STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676241	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhill Villas	2530 Greenhill Rd Mount Pleasant, TX 75455

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128 Based on observation, interview and record review the facility failed to ensure comprehensive care plans were reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for 2 of 18 residents (Resident #25 and Resident #34), reviewed for care plans. 1. The facility failed to revise Resident #25's care plan after returning from the hospital with a urinary catheter (tubing inserted to the bladder to drain urine). 2. The facility failed to revise Resident #25's care plan to indicate he refused to have his urinary catheter removed 3. The facility failed to revise and update Resident #34's comprehensive care plan to reflect the resident was placed on hospice. These failures could place residents of the facility at risk of not addressing their physical, mental, and psychosocial needs for each to attain or maintain their highest practicable physical, mental and psychosocial outcome. Findings included : 1. Record review of Resident #25's face sheet dated 5/20/24 revealed he was a [AGE] year old, who was initially admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included diabetes (high blood sugar), high blood pressure, chronic kidney disease, prostatic hyperplasia (prostate gland enlargement that can cause urination difficulty), and syphilis (sexually transmitted disease that can cause sores in private areas of the body). Record review of Resident #25's annual MDS dated [DATE] revealed reflected the resident's BIMS was 11 indicating he had moderate cognitive impairment. The MDS indicated the Resident #25 did not have a urinary catheter. Record review of Resident #25's incomplete significant change MDS dated [DATE] revealed the resident was readmitted from an acute care hospital. The MDS indicated Resident's BIMS was 9 indicating he had moderate cognitive impairment. The MDS indicated Resident #25 had a urinary catheter and hospice care. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/21/2024
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #25's undated care plan indicated he had bladder incontinence but did not include a care area related to his urinary catheter or interventions to care for his urinary catheter. Record review of Resident #25's Order Summary Report with active orders as of 5/20/24 revealed an order dated 4/30/24 to admit to hospice care services. The Order Summary Report did not reveal any orders for his urinary catheter or care for his urinary catheter. Record review of Resident #25's TAR dated 5/01/24-5/31/24 revealed he was scheduled to have his urinary catheter discontinued 5/10/24 or 5/11/24, but there were no other treatments for his urinary catheter. Record review of Resident #25's Progress Notes dated from 4/25/24-5/20/24 revealed he returned from the hospital on 4/29/24 and did not indicate he returned to the facility with a urinary catheter. The Progress Note dated 5/10/24 revealed the nurse notified hospice services regarding the need for a supporting diagnosis for Resident #25 to have a urinary catheter and received a new order to discontinue his urinary catheter. Resident #25 refused to have his urinary catheter removed at that time because he was trying to sleep with two more attempts made to remove it on 5/10/24 and he continued to refuse. The Progress Notes dated 5/11/24 revealed nursing staff attempted to remove the urinary catheter again and Resident #25 refused to have it removed and the physician was notified, and nurse would continue to make attempts to remove it. There was no further documentation after 5/11/24. During an observation and interview on 5/19/24 at 10:04 AM, Resident #25 was lying in bed and had a urinary catheter with the catheter bag hung from his bed frame. Resident #25 said he did not know how long or why he had a urinary catheter and his ex-wife put it in him. During interview on 5/21/24 at 1:05 PM, LVN C said the nurses were responsible for putting new or changed orders in when a resident returned from the hospital and the nurse, ADON, or DON could update the resident care plans. LVN C said the ADON or the DON usually updated resident care plans. LVN C said a new foley catheter would require the care plan to be updated with the Resident's new care areas with interventions to monitor and care for the new urinary catheter. LVN C said urinary catheters should have orders to assess, clean, change, monitor, catheter care, flushing and the leg strap should also be on it. LVN C said Resident #25 came into the facility with the urinary catheter and was on hospice. LVN C said Resident #25 received the urinary catheter because his scrotum was inflamed and had sores and he needed to keep urine from irritating the area. LVN C said then there was an order to discontinue the urinary catheter and the resident refused. LVN C said Resident #25 had been on hospice services for about two and a half weeks. LVN C said there should have been orders for Resident #25's urinary catheter and his care plan should have been updated to include the care of his urinary catheter. LVN C said she talked to the hospice nurse last week and was waiting on a response for the resident to keep his foley catheter , but she did not remember if she documented it. LVN C said she had not reported to her DON about waiting on orders from hospice services, but the facility was ultimately responsible for Resident #25's care. LVN said if Resident #25's urinary catheter was not care planned or there were no orders for the care of the urinary catheter, there was an Increased risk of infection or neglect if he did not receive the needed care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/24 at 1:34 PM, ADON G said the nurses, ADON, or the DON were responsible for revising the resident's care plan with any acute changes. ADON G said if it was not an acute change, the MDS nurse would update the resident's care plan. ADON G said a resident who had a new urinary catheter should have an order, supporting diagnosis, and should be care planned with inventions to monitor and provide care. ADON G said if there were no orders for a resident's urinary catheter and it was not care planned, then the resident may not receive the care needed to maintain the urinary catheter. ADON G said Resident #25 returned from the hospital approximately three weeks ago with a new urinary catheter. ADON G said she had talked to his hospice agency, and he had a prostate issue and needed to keep the urinary catheter. ADON G said there were no orders and Resident #25's care plan was not revised to include interventions for his urinary catheter. ADON G said Resident #25 should have had orders for his urinary catheter and his care plan should have been revised with interventions to care of his urinary catheter. During an interview on 5/21/24 at 2:09 PM, the Regional Compliance Nurse said the purpose of the care plan was so everyone knew how to take care of the resident. The Regional Compliance nurse said the nursing staff, ADON, and DON were responsible for revising the care plans with any acute changes and the MDS nurse would be responsible for revising care areas that were not acute. The Regional Compliance nurse said she would expect resident care plans to be revised to reflect any acute changes such as a resident receiving new urinary catheter. During an interview on 5/21/24 at 2:26 PM, the ADM in training said she would expect the residents' care plans to be revised with any needed care areas. She said the nursing staff or the MDS nurse would be responsible for revising the resident care plans. She said Resident #25's care plan should have been revised to reflect the care areas with interventions to care for his new urinary catheter. She said the care plan was individualized to the resident's care, so they knew what they needed to do to take care of the resident. She said if the care plan was not revised to include updated care areas, then they were not doing what they were supposed to do, to take care and meet the needs of the resident . 2. Record review of a face sheet dated 05/19/24, indicated Resident #34 was [AGE] years old and was admitted to the facility on [DATE] with diagnoses of stroke, dementia, and heart failure . The face sheet indicated the resident was receiving hospice services. Record review of physician's orders dated 05/19/24 indicated an order dated 10/18/23 for Resident #34 to be admitted to hospice services with an admitting diagnosis of senile degeneration of the brain (loss of intellectual ability). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #34 had a BIMS of 00 which indicated severe cognitive impairment. The MDS indicated Resident #34 had received hospice care while being a resident of the facility. Record review of a care plan last revised on 03/20/24 for Resident #34 did not indicate the resident was receiving hospice services. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/20/24 at 4:10 p.m., MDS Nurse F said Resident #34 was not care planned for receiving hospice services. She said when Resident #34 was admitted to the facility she was not receiving hospice services. She said the resident was later placed on hospice. She said typically when a resident was placed on hospice, herself or the Social Worker updated the care plan. She said she guessed she just missed adding it to the care plan. She said care plans were used as a guide for individualized plans of care for each resident. During an interview on 05/21/24 at 10:37 a.m., ADON G said the DON was not at the facility at this time because she had been hospitalized for several days. She said care plans were used to communicate the care and the needs of each resident. She said care plans also listed interventions. She said if someone was on hospice, she would have expected it to have been care planned. She said the MDS nurses were responsible for updating the care plans. She said because Resident #34 had an order for being on hospice she did not feel there would be a negative effect on the resident. She said she did receive hospice care. During an interview on 05/21/24 at 12:18 p.m., the Administrator said the MDS nurse was responsible for revising the care plans. She said care plans made sure staff knew how to take care of the residents. She said she would have expected for Resident #34 to have been care planned for hospice. She said a problem area not being care planned could cause a resident not to receive individualized care. Record review of an undated Comprehensive Care Planning facility policy indicated, .The comprehensive care plan will describe .The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences, and needs of the resident and in response to current interventions . 46062

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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** 46062 Based on observation, interview and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible and failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 18 residents (Resident #49) reviewed for accidents and supervision. The facility failed to ensure CNA A performed a safe mechanical lift transfer for Resident #49. This failure could place residents at risk of injury. Findings include: Record review of Resident #49's face sheet dated 5/21/24 indicated he was [AGE] years old and admitted to the facility on [DATE]. Resident #49 had diagnoses which included osteoarthritis left shoulder (degenerative disease of the shoulder joint), chronic pain, depression (persistent sadness), hemiplegia and hemiparesis (unable to move or weakness to one side of the body) following cerebral infarction (blood disruption to the brain causing brain tissue to die) and high blood pressure. Record review of Resident #49's quarterly MDS dated [DATE] indicated he was sometimes understood and usually understood others. The MDS indicated a Resident #49 had a BIMS of 14, which indicated he was cognitively intact. The MDS indicated Resident #49 used a wheelchair for mobility. The MDS indicated Resident #49 was dependent on staff for chair to bed/bed to chair transfers. Record review of Resident #49's undated care plan revealed he had an ADL self-care performance deficit with interventions which included he required assist times two with transfers via Hoyer Lift (mechanical lift). Record review of Resident #49's weight dated 5/15/24 revealed he weighed 304.2 pounds. During an observation on 5/21/24 beginning at 9:32 AM, CNA A, assisted by CNA B and CNA H, used a mechanical lift to transfer Resident #49 from his bed to the resident's wheelchair. CNA A positioned the mechanical lift over Resident #49 with the mechanical lift legs in the narrow position under the resident's bed. CNAs A and B attached the lift pad to the mechanical lift. CNA A then raised Resident #49 up above the resident's bed and lowered the bed, with the mechanical lift legs in the narrow position and the wheels of the mechanical lift were not locked. CNA A then pulled the mechanical lift with Resident #49 suspended in the air back away from the resident's bed and turned the mechanical lift with the lift legs still in the narrow position to her right and started pushing the mechanical lift toward Resident #49's wheelchair that was located at the end of his bed. CNA B and CNA H met Resident #49 at his wheelchair, and both grabbed the lift pad and guided him into the wheelchair as CNA A pushed the mechanical lift toward Resident #49's wheelchair with the legs in the narrow position and the legs went under the wheelchair. CNA A then lowered Resident #49 into his wheelchair as CNA B and CNA H pulled him to the back of his wheelchair into a comfortable position. CNA A did not lock the wheels of the mechanical lift while lowering Resident #49 into his wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/24 at 9:50 AM, Resident #49 said he had never been injured during a mechanical lift transfer. Resident #49 said there was always at least two staff members and he felt safe during the mechanical lift transfers. During an interview on 5/21/24 at 10:22 AM, CNA A said she had worked at the facility for two months and normally worked the day shift. CNA A said the wheels of the mechanical lift should be locked when raising/lifting a resident. CNA A said normally the legs of the mechanical lift should be opened to the wide position, but Resident #49's wheelchair was so wide, the mechanical lift would not go around the wheelchair, so she left the legs closed to go under his wheelchair. CNA A said the legs should be opened in the wide position to balance the lift. CNA A said the legs would not open under the beds and she did not normally open the mechanical lift legs to the wide position until ready to position the lift over the wheelchair. CNA A said Resident #49 was the only resident with a wheelchair that wide. CNA A said the resident could slip out of the wheelchair during lowering if the mechanical lift wheels were not locked. CNA A said it could be a disaster and the mechanical lift could tilt and the resident could fall if the mechanical lift legs were not opened to the wide position . During an interview on 5/21/24 at 10:37 AM, CNA B said she had worked at the facility for a month and normally worked on the day shift. CNA B said a mechanical lift transfer required at least two people to be present. CNA B said the mechanical lift legs should be spread in the wide position when lowering a resident into a wheelchair. CNA B said the mechanical lift legs would not spread under most of the residents' beds. CNA B said they normally spread the legs to the wide position after positioning the mechanical lift in front of the residents' wheelchairs. CNA B said the mechanical lift legs should be spread open wide during mechanical lift transfers to keep the mechanical lift steady. CNA B said the mechanical lift could tip over if legs were not spread to the wide position. CNA B said Resident #49's bed had an angled bed frame, and a lot of the beds were like it and the bed frame would not allow the mechanical lift legs to spread to the wide position during a lift. CNA B said the mechanical lift wheels should be locked during lifting or lowering the resident. CNA B said locking the wheels of the mechanical lift kept the resident from rolling backwards during the transfer. CNA B said she could not see if the wheels were locked during Resident #49's transfer, but the mechanical lift wheels should have been locked during lifting and lowering Resident #49 for his safety. During an interview on 5/21/24 at 1:34 PM, ADON G said staff should lock the wheels and place the mechanical lift legs in the widest position before transferring a resident from the bed to the wheelchair. The ADON said locking the wheels of the mechanical lift during raising or lowering of the resident during the transfer prevented the mechanical lift from moving. ADON G said the mechanical lift legs should be in the wide position when performing transfers to balance the lift. ADON G said by CNA A not locking the wheels of the mechanical lift or moving Resident #49 with the mechanical lift legs in the narrow position, the lift could have flipped over. ADON G said the mechanical lift legs should have been opened in the wide position and the wheels locked during lifting/lowering for the safety of Resident #49. During an interview on 5/21/24 at 2:09 PM, the Regional Compliance Nurse said she would expect staff to follow the facility's mechanical lift policy. The Regional Compliance Nurse said staff should lock the wheels of the mechanical lift for the safety of the resident and the legs should be in the wide position for steadiness of the lift during the transfer process. The Regional Compliance Nurse said staff would be performing an unsafe mechanical lift transfer if the lift legs were not in the wide position and if the lift wheels were not locked during lifting and lowering of the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/24 at 2:26 PM, the ADM in training said she would expect staff to perform safe mechanical lift transfers and follow the facility's mechanical lift policy. Record review of the facility's form titled C.N.A. Proficiency Audit dated 5/05/24, revealed CNA A was marked with an S, which indicated she had satisfactory performed the skill of a Hoyer Lift-2 person assist transfer. Record review of the facility's undated policy titled Hydraulic Lift, revealed . mechanical device used to transfer a resident from and to the bed and chair . reserved for the paralyzed, obese, or too weak to transfer without complete assistance . resident would achieve a safe transfer to bed or chair . arrange the furniture in the room to accommodate the lift . raise the bed to accommodate the lift under the bed . prepare the lift by setting the adjustable base to its widest position . lock or unlock the base wheels according to the manufacturer's recommendations . Record review of Patient Lifts by the U.S. Food and Drug Administration, Patient Lifts | FDA was accessed on 05/16/24 indicated . the FDA has compiled a list of best practices that, when followed, can help mitigate the risks associated with patient lifts . users should . keep the base (legs) of the patient lift at maximum open position and situate the lift to provide stability . Record review of Best Practices for Using Patient Lifts by the U.S. Food and Drug Administration (FDA), Best Practices For Using Patient Lifts (fda.gov) was accessed on 5/16/24 indicated . patient lifts were designed to lift and transfer patients from one place to another . found improper use of patient lifts have lead to patient falls . resulted in head traumas, fractures, deaths . can mitigate risks by doing the following . receive training and understand how to operate the lift . keep the base (legs) of the patient lift in the maximum open position .

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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** 46062 Based on observation, interview and record review, the facility failed to ensure a resident with urinary incontinence, based on the resident's comprehensive assessment, received appropriate treatment and services to prevent urinary tract infections (UTI) for 2 of 4 residents (Residents #17 and Resident #25) reviewed for catheters. 1. The facility failed to ensure Resident #17 had an indwelling urinary catheter (tube inserted into the bladder to drain urine) securement/anchor device (used to secure an indwelling urinary catheter). 2. The facility failed to ensure Resident #25 had orders for care of his indwelling urinary catheter. These failures could place residents at risk for indwelling urinary catheter dislodgement, urethral (empties urine from the bladder and out of the body) damage, pain, urinary tract infections, and not receiving needed care. Findings included: 1. Record review of Resident #17's face sheet dated 5/21/24 indicated Resident #17 was [AGE] years old and was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #17 had diagnoses which included dementia (progressive or persistent loss of intellectual functioning with impairment or memory and thinking and often with personality changes), history of UTI (urinary tract infection), stage 4 pressure ulcer (most severe type of bedsore caused from pressure involving full thickness skin loss extending to expose bone, muscle, or tendons), diabetes (high blood sugar), and urine retention. Record review of Resident #17's quarterly MDS assessment dated [DATE] indicated Resident #17 was understood and understood others. The MDS indicated Resident #17 had a BIMS score of 9 which indicated she had moderate cognitive impairment. Resident #17 was dependent on staff for toileting hygiene. The MDS indicated Resident #17 had an indwelling catheter (urinary catheter) and was always incontinent of bowel. Record review of Resident #17's undated care plan indicated she had the renal insufficiency related to retention of urine, had a pressure ulcer stage 4 to sacrum (triangular bone at the base of the spine), had a UTI, and was on enhanced barrier precautions with interventions of gloves and gown should be donned (put on) if any of the following activities occurred: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bathing, or other high contact activity. Record review of Resident #17's Order Summary Report dated 5/21/24 revealed an order to ensure catheter strap in place and holding every shift change as needed with a start date of 1/05/24. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 5/21/24 at 9:58 AM, observed CNA A perform incontinent/catheter care for Resident #17 and there was not a leg strap or catheter securement device to secure her urinary catheter. Resident #17's catheter was laying taunt in Resident #17's crease between her left leg and groin area. CNA A said she did not know why Resident #17 did not have a leg strap or catheter securement device and she did not remember her having one when she provided incontinent care earlier that morning . CNA A said she had not reported Resident #17 did not have a catheter secure and she really did not know what it was used for. 2. Record review of Resident #25's face sheet revealed he was [AGE] years old and was initially admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included diabetes (high blood sugar), high blood pressure, chronic kidney disease, prostatic hyperplasia (prostate gland enlargement that can cause urination difficulty), and syphilis (sexually transmitted disease that can cause sores in private areas of the body). Record review of Resident #25's incomplete significant change MDS assessment dated [DATE] indicated Resident #25 re-entered the facility on 4/29/24 from a short-term hospital. The MDS indicated he was understood and understood others. The MDS indicated Resident #25 had a BIMS score of 9, which indicated he had moderate cognitive impairment. The MDS indicated Resident #25 did not have behavioral symptoms and did not reject care. Resident #25 was dependent on staff for toileting hygiene. The MDS indicated Resident #25 had an indwelling catheter (urinary catheter) and was always incontinent of bowel. The MDS indicated Resident #25 was receiving hospice care services . Record review of Resident #25's undated care plan indicated he had bladder incontinence. Resident #25's care plan did not have any care areas or interventions related to the care of his urinary catheter. Record review of Resident #25's Order Summary Report dated 5/20/24 revealed an order to admit to hospice services with an order date of 4/30/24. There were no orders related to Resident #25's urinary catheter or its care. Record review of Resident #25's TAR dated 5/01/24-5/31/24 revealed he was scheduled to have his urinary catheter discontinued 5/10/24 or 5/11/24, but it was not documented as completed. The TAR did not have any other treatments for the care of his urinary catheter. Record review of Resident #25's Progress Notes dated 4/25/24-5/20/24 revealed Resident #25 was transferred to the hospital on 4/25/24 related to falls, high blood sugar, and increased shortness of breath. The progress note dated 4/30/24 revealed Resident #25 returned from the hospital on 4/29/24 and new orders were received and noted to admit to hospice services and there was no mention of him having a urinary catheter. There was no mention of Resident #25 having a urinary catheter until on 5/10/24. The progress notes dated 5/10/24 revealed the nurse had spoken to the hospice nurse regarding needing a supporting diagnosis for the resident to have a urinary catheter and received a new order to discontinue the urinary catheter and then Resident #25 refused multiple times to have the urinary catheter discontinued and the RP was notified. The progress note dated 5/11/24 revealed Resident #25 refused for the nurse to discontinue the urinary catheter and became verbally abusive, and the physician was notified. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 5/19/24 at 10:04 AM, Resident #25 was lying in bed and had a urinary catheter and drainage bag hung on his bed frame below the bed. Resident #25 said he did not know why he had a urinary catheter put in him. During an observation on 5/20/24 at 10:55 AM, Resident #25 continued to have a urinary catheter hung from his bed frame under the bed . During an interview on 05/21/24 at 1:05 PM, LVN C said a new urinary catheter should have orders to assess, clean, change, monitor, catheter care, flushing, and for the leg strap. LVN C said Resident #25 came back into the facility from the hospital with the new urinary catheter because his scrotum was inflamed, and he was admitted to hospice. LVN C said then there was an order to discontinue Resident #25's urinary catheter. LVN C said there was an increased risk of infection or neglect if there was no care for his urinary catheter. LVN C said there should have been orders for Resident #25's urinary catheter and care. LVN C said she spoke to the hospice nurse last week about Resident #25 refusing removal of his urinary catheter and wanting to keep the urinary catheter and LVN C said she was still waiting on a response from the hospice nurse. LVN C said she had not reported to the DON that she was still waiting on orders from hospice related to Resident #25's urinary catheter to see if she could reach out to the hospice agency to obtain orders. LVN C said the nurse was responsible for updating physician orders with changes. LVN C said the urinary catheter care should have been included on Resident #25's TAR and the urinary catheter care should have been documented there. LVN C said she provided care for Resident #25's catheter but did not document it. LVN C said the physician orders and care plan should be followed to ensure the leg strap or catheter securement device was in place for Resident #17. LVN C said the purpose of the urinary catheter leg strap or securement device was so the urinary catheter did not cause irritation, to prevent tugging, pain, and position to ensure urine flowed away from the resident to prevent infections, urinary tract infections, and it held the urinary catheter in place . During an interview on 5/21/24 at 1:34 PM, ADON G said she would expect physician orders to be followed and a urinary catheter securement device should have been in place for Resident #17. ADON G said the urinary catheter securement device was to prevent injury to the resident and hold the urinary catheter in place. ADON G said if a resident received a new urinary catheter, there should be orders for the urinary catheter, urinary catheter care, a qualifying diagnosis, and it should be included on the care plan with interventions for care. ADON G said if Resident #25 did not have orders for his urinary catheter care, then he was at risk of not getting the care he needed. ADON G said Resident #25 returned from the hospital with the urinary catheter about three weeks ago. ADON G said they talked to hospice, and he had a prostate issue and needed to keep the urinary catheter. ADON G said there were no orders and Resident #25's care plan was not revised to include interventions for his urinary catheter. ADON G said Resident #25 should have had orders and interventions for the care of his urinary catheter. During an interview on 5/21/24 at 2:09 PM, the Regional Compliance Nurse said she would expect the physician orders to be followed and Resident #17 should have had a catheter leg strap or securement device to prevent complications of the urinary catheter. The Regional Compliance Nurse said Resident #25 should have had orders to care for his new urinary catheter acquired from the hospital and the care should have been documented . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhill Villas	2530 Greenhill Rd Mount Pleasant, TX 75455

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/24 at 2:26 PM, the ADM in training said she would expect the physician's orders to be followed. The ADM in training said if Resident #17 had an order for a urinary catheter leg strap or securement device, she would expect staff to ensure the resident had it in place. The ADM in training said Resident #25 should have had orders to care for his urinary catheter after returning from the hospital with a new urinary catheter and when he refused to have it removed. The ADM in training said if staff were not following physician orders or not ensuring orders were updated with any needed changes, they were not doing what they were supposed to do to take care of the resident. Record review of the facility's policy titled Catheter Care dated February 13, 2007 revealed . check the resident frequently to be sure he/she was not lying on the catheter and to keep the catheter and tubing free of kinks . keep tubing off the floor and minimize friction or movement at insertion site . review the resident's plan of care daily for changes . be sure the catheter tubing and drainage bag were kept off the floor . empty the collection bag at least every shift . observe resident for signs and symptoms of urinary tract infection and urinary retention . change the catheter and drainage system as needed unless ordered otherwise by the physician . Record review of the undated CDC Indwelling Urinary Catheter Insertion and Maintenance revealed CAUTI (catheter-associated urinary tract infections) were costly and increased morbidity . maintenance catheter care essentials . when an indwelling urinary catheter was indicated, the following interventions should be in place to help prevent infection . use indwelling catheters only when medically necessary . properly secure indwelling catheters to prevent movement and urethral traction . maintain good hygiene at the catheter-urethral interface . maintain unobstructed urine flow . maintain drainage bag below level of bladder at all times . remove catheters when no longer needed, document indication for urinary catheter on each day of use . use a catheter securement device to anchor the catheter . perform peri and catheter care per facility policy . assess the patient for any pain or discomfort . inspect for redness, irritation and drainage . once a urinary catheter was inserted, maintaining it according to evidence-based guidelines was crucial to prevent CAUTI .

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F 0692

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide enough food/fluids to maintain a resident's health.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46062

Based on observations, interviews, and record review the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrated that this was not possible or resident preferences indicated otherwise for 1 of 18 residents (Resident #66) reviewed for nutrition.

1. The facility failed to follow the dietician's recommended tubing feeding for Resident #66 to receive Glucerna 1.2 - 474 ml (2 cartons) four times a day for 2275 calories per day.

2. The facility failed to follow the facility's weight policy of weighing Resident #66 weekly times four weeks after readmission from the hospital on 4/02/24, did not follow up on Resident #66's 15 pound weight loss from admission on 3/20/24 to readmission on 4/02/24, and there was no weight obtained within 24 hours after readmission from the hospital on 5/11/24.

These failures could place residents at risk for malnourishment, weight loss, skin breakdown, and decreased quality of life.

Findings included:

Record review of Resident #66's face sheet dated 5/19/24 revealed he was [AGE] years old who was initially admitted to the facility on [DATE] initially and readmitted on [DATE]. Resident #66 had diagnoses which included dehydration (dangerous loss of body fluid caused by illness, sweating, or inadequate intake), protein-calorie malnutrition, diabetes (high blood sugar), and gastrostomy tube (also known as a peg tube, surgical opening created into through the abdomen into the stomach to insert a tube to provide nutrition).

Record review of Resident #66's unlabeled MDS assessment dated [DATE] indicated Resident #66 had a reentry to the facility from a short-term hospital on 4/02/24. Resident #66 was understood and understood others. The MDS indicated Resident #66 had a BIMS score of 5, which indicated he had severe cognitive impairment. The MDS indicated Resident #66 had a diagnosis of malnutrition. The MDS indicated Resident #66 was 71 inches in height and weighed 154 pounds and had not had a weight loss of 5% in the past month or loss of 10% or more in the last 6 months. The MDS indicated Resident #66 had a feeding tube (gastrostomy/peg tube) upon admission and prior to admission to the facility. The MDS indicated Resident #66 received 51% or more of total calories through his feeding tube and his average fluid intake per day through his feeding tube was 501 cc per day. The MDS indicated Resident #66 had three stage 3 pressure ulcers (bedsore- deep crater-like wound that involves full-thickness skin loss and damage to underlying tissue) upon admission or reentry to the facility. The MDS indicated Resident #66 had 3 unstageable pressure ulcers (bedsore covered by dead tissue and unable to determine the underlying damage) upon admission or reentry to the facility.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #66's undated care plan indicated he had a potential fluid deficit with interventions including to administer fluids per G-tube (feeding tube) as ordered and monitor vital signs as ordered/per protocol and record, notify MD of significant abnormalities, and monitor for signs/symptoms of dehydration and report to MD. The care plan indicated Resident #66 required tube feedings with interventions which included the Registered Dietician to evaluate quarterly and as needed to monitor caloric intake, estimate needs, make recommendations for changes to tube feedings as needed and Resident was dependent with tube feeding and water flushes, see MD orders for current feeding orders. The care plan indicated Resident #66 had a pressure ulcer with interventions which included to monitor nutritional status, serve diet as ordered, monitor intake and record. The care plan indicated Resident #66 was at a potential risk for malnutrition with interventions including to administer enteral feedings as ordered, monitor resident weights, and to notify the physician with any negative findings. Record review of Resident #66's Order Summary Report dated 5/20/24 revealed an order for Glucerna 1.2 355 ml through the peg tube four times a day with an order date of 3/26/24 and another order for Glucerna 1. 2 355 ml through the peg tube four times a day with a start date of 5/20/24. Record review of Resident #66's TAR dated 3/01/24-3/31/24 revealed Glucerna 1.5 355 ml through the peg tube four times a day was administered 3/21/24 to 3/26/24 at 4:00 PM and was discontinued on 3/26/24. The TAR revealed Glucerna 1.2 355 ml via peg tube four times a day was administered starting 3/26/24 at 8:00 PM and had a discontinue date of 5/20/24. Record review of Resident #66's hospital discharge orders dated 3/20/24 revealed orders for Glucerna 1.5 at 355 ml through peg tube four times daily. Record review of Resident #66's Nutritional Risk Assessment performed by the Dietician dated 3/20/24 revealed he had diagnoses including protein-calorie malnutrition and dehydration. The Nutritional Risk Assessment indicated Resident #66 weighed 168.6 and was 71 inches in height. The Nutritional Risk Assessment indicated the Dietitian recommended if Glucerna 1.5 could be ordered, continue the current tube feeding order, but if only Glucerna 1.2 was available, she recommended 2 cartons (474 ml) four times a day for 2275 calories per day. Record review of Resident #66's hospital discharge summary dated 4/02/24 revealed he was hospitalized [DATE]-[DATE] and very ill with diagnoses which included COVID-19 (coronavirus-respiratory infection), dehydration, a urinary tract infection, and continued severe malnutrition. Record review of Resident #66's hospital discharge summary dated 5/11/24 revealed he was hospitalized [DATE]-[DATE] with a bleeding duodenal ulcer, urinary tract infection, sepsis (severe life-threatening infection), and continued severe malnutrition. Record review of Resident #66's weight summary indicated he weighed: 168.6 pounds on 3/20/24 (admission) 153.5 pounds on 4/02/24 (readmission) 152.9 pounds on 5/15/24 (after 5/11/24 readmission) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #66's wound care notes indicated his pressure ulcers were improving and had not declined . During an observation and interview on 5/19/24 at 10:23 AM, Resident #66 was sitting up in his wheelchair and appeared to be thin. Resident #66 had a specialty mattress on his bed. Resident #66 said he had wounds on his bottom and back that had started when he was still at home. Resident #66 said the wounds were getting better . Resident #66 said he did not eat and had a tube in his stomach and raised his shirt revealing a feeding tube. During an interview on 5/21/24 at 12:45 PM, the Dietitian said she sends her completed dietary recommendations to the nurses, ADON, DON, ADM, and the clinical regional nurse. The Dietitian said she would expect her recommendations to be followed unless there was an issue and then she would re-evaluate the resident. The Dietitian said the order for Glucerna 1.2 355 ml did not reflect what she recommended for Resident #66. The Dietitian said the Glucerna 1.2 at 355 ml four times daily that was being administered to Resident #66 only provided 1704 calories per day and would not meet Resident #66's caloric needs. The Dietitian said her recommendation of Glucerna 1.5 at 355 ml would have provided 2130 calories. The Dietitian said her recommendation was to either continue the Glucerna 1.5 at 355 ml four times daily or change it to Glucerna 1.2 at 474 ml (2 cartons) four times daily, which would have provided Resident #66 with 2275 calories and 113.6 grams of protein. The Dietitian said Resident #66 could have weight loss and his wounds could deteriorate without proper nutrition. The Dietitian said there had been a lot of staff turnover at the facility and felt it could have contributed to her recommendation for Resident #66 not being implemented. The Dietitian said she would think they would weigh residents on tube feedings at least weekly unless their weights were stable . During an interview on 5/21/24 at 1:05 PM, LVN C said the nurses were responsible for updating resident orders. LVN C said the ADON received the recommendations from the dietician and updated the resident's orders with any recommendations. LVN C said if a resident came back from the hospital with a significant weight loss, she would monitor their meals, or tube feedings may need an increase in calories, and would need a physician order for any dietary changes. LVN C said they normally weighed residents weekly if there was a significant weight loss. LVN C said the dietitian should be notified immediately with a significant weight loss. LVN C said if a resident was not receiving the dietitian's recommended amount of tube feeding, the resident could have a significant weight loss, dehydration, and wound deterioration. LVN C said wounds would not heal without proper nutrition. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/24 at 1:34 PM, ADON G said the ADON was responsible for ensuring weights were completed. ADON G said she was only working Wednesday through Fridays and was she was not responsible for the weights until about two weeks ago. ADON G said the previous ADON who no longer worked at the facility would have been responsible for monitoring Resident #66's weights from admission and readmissions. ADON G said she identified Resident #66 as a significant weight loss when she reviewed his weights the month of May and placed him on the Weight Watchers plan (weighed and assessed weekly for at least four weeks, referred to Dietician for recommendations, notified MD, implement interventions to prevent further weight loss) after his 5/11/24 readmission to the facility from the hospital. ADON G said they weighted residents by the 10th of the month. ADON G said if a resident returned from the hospital and had lost 15 pounds since admission, she would have weighed him again for verification, notified the dietician and the physician to see what interventions needed to be implemented. ADON G said the dietician emailed resident dietary recommendations to the ADON and DON, and the ADON/DON and/or the unit manager would update the resident orders with the dietary recommendations. ADON G said by Resident #66 not getting the recommended number of calories per the dietitian's recommendations, the resident could have weight loss and dehydration. ADON G said Resident #66 should have been weighed per the facility's weight policy after returning from the hospital. During an interview on 5/21/24 at 2:09 PM, the Regional Compliance Nurse said dietary recommendations should be followed up on correctly and in a timely manner . The Regional Compliance Nurse said they should have started managing Resident #66's weights and interventions put in place to prevent weight loss upon admission and readmission. The Regional Compliance Nurse said she would expect staff to follow the Resident Weight policy. During an interview on 5/21/24 at 2:26 PM, the ADM in training said if a resident returned from the hospital with a 15-pound weight loss, the resident should have been weighed more frequently than monthly to try and figure out why they had the weight loss and then they could have put interventions in place to prevent further weight loss. The ADM in training said she would expect Resident #66's dietary recommendations to have been followed. The ADM in training said by not following the dietary recommended tube feeding, could have contributed to his weight loss. The ADM in training said she would expect staff to follow the facility's Resident Weight policy. Record review of the facility's policy titled Resident Weight dated February 13, 2007 revealed . all residents would be weighed by the 10th of the month and their weights documented correctly . the appropriate actions regarding significant changes would be carried out . weights would be obtained and documented at admission, readmissions, and monthly unless ordered otherwise by the physician, or unless dictated more frequently by the resident's condition . factors indicating the need for more frequent weights included significant weight loss, drastic decrease in food consumption . or pressure ulcers that were not resolving as expected . all new admissions and readmissions would have a height and weight obtained within 24 hours of admission then weighed at least weekly times four weeks . the Nutritional Risk Assessment form would be completed by the Registered Dietitian upon admission, annually, and updated if the resident had a significant change . the DON or designee would review all weights to determine the need for any re-weighs . facility review resident weights after monthly weights were obtained to determine residents with significant weight changes . significant weight change would be defined as 5% or great in one month, 7.5% or greater in three months, or 10% or greater in six months . all significant weight changes would be referred to the Regional Dietitian on the next visit . the Regional Dietitian would review all facility interventions, and would make appropriate recommendations, which would be approved by the physician, if necessary .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44128 Based on observation, interview and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food and nutrition services. 1. The facility failed to ensure all food items were properly dated and labeled in Refrigerator #1, Refrigerator #2, and Freezer #2. 2. The facility failed to ensure all food items were properly sealed in Freezer #1. 3. The facility failed to ensure Dishwasher E properly wore a facial hair cover while in the kitchen. These failures could place residents at risk of foodborne illness and food contamination. Findings include: During an observation on 05/19/24 at 9:14 a.m., revealed in Refrigerator #2 there were 2 small plastic bowls with lids which contained a thick, yellow food item with a creamy appearance that was not dated or labeled. There were 3 small plastic bowls with lids which contained round purple food items with no date or label. There was 1 small plastic bowl with red food items with no date or label. There was a sign on the door that read, Close door when using! Keep Clean! Label and date everything!. During an observation on 05/19/24 at 9:18 a.m., on the door of Freezer #3, revealed a sign which read, Close door when using! Keep Clean! Label and date everything!. During an observation on 05/19/24 at 9:19 a.m., in Freezer #2 there was 1 large plastic bag which contained a frozen unknown meat with no label. During an observation on 05/19/24 on 9:21 a.m., in Freezer #1 there was one bag of onion rings that was open to air. There was one onion ring sitting on the food item bag next to the bag of onion rings. During an observation on 05/19/24 at 9:25 a.m., in Refrigerator #1 there was a round dark brown patty in a plastic bag, dated 5/18/24, with no label. There was a plastic bag which contained 2 egg shaped white food items with no date or label. During an interview on 05/20/24 at 10:41 a.m., [NAME] D said, whoever puts it in there should date and label. She said on 5/19/24 she saw the food items were not dated and labeled during the initial tour of the kitchen. During an observation on 05/20/24 at 11:45 a.m., while observing temperatures being taken of foods on the steam table, Dishwasher E walked across the kitchen and placed silverware on a cart near the steam table. Dishwasher E had a beard and a mustache but did not have on a facial hair covering. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 05/20/24 at 11:48 a.m., Dishwasher E walked across the kitchen and placed silverware on a cart near the steam table. He had a beard and a mustache but did not have on a facial hair covering on. He said he normally wore a beard covering, but just did not get one today . During an interview on 05/21/24 at 8:57 a.m., the Dietary Manager said all kitchen staff were responsible for dating and labeling foods as they were stored, per use, and if anything was opened. She said she was ultimately responsible for making sure foods were dated and labeled. She said food not being dated the food could go bad, bacteria could grow, and staff might not know how long the food had been in the refrigerator or freezer. She said food not being labeled could cause a food item being served to a resident who did not eat that food item or there could be an allergy. She said food items were supposed to be properly sealed, bagged, labeled, and dated. She said food items not being sealed could cause food to go bad or cause freezer burn. She said all male staff were supposed to be wearing facial hair coverings. She said Dishwasher E not wearing a facial hair covering was unsanitary and hair could fall on to the dishes or food. During an interview on 05/21/24 at 12:18 p.m., the Administrator in Training said whoever put food in the refrigerator or freezer should date and label all foods. She said the Dietary Manager should make sure staff date and label foods because it was her staff. She said if food was in there long enough it could be spoiled, or staff might not know when it was put in the refrigerator or freezer. We sure do not need a bunch of sick residents. She said without a label you might not know what the food was. She said if you did not know what a food was you might serve a resident something they were allergic to or something they were not supposed to eat. She said all food items should be sealed appropriately when they were stored. She said items not being sealed could cause freezer burn. She said staff should wear hair restraints and facial hair restraints. She said all facial hair should be covered. Record review of an undated Food Storage and Supplies facility policy indicated, . All facility storage areas will be maintained in an orderly manner that preserves the condition of foods and supplies .Open packages of food are stored in closed containers with covers or in sealed bags, and dated as to when opened . Perishable items that are refrigerated are dated once opened and used with 7 days .If a frozen food does not have an expiration date or a dated shipping label it will be dated when received or is removed from original packaging. Any frozen food more than one year old will be inspected for food quality and freezer burn before being used . Record review of an undated Infection Control facility policy indicated, .We will ensure that all employees practice infection control in the Dietary Service Department and maintain sanitary food preparation. All dietary service employees will follow Infection control Policies as established and approved by the Infection Control committee .Facial hair is to be closely trimmed and is to be covered with a hair restraint . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of a 2022 Food Code for the U.S. Food and Drug Administration indicated, .2-402 Hair restraints .food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food .Annex 4. Establish First-In-First Out (FIFO) Procedures. Product rotation is important for both quality and safety reasons. First-In-First-Out (FIFO) means that the first bath of product prepared and placed in storage should be the first one sold or used. Date marking food as required by the Food Code facilitates the use of a FIFO procedure in refrigerated, ready-to-eat, TCS (temperature control storage) foods. The FIFO concept limits the potential for pathogen growth, encourages product rotation, and documents compliance with time/temperature requirement .

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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** 46062 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 1 of 18 residents (Resident #17) reviewed for infection control. 1. The facility failed to ensure CNA G changed her gloves after providing incontinent care to Resident #17 prior to touching Resident #17's clean brief, shoulder, hip, gown and her blanket. 2. The facility failed to ensure CNA G handled dirty linen appropriately. 3. The facility failed to ensure CNA G performed appropriate hand hygiene prior to handling Resident #17's bed remote, drinking cup and bedside table. 4. The facility failed to ensure CNA A followed the Enhanced Barrier Precautions (interventions to prevent spread of infection in high-risk residents) to wear a gown while performing incontinent care for Resident #17 who had a urinary catheter and stage 4 pressure ulcer (most severe pressure ulcer, full thickness skin loss, may be muscle, bone tendon, or joint involvement). These failures could place residents at risk for cross-contamination, increased risk of infection and the spread of infection. Findings included: Record review of Resident #17's face sheet dated 5/21/24 indicated she was [AGE] years old and initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #17 had diagnoses which included dementia (progressive or persistent loss of intellectual functioning with impairment or memory and thinking and often with personality changes), history of UTI (urinary tract infection), stage 4 pressure ulcer (most severe type of bedsore caused from pressure involving full thickness skin loss extending to expose bone, muscle, or tendons), diabetes (high blood sugar), and urine retention. Record review of Resident #17's quarterly MDS assessment dated [DATE] indicated Resident #17 was understood and understood others. The MDS indicated Resident #17 had a BIMS score of 9 which indicated she had moderate cognitive impairment. Resident #17 was dependent on staff for toileting hygiene. The MDS indicated Resident #17 had an indwelling catheter (urinary catheter) and was always incontinent of bowel. Record review of Resident #17's undated care plan indicated she had the renal insufficiency related to retention of urine, had a pressure ulcer stage 4 to sacrum (triangular bone at the base of the spine), had a UTI, and was on enhanced barrier precautions with interventions of gloves and gown should be donned (put on) if any of the following activities occurred: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bathing, or other high contact activity. Record review of Resident #17's Order Summary Report dated 5/21/24 revealed an order for may have enhanced barrier precautions with a start date of 4/19/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/21/2024
NAME OF PROVIDER OR SUPPLIER Greenhill Villas		STREET ADDRESS, CITY, STATE, ZIP CODE 2530 Greenhill Rd Mount Pleasant, TX 75455	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/19/24 at 10:58 AM, observed an isolation cart outside Resident #17's room and a sign posted on her door, which stated Multidrug-resistant organisms (MDROs) were a threat to our residents . Enhanced Barrier Precautions Steps . perform hand hygiene, wear gown, wear gloves, dispose of gown and gloves in room . use Enhanced Barrier Precautions during high-contact care activities for residents with Indwelling Medical devices . wounds . During an observation on 5/21/24 at 9:58 AM, observed an isolation cart outside Resident #17's room and a sign of Enhanced Barrier Precautions on Resident #17's door. CNA A entered Resident #17's room and sanitized hands with hand sanitizer, applied gloves and did not put on a gown. CNA A then rolled Resident #17 toward the left and applied a towel under the resident, then rolled Resident #17 over toward the right facing CNA A. CNA A then reached over Resident #17 and pulled the towel under the resident, allowing the front of CNA A's clothes to touch Resident #17. CNA A then cleaned the urinary catheter with soapy water wiping away from body. CNA A cleansed Resident #17's front perineal (private) area. CNA A removed her gloves and leaned over the top of Resident #17 and threw her gloves in the trash on the opposite side of the bed, which allowed her clothing to touch Resident #17. CNA A sanitized her hands, applied gloves, dried Resident #17's front perineal area. CNA A turned Resident #17 onto the resident's right side, cleaned bowel movement from her back perineal/buttocks with wipes, applied a clean brief, pulled Resident #17 toward her by placing the same gloved hands on Resident #17's shoulder and hip, turned and positioned the resident onto the resident's back, pulled the resident's gown down, covered the resident with a blanket, then removed gloves and threw them in the trash. CNA A grabbed washcloths used during perineal and catheter care with her bare hands and put them in a trash bag, opened Resident #17's bathroom door, dumped water from the wash basin in the sink, returned to the bedside and lowered Resident #17's bed with her bed remote, picked up dirty bed linen and towel off the floor and put it in a trash bag with her bare hands and then CNA A positioned Resident #17's drinking cup on her bedside table and moved the bedside table over Resident #17. CNA A picked up the trash bag of linens and exited the room and did not wash her hands or use hand sanitizer. During an interview on 5/21/24 at 10:22 AM, CNA A said she had worked at the facility for two months and normally worked on the day shift. CNA A said she thought they removed Resident #17 from isolation precautions. CNA A said she should have been paying attention to Resident #17 having an isolation cart and the sign on the door. CNA A said by not following the Enhanced Barrier Precautions and not wearing a gown, she could spread anything to Resident #17 if she had something on her clothing. CNA A said she could transfer sickness to Resident #17 or other residents from not wearing the gown. CNA A said she should have removed her gloves after she cleaned Resident #17's bowel movement and sanitized her hands. CNA A said she should have put on gloves prior to handling the used/soiled washcloths and linens when placing them in a bag. CNA A said she should have washed her hands prior to touching Resident #17's items in her room. CNA A said she cross-contaminated and it was an infection control issue. During an interview on 5/21/24 at 1:34 PM, ADON G said Enhanced Barrier Precautions were to prevent infections in residents that were high risk. ADON G said PPE of gown and gloves should be used during incontinent care. ADON G said by CNA A not properly performing hand hygiene after cleaning Resident #17's bowel movement and then handling multiple areas of the resident's room and not wearing the appropriate PPE, placed Resident #17 at an increased risk of infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/21/24 at 2:09 PM, the Regional Compliance Nurse said staff should perform hand hygiene following incontinent care prior to touching items in the resident's room. The Regional Compliance Nurse said CNA A contaminated Resident #17's room and she would ensure the room was cleaned. The Regional Compliance Nurse said Enhanced Barrier Precautions were interventions to prevent spreading infections to and from residents. The Regional Compliance Nurse said CNA A could have spread infection to Resident #17 and other residents by not performing proper hand hygiene or not wearing the required gown with her gloves while performing incontinent care. During an interview on 5/21/24 at 2:26 PM, the ADM in training said Enhanced Barrier Precautions required an isolation cart outside the resident's room and a sign on the door that told what PPE was needed for residents who were at high risk of infection. The ADM in training said the staff should wear PPE when providing close contact resident care. The ADM in training said staff could spread infection to the resident and to other residents if they did not wear the appropriate PPE. The ADM in training said she would expect staff to perform proper hand hygiene, follow the facility's infection control policy, and read the isolation sign on the resident's door to ensure the appropriate PPE was worn to take care of the resident and not spread infection to residents. Record review of the facility's form titled C.N.A. Proficiency Audit dated 5/05/24, revealed CNA A was marked with an S, indicating she had satisfactory performed the skills of handwashing, perineal (private area) care of female, turns/repositions residents timely/correctly, infection control awareness, and handled dirty linen appropriately. Record review of the facility's undated policy titled Hand Hygiene revealed . you may use alcohol-based hand cleaner or soap/water for the following: . before and after entering isolation precaution settings . after contact with a resident's mucous membranes and body fluids or excretions . after handling soiled or used linens, dressings, bedpans, catheters and urinals . after completing a duty . you must use soap/water for the following: . before and after assisting a resident with toileting . Record review of the facility's policy titled Infection control Plan: Overview with an updated date of March 2023 revealed . the facility would establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection . when the Infection Control Program determines a resident needed isolation to prevent the spread of infection, the facility would isolate the resident . facility would require staff to wash their hands after each direct resident contact for which handwashing was indicated by accepted professional practice . facility would require staff to Donn and doff PPE before and after contact with resident who needs isolation to prevent the spread of infection to others in the facility . personnel would handle, store, process and transport linens so as to prevent the spread of infection . (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 the facility's undated policy titled Enhanced Barrier Precautions revealed . Multidrug-resistant organism (MDRO) transmission was common in long term care facilities . many residents in nursing homes were at increased risk of becoming colonized and developing infections with MDROs . Enhanced Barrier Precautions (EBP) referred to an infection control intervention designed to reduce transmission of MDROs that employ targeted gown and glove use during high contact resident care activities . EBP were used in conjunction with standard precautions and expand the use of PPE (personal protective equipment) to donning (putting on) of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing . EBP were indicated for residents with any of the following . wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO . indwelling medical device examples include . urinary catheters .