernails/Toenails, dated October 2010, revealed The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. General Guideline 1. Nail care includes cleaning and trimming 2. Proper nail care can aid in the prevention of skin problems around the nail bed .4. Trimmed and smouth nails prevent the resident from accidentally scratching and injuring his or her skin . Reporting 1. Notify the supervisor if the resident refuses the care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 42971 Based on observation, interview, and record review the facility failed to ensure residents receive adequate supervision and assistance devices to prevent accidents for one (Resident #11) of two residents observed during a transfer. The Facility failed to ensure CNA C used a gait belt when transferring Resident #11 from her bed to the wheelchair. This failure could affect the residents by placing the residents at risk for falls, discomfort, pain, and/or injury. Findings included: Record review of Resident #11's Quarterly MDS assessment, dated 08/11/24, reflected an admitted [DATE]. Resident #11 had a BIMS score of 10, meaning her cognition was moderately impaired. she required moderate one-person assist with transfers from a bed to a wheelchair. Resident #11's active diagnoses included abnormal posture, unsteadiness on feet, retention of urine, and muscle weakness. Record review of Resident #11's care plan, dated 09/15/23, reflected . [Resident#11] has an ADL self-care performance deficit related to weakness .Interventions included .Transferring: Resident requires assistance with transferring . An observation on 10/16/24 at 10:38 AM revealed CNA C assisted Resident #11 onto the side of the bed. CNA C placed the wheelchair next to the bed facing toward the head of the bed and locked the wheels. CNA C placed her feet outside of the resident legs and lifted her by her arm pits and she lifted her from the bed toward the wheelchair. Resident #11 hollered ouch. Resident stated it hurt under the breasts. In an interview with CNA C on 10/16/24 at 11:06 AM she stated she had been working at the facility since June 2024. She stated she was supposed to use a gait belt when transferring residents. She stated not using a gait belt could lead to a fall, or she could injure herself. She stated she had been in serviced on gait belt transfers when she was hired in June. In an interview with the DON on 10/17/24 at 08:32 AM she stated it was the expectation for staff to use a gait belt when providing transfers to residents to prevent the risk of injury to the resident and the staff. She stated at no time were they to lift a resident under the arms. She stated they had issued gait belts to all the CNAs, and she expected them to always have the belts with them to use it. She stated going forward she would do skills check monthly and she would do her rounds for monitoring. In an interview with the DOR on 10/17/24 at 11:45 AM she stated all transfers should utilize a gait belt to prevent injury to the employee and the resident. Record review of CNA C's orientation checklist dated 06/18/24 did not specify gait belt training. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy, Safe Lifting and Movement of Residents revised September 2024, reflected, In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents.

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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 that a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for one (Resident #11) of one resident reviewed for catheter care. The facility failed to ensure CNA C kept Resident #11's urine catheter bag below the level of the bladder during a transfer from bed to wheelchair. This failure could place residents at risk for urinary tract infections. Findings included: Record review of Resident #11's Quarterly MDS assessment, dated 08/11/24, reflected an admitted [DATE]. Resident #11 had a BIMS score of 10, meaning her cognition was moderately impaired. She required moderate one-person assist with transfers from a bed to a wheelchair. Resident #11's active diagnoses included abnormal posture, unsteadiness on feet, retention of urine, and muscle weakness. Record review of Resident #11's care plan, dated 09/15/23, reflected . [Resident#11] is at risk for UTI due to use of urinary catheter related .Interventions included .Position catheter bag and tubing below the level of the bladder and away from entrance room door . Review of Resident #11's Physician Orders Report dated 10/16/24 reflected, . Change urinary catheter and accessories Q month .Ensure tubing and privacy bag is intact and secure every shift . Observation on 10/16/24 at 10:38 AM revealed CNA C completing ADL care on Resident #11 in preparation to transfer from bed to wheelchair. CNA C provided incontinent care to Resident #11 while the urinary catheter hanging to the right side of the bed. CNA C placed the Resident #11's urinary catheter bag on the bed, and she changed resident's shirt and put on a clean pants. CNA C assisted Resident #11 onto the side of the bed. Urine was observed backing up in the tubing back toward the resident's bladder. Resident #11 was transferred into her wheelchair and staff hooked the urinary catheter bag on the wheelchair. In an interview on 10/16/24 at 11:06 AM, CNA C stated the urinary drainage bag was to be always kept below the resident's bladder. CNA C stated she knew better; she stated by failing to do this it put the resident at risk for urinary tract infections. Record review of CNA C's skills verification checklist dated 06/18/24 reflected she was competent in Peri-care-Foley catheter tubing care. In an interview with the DON on 10/17/24 at 08:32 AM she stated the catheter was to be maintained below the level of the bladder. She stated placing the drainage bag on the bed was not maintaining it below the bladder. She stated by not keeping it below the bladder urine could back up into the bladder and increase the risk of urinary tract infections. She stated she would do monthly skills check on nursing staff and she would do her random checks to monitor staff. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled, Catheter Care, Urinary, revised January 2023, 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 - Few	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 #77) reviewed for respiratory care. The facility failed to ensure Oxygen (O2) in use signage was on Resident #77's room doorway. This failure could place residents at risk of not receiving appropriate respiratory care. The findings were: Review of Resident #77's face sheet dated 10/15/2024 revealed he was an [AGE] year-old-female admitted to the facility on [DATE]. Her diagnoses included: Dementia, hypertensive chronic kidney disease (kidneys are damaged and cannot filter blood adequately), Hyperlipidemia (high blood lipid levels). Record Review of Quarterly MDS assessment dated [DATE] reflected, Resident #77 was on Hospice. It also reflected, Resident #77 had BIMS of 2, which indicated that she had severe cognitive impairment. Record review of Resident #77's Hospice Orders dated 8/20/2024 reflected, Oxygen at 2-5 Liter per minute to Maintain O2 Saturation more than 90 percent. Record Review of Resident #77's Care plan, revised on 9/12/24 reflected, Focus: [Resident #77] chooses Hospice - Hope Health Care for diagnosis of Hypertensive Kidney Failure. Goal: [Resident #77] comfort will be maintained through the review date. Interventions: Work with nursing staff to provide maximum comfort for [Resident #77] including hospice therapies. In an observation on 10/15/24 at 11:10 PM revealed Resident #77 was on Oxygen therapy via nasal cannula. Observed Resident #77's room did not have signage for Oxygen in use outside the door. In an interview on 10/15/25 at 1:23 PM with resident representative stated Resident #77 was on hospice and had been on Oxygen therapy for more than a month. In an interview and observation on 10/15/24 at 11:30 AM with CNA F stated Resident #77 was on hospice and on Oxygen therapy. She stated she did not see the Oxygen in use sign on Resident #77's room door. She stated every resident on oxygen therapy should had the sign to ensure safety regarding smoking in the building and to alert staff in case of any emergency or evacuation. In an interview on 10/15/24 at 1:39 PM with LVN G stated Resident #77 was on hospice as well as on Oxygen therapy. She stated Resident #77's room should have a signage on the door for oxygen in use to alert other staff members. She stated 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. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/16/24 03:55 PM with the DON, she stated her expectation was if the resident was 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 the facility was a smoking facility and Oxygen in use sign was placed to warn people not to smoke or have open flames near oxygen. She stated the risk of not having appropriate signage on the door was staff may not be aware that resident was dependent on Oxygen therapy. She added the risk of inadequate signage was Resident will not receive the care they need, and quality of care will be compromised. Record review of facility policy titled Oxygen Administration revised October 2010 reflected, Equipment and Supplies: The following equipment and supplies will be necessary when performing this procedure .3. No smoking/Oxygen in Use signs .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 (Resident #3) of 4 residents reviewed for pharmacy services. The facility failed to ensure RN B followed physician ordered water flushes before and after medication administration given via the G-Tube for Resident #3. This failure could place residents at risk of tube obstruction and a decrease in hydration. Findings include: Record review of Resident #3's undated face sheet reflected a [AGE] year-old female with and admitted [DATE] and a re-admitted [DATE]. Diagnoses included dysphagia (difficulty swallowing), cerebral infarction (stroke), constipation, mild protein-calorie malnutrition, and seizures (convulsion). Record review of Resident #3's quarterly MDS assessment, dated 08/29/24, reflected Resident #3 had BIMS score of 7 which indicated she was severely cognitively impaired. She was totally depended on all ADL and always incontinent of bowel and bladder and she received 51 percent or more of total calories through a feeding tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach). Record review of Resident #3's care plan with a revision date of 09/07/23 reflected, . [Resident #3] requires tube feeding .Interventions .The resident needs total care with tube feeding and water flushes. See physician orders . Record review of Resident #3's Physician orders report dated October 2024 reflected, . Enteral feed order every shift enteral: Flush tube with 15 to 30 ml of water between each medication . with a start date of 12/01/23. Record review of Resident #3's Medication administration record for October 2024 reflected, .Flush tube with 15 to 30 ml of water between each medication . Record review of Resident #3's Medication administration record for October 2024 reflected: Escitalopram Oxalate Oral Tablet 10 MG (Escitalopram Oxalate) Give 1 tablet via G-Tube one time a day . with a start date of 12/01/2023. Farxiga Oral Tablet 10 MG (Dapagliflozin Propanediol) Give 1 tablet via G-Tube one time a day . with a start date of 08/22/2024. Valproic Acid Oral Solution 250 MG/5ML (Valproate Sodium) Give 5 ml via G-Tube two times a day . with a start date of 04/15/2024. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Aspirin 81 Oral Tablet Chewable (Aspirin) Give 1 tablet via G-Tube one time a day . with a start date of 12/02/2023. An observation on 10/16/24 at 07:58 AM of G-Tube medication administration for Resident #3 revealed RN B prepared medication for Resident #3. RN B placed 1 tablet Escitalopram 10 mg (anti-depressant), 1 tablet of Dapagliflozin 10 mg (treat diabetes), 1 tablet of Aspirin 81 mg, and 15 ml of Valproic Acid 250 mg/5 ml in an individual cup and crushed each tablet in each cup. RN B crushed each tablet and entered the resident's room. RN B then filled a plastic cup with water from the bathroom sink and poured approximately 5-10 ml of water into each medication cup. He then retrieved a 60-ml piston syringe and placed the piston syringe into the G-tube connector and checked for residual (the volume of fluid remaining in the stomach at a point in time during enteral nutrition feeding) and flushed the G-tube with 60 ml of water. RN B then administered each medication by gravity and did not flush the tube feeding between each medication. At the completion of the medication administration RN B then flushed with 60 ml of water. RN B then reconnected the feeding tube. In an observation and interview with RN B on 10/16/24 at 08:18 AM, he stated he was not required to flush the G-tube between each medication because he did not have an order for that. When RN B looked at the medication administration record, he stated oh I have an order to flush with 15 to 30 ml of water between each medication. RN B stated he was required to review physicians' orders prior to giving any medication and had not reviewed it. He stated not flushing with the prescribed amount of water could result in tube occlusion (clogged) or a resident not getting enough water intake. In an interview with the DON on 10/17/24 at 8:32 AM, the DON stated staff were to always follow the doctors' orders on the amount of fluid to flush before and after medications. She stated failing to follow the orders could result in a clogged G-tube which would require the resident to be sent out to the hospital for replacement and it could result in a decrease in hydration. She stated all nurses are skills checked prior to G-tube medications. She stated they would also be doing follow up monitoring to ensure staff are following proper procedures. Record review of RN B's competency assessment dated [DATE] reflected he was competent in G-tube medication administration. Record review of the facility's Policy titled, Administration Medications Through an Enteral Tube, revised 07/05/2019 reflected, . 19. If administering more than one medication, flush with 15 ml (or prescribed amount) water between medication .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48560 50910 Based on observations, interviews and record review, the facility failed to store and label food in accordance with professional standards for food service safety for the facility's only kitchen in that: The facility failed to ensure food items in the facility refrigerator and freezer were covered, dated, or labeled. These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness if consumed and food contamination. Findings Include: Observation in facility's kitchen walk-in refrigerator on 10/15/24 at 9:35am revealed 2 medium circular foiled covered items (about 9 inches) without a label or date used by. Observation in facility's kitchen walk-in refrigerator on 10/15/24 9:36am revealed 1 white and red square container labeled chicken with lid opened to about 1/4 inch on one corner of the container. Observation in facility's kitchen walk-in refrigerator on 10/15/24 9:37am revealed 4 fruit cups in circular plastic containers covered with plastic wrap on a tray without a date or label date used by. Observation in facility's walk-in refrigerator on 10/15/24 9:37am revealed 1 tray with approximately 20 half cut ham and cheese sandwiches with plastic wrap on the tray without a label or date used by. Observation in facility's walk-in freezer on 10/15/24 9:39am revealed an opened box, half full of cut carrots in a blue bag. The bag was open to where the carrots were visible, and the box was not securely closed with no date used by label. In an interview with Dietary Manager on 10/15/24 9:39am revealed the walk-in freezer has not been working and they were fixing it. She stated that the meat was being held in an outside trailer (Bone [NAME] Freezer) to ensure it stayed frozen. She stated the kitchen walk-in freezer had not been working since 10/5/24 and a work order to repair it was done same day. Observation in facility's Bone and [NAME] Trailer (Freezer) on 10/15/24 9:45am revealed an opened box of chicken cut in cubes, with open bag inside not closed/secured and no used by date listed on the box. There was one bag of chicken about 3lbs and it was about 80% full. The Dietary Manager removed the box of chicken and threw it in the trash. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation in facility's Bone and [NAME] Trailer (Freezer) on 10/15/24 9:46am revealed the following: *Opened box of frozen burritos in plastic bag that was opened and exposed to the air. The box had about 25 burritos, had no used by date label. * Opened box of dinner rolls inside a plastic bag that was exposed and not closed. The box had about 50 rolls with no used by date label. * Opened box of lasagna rolls, with a bag inside that was open and exposed to the air. There were about 30 lasagna rolls and there was no used by date label. During an interview with the Dietary Manager on 10/15/24 10:01am revealed the cooks were responsible for labeling items and putting a used by date for all the food items opened in the freezer. She stated all kitchen staff were responsible for labeling any items in other areas such as refrigerators and dry storage. She stated items should be completely closed and sealed. She stated no food should be exposed to air while in the freezer and should always be closed. She stated if items are not closed then food can get contaminated, get freezer burn and make residents sick. Observation of facility's kitchen refrigerator on 10/15/24 10:09am revealed a tray of 12 white drinks in cups with plastic tops not labelled what they were or a use by date. There were also 2 cups of brown liquid covered without labels of what they were or used by date. During an interview with [NAME] Aide E on 10/16/24 02:31pm revealed that everyone was responsible for labeling items in the refrigerator and dry good storage. He clarified that the cooks were in charge labeling and dating items in the freezer outside (trailer). He stated it was very difficult to label things in that trailer because there was no light and when the door was left open too long there was a bunch of smoke from the coldness. He stated the risk to the residents of not labeling and dating items or closing them appropriately was cross contamination and sickness or even death. In an interview with [NAME] D on 10/17/24 9:27am revealed she was training to be a cook. She stated cooks were in charge of dating and labeling items in the freezer. She stated cooks needed to be cognizant of expiration dates and dates they opened an item so they were aware of how long they can use the items before they discard them. She stated not labeling and dating food items could cause them to get freezer burn, cross contaminated and potentially cause illness in residents. She stated when she opened an item she would close it tightly, wrap it with plastic or foil, label, and date when the item needed to be discarded. She stated it was also important to inspect the items by looking and smelling them before using them, to ensure they were still good regardless of the expiration date. Record Review of Food Receiving and Storage Policy, revised July 2014 reflected, .7. All food stored in the refrigerator and freezer will be covered, labeled, and dated (used by date). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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

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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** 42971 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 3 residents (Resident #5, Resident#69, and Resident #199) of 8 residents observed for infection control. The facility failed to ensure: 1- CNA A performed hand hygiene between change of gloves during incontinent care for Resident #5. 2- CNA H donned the appropriate PPE during Resident #69 interaction who was on droplet precautions. CNA H performed hand hygiene between Resident #69 and another resident's room. 3- CNA L and CNA O donned the appropriate PPE during incontinent care for Resident #199 who was on enhanced barriers precautions. These failures could place residents at risk for infection and cross contamination of pathogens and illness. Findings included: Resident #5 Record review of Resident #5's Quarterly MDS assessment dated [DATE] reflected Resident #5 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses included Alzheimer's disease, muscle weakness, and cognitive communication deficit. Resident #5's had a BIMS score of 15, which indicated Resident #5's cognition was intact. The MDS assessment indicated Resident #5 was frequently incontinent of bladder and bowel. Record review of Resident #5's Care Plan dated 04/16/24, reflected the following: Focus: [Resident #5] has an ADL self-care performance deficit . Interventions: . Staff to assist with all ADL's as required . Observation on 10/15/24 at 10:00 AM revealed CNA A entered Resident #5's room to provide incontinence care. CNA A sanitized his hands and donned gloves, he unfastened Resident #5's brief and cleaned the front pubic area. The resident was assisted onto her side revealing she had a small bowel movement. CNA A discarded the dirty gloves, without hand hygiene he donned clean gloves. He cleaned the resident's buttocks area using several wipes. CNA A removed and discarded the dirty gloves, without hand hygiene, he donned clean gloves. He placed a clean brief under resident buttocks, he fastened the brief, and coved the resident in the bed. CNA A gathered the dirty clothes and trash, removed his gloves, washed his hands, and left the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/15/24 at 10:25 AM, CNA A stated he supposed to perform hand hygiene between change of gloves. CNA A stated he should change his gloves and perform hand hygiene when he went from dirty to clean. CNA A stated failing to provide proper care exposed the resident to infections. Resident #69 Record review of Resident #69's face sheet, dated 10/17/2024, revealed the resident was [AGE] years old male and admitted to the facility on [DATE] and readmitted to the facility on ,d+[DATE] with the diagnosis of metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance in the blood that affects the brain), pneumonia (a serious lung infection that occurs when the air sacs in the lungs fill with fluid or pus), and COVID-19 (an infectious disease caused by the SARS-CoV-2 virus). Record review of Resident #69's Quarterly MDS assessment dated [DATE], reflected Resident #69 had a BIMS 3 indicated Resident #69's cognition was severely impaired. Record review of Resident #69's Comprehensive Care Plan, initiated 10/11/24, reflected the following: Focus: [Resident #69] Isolation- Strict Single Room .will remain in isolation until no longer contagious to others. The resident has impaired immunity related to COVID. Intervention: .Post appropriate isolation precaution signs. Use universal precautions as appropriate. Provide proper protective equipment. Observation on 10/15/24 at 2:40 PM revealed Resident #69 was on Droplet precautions. There was signage on the right side of the door that read: visitors/staff he was on Droplet precautions, perform hand hygiene before and after leaving room, necessary PPE to wear in room, and donning/doffing (put on/remove) information. CNA H approached Resident #69 in the doorway of his room. CNA H bent down and was face to face with Resident #69 without a mask on. CNA H left Resident #69 room to answer another resident's call light. CNA H did not perform hand hygiene before she entered the resident's room. Interview with CNA H on 10/16/24 at approximately 2:40 PM revealed she did not put on a mask because all she did was talked to Resident #69 and care was not being provided. CNA H stated the facility expectation was to don and doff PPE when signage was outside door. CNA H stated the risk of not using PPE or hand sanitizing was infection to the resident and others. Resident #199 Review of Resident #199's MDS, dated [DATE], revealed she was a [AGE] year-old female who admitted to the facility on [DATE]. Her BIMS score was 15 out of 15 which indicated intact cognition. Her diagnoses included hypertension (high blood pressure), diabetes mellitus (high sugar level in the blood), cerebrovascular accident, and Non-Alzheimer's 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). Resident#199 skin condition section revealed, she was admitted with one unstageable pressure ulcers to the coccygeal (the tail bone) area. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #199's Care Plan, dated 10/14/24, revealed Focus: At risk for EBP r/t patients are indicated for the following residents who are: At increased risk of MDRO acquisition (e.g., resident has a wound) Goal: EBP care should be maintained for the residents' entire stay or until wounds have healed Interventions: . Provide patient standard precaution using gown, and gloves during .changing briefs or assisting with toileting Observation on 10/16/24 at 09:13 AM revealed Resident #199 was on Enhanced barriers precautions. There was signage on the left side of the door that informed visitors/staff she was on enhanced barriers precautions, perform hand hygiene before and after leaving room, necessary PPE to wear in room, and donning/doffing (put on/remove) information. CNA L and CNA O entered Resident #199's room without any form of PPE, there was PPE cart inside the Resident#199 room on the right side of the window, and the resident bed was on the left side of the window. Both CNAs washed hands, donned gloves and procced to do incontinent care for Residnt#199 without wearing gowns. Interview with CNA O on 10/16/24 at 09:28 AM revealed she knew she supposed to wear a gown for the resident peri care, but she forgot. She stated she was nervous. She stated she was in-serviced regarding different type of infection control during orientation. She stated the risk of not wearing proper PPE in enhanced barriers precautions residents' rooms was exposing herself and others to the development of infection and spreading germs from one resident to another resident. Interview with CNA L on 10/16/24 at 09:54 AM revealed he knew he supposed to wear gown for the resident peri care, but he forgot, because he was thinking the signage in front of the room was for the resident in bed A, and the resident he provided peri care to was in bed B. He could not recall the last time he had in service on infection control. He stated the risk to residents' cross contamination and development of infection. In an interview on 10/17/24 at 8:32 AM, the DON stated she expected the staff to complete hand hygiene before and after care. The DON also stated in between care CNA was to complete hand hygiene and change gloves because her hands were considered dirty after cleaning the resident. The DON stated the staff were to complete hand hygiene during care to prevent the spread of infection and cross contamination. The DON stated she would be doing quarterly skills check to monitor her staff. Interview with the DON on 10/17/24 at 08:34 AM, she stated enhanced barriers precaution (EBP) was new this year. The DON stated for the EBP they had signage outside the resident's room, and for any high contact activity with the resident on EBP including transfer, peri care .staff should be gowning and gloving. She stated she and the staffing coordinator were responsible for training staff on infection control. The DON further stated training for EBP was done on hire, on monthly staff meeting, and as needed. The DON stated They used EBP to prevent infection to high-risk residents. Record review of the facility's policy, Handwashing / Hand Hygiene, revised 12/22/23, reflected, .7. Use an alcohol-based hand rub ., or alternatively, soap and water for the following situations: . m. After removing gloves . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility provided literacy on infection control The Health and Human Services Commission of Texas Handbook on the frequently encountered infections in long-term care facilities., Version 1.0 dated 10/07/22 revealed Transmission-Based Precaution are the second tier of basic infection control and are to be used in addition to Standard Precautions for residents who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission. 47690 49837