STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676250	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pecan Valley Rehabilitation and Healthcare	3838 E Southcross Blvd San Antonio, TX 78222

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on observations, interviews, and record review the facility failed to ensure each resident was treated with respect, dignity, and care for 1 of 6 residents (Resident # 67) observed for resident rights. The facility failed to ensure CNA F sat down while feeding Resident #67 in her room on 10/29/2024. This failure could place residents at risk of not being treated with dignity and respect. Findings included: Record review of Resident #67's face sheet dated 10/28/2024, revealed a [AGE] year-old female with an admitted [DATE], and diagnoses which included: Dysphagia (difficulty swallowing) following cerebral infarction (stroke); and gastrostomy status (has g-tube to bring nutrition directly into the stomach) Record review of Resident #67's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 4, indicating severe cognitive impairment. Further review under Section GG - Functional Abilities and Goals, shows Resident #67 was assessed as needing Supervision or touching assistance for eating. Record review of Resident #67's Care Plan dated 09/22/2024 reflected a focus area for potential nutritional problem r/t PEG tube, mechanically/therapeutically altered diet, and dysphagia (difficulty swallowing) post CVA (stroke), with interventions that included Patient to be up in chair for all meals. Observation on 10/29/2024 at 12:55 p.m. revealed Resident #67 was lying in her bed, and the bed was in the lowest position closest to floor, the head of bed was elevated, and her lunch tray was in front of her on an overbed table. She was observed to be only picking at her dessert (a square of cake) with her fingers, not eating. CNA F came into her room at 1:02pm and asked Resident #67 if she would like some assistance eating her food, and proceeded to stand next to her bed, bending over at the waist to reach down to her utensils and food and proceeded to feed her. After a few bites, Resident #67 pushed her tray away. (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: 676250	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/29/2024 at 1:05 p.m., CNA F stated he had worked at the facility for about 3 years, and they always tried to give Resident #67 time to eat on her own at beginning of meal to encourage independence, but will check on her and if she was not eating, they will offer her assistance. He stated I'm used to standing up when feeding Resident #67, but also stated that he knew he should sit down, to get closer to her level to feed her, and indicated he had received training in feeding residents. CNA F proceeded to obtain a chair from the corner of the room, placed it next to Resident #67's bed and asked her if she wanted to try to eat some more of her meal. She indicated yes, and CNA F proceeded to feed her more of her meal while sitting next to her in a chair. During an interview on10/31/2024 at 12:17 p.m., the DON stated that when staff were assisting a resident with feeding, they should sit, not stand over the resident, because it would make them feel like the staff were towering over the resident, and that all staff should have received training and competency checks on this. Record review of Competency Skill Assist with Meal dated 10/7/2024 indicated CNA F met requirements in this skill area, which included Sits in a chair facing the resident. Record review of facility policy titled Nursing Administration - Resident Rights (undated) indicated, .The resident has the right: 1. To be treated with consideration, respect and full recognition of his or her dignity and individuality.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34788 Based on observation, interview, and record review, the facility failed to ensure residents have a right to personal privacy for 1 of 5 residents (Resident #351) reviewed for privacy, in that: 1. LVN A and LVN B failed to provide privacy to Resident #351 while providing wound care by not closing completely Resident #351's privacy curtain. 2. LVN A failed to protect Resident #351's record by not locking the screen of her laptop. These deficient practices could place residents at-risk of loss of dignity due to lack of privacy. The findings include: Record review of Resident #351's face sheet, dated 10/31/2024, reflected an admitted [DATE] and, a readmitted [DATE], with diagnoses which included: Osteomyelitis (infection of bone), Hydronephrosis (kidney swelling), Colostomy status (opening in the large intestine created by surgery), Major depressive disorder (mental disorder characterized by at least two weeks of pervasive low mood, low self-esteem, and loss of interest or pleasure), Chronic kidney disease (gradual loss of kidney function), Type 2 diabetes mellitus (high level of sugar in the blood), Pressure ulcer of sacral region stage 4 (damage of skin and/or underlying tissue over a bony prominence). Record review of Resident #351's Quarterly MDS assessment, dated 10/09/2024, reflected the resident had a BIMS score of 14, indicating he was mildly cognitively impaired. Resident #351 required extensive assistance to total care with his ADLs and, had an ostomy and indwelling catheter. Record review of Resident #351's care plan, dated 06/30/2023, reflected a problem of has a stage 4 pressure ulcer to sacrum, admitted with related to immobility., with an intervention of Administer treatments as ordered and monitor for effectiveness. 1. Observation on 10/29/2024 at 3:25 p.m. reflected LVN A and LVN B did not completely close the privacy curtains while they provided wound care for Resident #351 because the privacy curtain was too short to cover the end of the bed. The resident's roommate was in the room and the resident's buttock was exposed. During an interview with LVN A on 10/29/2024 at 4:40 p.m., LVN A verbally confirmed the privacy curtains was not completely closed while she provided care for Resident #351, but it should have been. She stated she received resident rights training within the year. During an interview on 10/29/2024 at 3:45 p.m., Resident #351 confirmed the privacy curtain had been too short for awhile and he had received care multiple time without the privacy of a full curtain. 2. Observation on 10/29/2024 at 4 p.m. revealed after care was provided, this surveyor walked out of the room and noticed LVN A's laptop's screen was not locked and was showing residents' information. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN A on 10/29/2024 at 4:02 p.m., she verbally confirmed her laptop's screen should have been locked when she was not using it to protect the privacy of information of the residents. During an interview with the DON on 10/31/24 at 9:20 a.m., the DON stated privacy must be provided during nursing care and Resident #351's privacy curtains should have been closed completely. She confirmed Laptop screens should always been locked when not in used to protect residents' information. She stated the staff had received training on resident rights within the year and the training was provided by the DON and ADONs. They also checked the staff skills annually and as needed. Review of the facility's policy titled HIPAA, undated, reflected, Do not leave computers screens open with patient/resident information. Review of facility's care evaluation, undated, revealed provide privacy - pull curtain, shut door and/or window curtain.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34788 Based on interview and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 7 residents (Resident #48) whose assessments were reviewed, in that: Resident #48's quarterly MDS assessment incorrectly documented the resident as not receiving an anticoagulant medication. This failure could place residents at-risk for inadequate care due to inaccurate assessments. The findings were: 1. Record review of Resident #48's face sheet, dated 10/28/2024, revealed an admitted [DATE] and, a readmitted [DATE] with diagnoses that included: Cerebral infarction (stroke), Deep vein thrombosis (blood clot). Record review of Resident #48's Physician orders and Medication administration record for October 2024 revealed an order for: Eliquis (an anticoagulant) Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day for DVT [deep vein thrombosis right popliteal (back of the knee) vein]. Resident #48 had received Eliquis in the month of September 2024. Record review of Resident #48's Quarterly MDS, dated [DATE], revealed the assessment indicated Resident #48 did not receive an anticoagulant. During an interview with MDS nurse C on 10/31/2024 at 6:50 a.m., the MDS nurse verbally confirmed she had completed the MDS. MDS nurse C confirmed Resident #48's quarterly MDS was coded as the resident not receiving an anticoagulant when Resident #48 had received Eliquis (an anticoagulant). MDS nurse C revealed she did not know why she had not coded Eliquis as an anticoagulant. She verbally confirmed Eliquis was an anticoagulant and should have been coded as an anticoagulant. The MDS nurse revealed the RAI was used as reference for the MDS and she had access electronically to the RAI on her computer. Record review of, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual,Version 1.18. 11, October 2023, revealed, N0415E1. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on observations, interview and record review the facility failed to ensure that a resident who was unable to carry out activities of daily living received the necessary services to maintain good personal hygiene for 1 of 6 residents (Resident #67) reviewed for hygiene, in that. The facility failed to ensure Resident #67 received a shower or bath as scheduled on 10/12/2024 and 10/14/2024. This deficient practice could place residents who were dependent on staff for ADL care at risk for loss of dignity, and/or a diminished quality of life. The findings were: Record review of Resident #67's face sheet, dated 10/28/2024, revealed a [AGE] year-old female with an admitted [DATE], and diagnoses which included: Dysphagia (trouble swallowing) following Cerebral Infarction (stroke resulting from blood flow to brain being blocked); Seizures (uncontrolled jerking, loss of consciousness, blank stares or other symptoms caused by abnormal electrical activity in brain); Contracture (fixed tightening of muscle and tissue that prevents normal movement) right hand; Age-Related physical Debility (physical weakness) and Need for Assistance with Personal Care. Record review of Resident #67's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 4, indicating severe cognitive impairment. Further review under Section GG - Functional Abilities and Goals, shows Resident #67 was assessed as being totally dependent in bathing. Record review of Resident #67's Care Plan dated 09/22/2024 reflected a focus area for ADL Self Care Performance Deficit r/t CVA, impaired mobility, with interventions that include Shower/Bathe Self: Dependent x1-2 staff members. Record review of Resident #67's shower and bathing log for October 2024 revealed no showers or full baths were documented as having been given between 10/11/2024 and 10/16/2024. During an interview with LVN H on 10/31/2024 at 9:37a.m., LVN H stated Resident #67 was scheduled to receive showers 3 days a week, and after reviewing the shower/bathing log confirmed Resident #67 did not receive a shower or bath on scheduled days of 10/12 and 10/15 and had not received any bath or shower on non-scheduled days between 10/11/2024 and 10/16/2024. LVN H stated that Resident #67 does not want to get out of bed at times and will refuse her shower, but also stated that refusals should be documented in the POC. Observation and interview on 10/29/2024 at 12:55pm with Resident #67 revealed she was lying in bed, wearing clean clothes and no body odor noted, but was not able to answer questions regarding bathing. (continued on next page)

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	676250	A. Building B. Wing	10/31/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/28/2024 at 09:41a.m. with Resident #67's Responsible Party (RP) revealed that Resident #67 was supposed to be bathed three times a week, on Tuesday, Thursday and Saturdays, but she sometimes sees Resident #67 wearing the same clothes with bad body odor and does not believe she is getting showered/bathed as scheduled. During an interview with CNA G on 10/30/2024 at 2:05p.m., CNA G stated that residents on left side of hall where Resident #67's room was located were to receive showers on Tuesday, Thursday, and Saturdays. If resident refused, they were supposed to give resident some time and offer a shower a little later or other option such as a bed bath if they were not feeling well. If resident continued to refuse, they were to notify the Charge Nurse and document in POC (Point of Care electronic record). CNA G stated that Resident #67 did refuse showers and hygiene at times, but she would document the refusal in POC. CNA G stated it was important to document all showers given and any refusals, to make sure care is being provided. During an interview with the DON on 10/30/2024 at 1:30pm, the DON stated that staff should be documenting all hygiene activities, including bathing and oral hygiene and any refusals in the resident's record, and that if not documented, could be considered not done. The DON stated that not showering residents as scheduled could result in residents developing body odor or skin problems. Record review of ADL Policy (undated) revealed under Procedures #6 Nursing assistants will provide assistance with ADL's based on the resident's individualized plan of care. These interventions will be on the Kardex, which is accessed in Point of Care (POC). Any changes noted in the resident's performance or abilities will be reported to the licensed Nurse. Record review of facility Policy titled Charting and Documentation revised 5/2007, revealed the following: The resident's clinical record is a concise account of treatment, care, response to care, signs, symptoms and progress of the resident's condition and Notes to be written on all long-term residents by day, evening and night shifts.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36232 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 for 1 of 1 kitchen reviewed for kitchen sanitation. The facility failed to store, label and date two containers of milk properly in the walk-in cooler. This failure could place residents who received meals and/or snacks from the kitchen at risk for food borne illness. The findings included: Observation on 10/28/2024 at 10:52 AM in the walk-in cooler revealed a one-gallon container of whole milk and a one-gallon container of Lactose-Free whole milk. The container of whole milk was opened, there was approximately 1 cup remaining in the container, and labeled 10/25. The container of Lactose-Free milk was opened, there was approximately one quart of milk remaining in the container and labeled 10/15. During an interview on 10/28/2024 at 10:53 AM, the DS stated the dates on the containers of milk were the dates they were received by the facility and stored in the cooler. They did not indicate the date they were opened or the use-by date. They should have both been labeled with the use-by date. Staff storing opened food in the coolers were responsible for properly labeling and dating all food items in the cooler with the date opened and use-by date; failure to do so could cause proliferation of bacteria that could lead to food borne illness. All staff was trained upon hire and during monthly inservices. All staff had current food-handler certificates. The facility used the TFER as their policy manual. Record review of the TFER, 2015, revealed, S228.75(g)(1) (g) Ready-to-eat, time/temperature controlled for safety food, date marking. (2) Except as specified in paragraphs (5) - (7) of this subsection, refrigerated, ready-to-eat, time/temperature controlled 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 held at a temperature of 41 degrees Fahrenheit (5 degrees Celsius) or less 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 paragraph (I) of this paragraph: A) the day the original container is opened in the food establishment shall be counted as Day 1; and (B) 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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 3-501.17 Ready-to-Eat/Time Temperature Control for Safety Food, Date Marking. (B) Except as specified in (E) - (G) of this section, 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 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. 36232 Based on observation, interview and record review, the facility failed a to dispose of garbage and refuse properly for 2 of 2 dumpsters (dumpsters #1 and #2) reviewed for disposal of garbage. 1. The facility failed to ensure the waste in dumpster #1 was removed to allow the top lid to close 2. The facility failed to ensure dumpster #2 had a drainage plug and the right door was completely shut These deficient practices could place residents at risk for exposure to germs and diseases carried by vermin and rodents. The findings were: 1. Observation on 10/30/2024 at 11:59 AM revealed there was overflowing trash at the top of the dumpster, preventing the lid from closing and leaving a gap approximately 18 in length. There was a piece of cardboard approximately 2' x 3' on the ground in front of dumpster #1, and there were flies circulating between the two dumpsters. During an interview on 10/30/2024 at 12:00 PM, the DS stated the top lid should have been closed, the facility's trash was supposed to be picked up daily, and it did not appear the trash had been picked up recently. She told the maintenance department to contact the local waste management and request two large dumpsters to better manage the amount of trash generated by the facility. The dumpsters were used by both the dietary and nursing departments. 2. Observation on 10/30/2024 at 12:01 PM revealed the sliding door on the right side of dumpster #2 was open approximately 12. There was also a drainage plug missing from right side of the dumpster. During an interview on 10/30/2024 at 12:02 PM, the DS stated the door to the dumpster should not have been open, as it presented an unsanitary condition and an opportunity for the proliferation of rodents. This dumpster had recently been replaced, and the previous one had a drainage plug. During an interview on 10/30/2024 at 12:05 PM, OM L stated the facility's trash was supposed to be picked up daily and it did not appear the trash had been picked up for over a day. Failure to remove trash in a timely manner could attract pests which carry disease. During an interview on 10/31/2024 at 12:50 PM, the DS stated the facility used the Texas Food Establishment Rules as their policy manual. Record review of the Texas Food Establishment Rules, 2015, S228.152(n)(2), revealed: Covering Receptacles. Receptacles and waste handling units for refuse, recyclables, and returnables shall be kept covered: (2) with tight-fitting lids or doors if kept outside the food establishment. (o) Using Drain Plugs. Drains in receptacles and waste handling units for refuse, recyclables, and returnables shall have drain plugs in place. (continued on next page)

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 5-501.113 Covering Receptacles. Receptacles and waste handling units for refuse, recyclables, and returnables shall be kept covered: (B) With tight-fitting lids or doors if kept outside the food establishment. 5-501.114 Using Drain Plugs. Drains in receptacles and waste handling units for refuse, recyclables, and returnables shall have drain plugs in place.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 36232 Based on interview and record review, the facility failed to ensure the governing body appointed an administrator who was licensed by the State, where licensing is required; responsible for management of the facility; and reports to and is accountable to the governing body for 1 of 1 facility reviewed for the governing body, in that: The governing body failed to appoint an administrator who was responsible for the management of the facility. This deficient practice could result in the facility not being managed in a responsible manner, which could affect the health and safety of all residents. The findings include: During an interview on 10/28/2024 at 9:05 AM, OM L introduced himself to the survey team as the OM of the facility and stated he did not have an administrator license but was in the process of obtaining one. The facility had an administrator who did not work at the facility full-time. He was at the facility full-time and was responsible for the daily management of the facility. During an interview on 10/30/2024 at 12:35 PM, the Administrator stated she assumed the position of administrator for the facility sometime the end of February 2024 but was unsure of the exact date. She had not been in the facility on a daily basis, did not spend 40 consecutive hours per week at the facility, and visited the facility as needed. She was available at home if the facility needed her. During a telephonic interview on 10/30/2024 at 1:47 PM, OM M stated he had taken over leadership of the facility from the previous administrator. He was not a licensed administrator, but in the process of becoming an administrator. He remained the OM when the administrator assumed the position in February 2024, was at the facility daily, and was responsible for the daily operation and management of the facility. The administrator was not at the facility daily. Record review of hire dates provided by the facility revealed the following: - Previous licensed administrator was employed by the facility from 12/27/2022 - 01/16/2024. - OM M became the OM of the facility on 02/11/2024 - 10/01/2024. - OM L became the OM of the facility on 10/08/2024. - The facility's current administrator's hire date was 03/01/2024. During an interview on 10/31/2024 at 1:26 PM, OM L stated the facility did not have a specific policy regarding the administration of the facility, they just followed the regulation.

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NAME OF PROVIDER OR SUPPLIER Pecan Valley Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 3838 E Southcross Blvd San Antonio, TX 78222	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on interview and record review, the facility failed to maintain medical records on each resident that were complete and accurately documented for 1 (Resident #67) of 6 residents reviewed for clinical records. The facility failed to ensure CNA F documented oral hygiene care that was offered, performed or refused by Resident #67 on 10/4/2024, 10/7/2024, 10/11/2024, 10/15/2024, 10/25/2024, 10/28/2024 and 10/29/2024. This deficient practice could place residents at risk of improper care due to inaccurate medical records. The findings were: Record review of Resident #67's face sheet, dated 10/28/2024, revealed a [AGE] year-old female with an admitted [DATE], and diagnoses which included: Dysphagia (trouble swallowing) following Cerebral Infarction (stroke resulting from blood flow to brain being blocked); Non-Traumatic Intracerebral Hemorrhage in Hemisphere (bleeding in the brain); Seizures (uncontrolled jerking, loss of consciousness, blank stares or other symptoms caused by abnormal electrical activity in brain); Type 2 Diabetes mellitus (a long-term condition in which the body has trouble regulating blood sugar); Contracture (fixed tightening of muscle and tissue that prevents normal movement) right hand; Age-Related physical debility (physical weakness) and Need for Assistance with Personal Care. Record review of Resident #67's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 4, indicating severe cognitive impairment. Further review under Section GG - Functional Abilities and Goals, shows Resident #67 was assessed as needing partial to moderate assist in oral hygiene. Record review of Resident #67's care plan dated 09/22/2024 reflected a focus area for ADL Self Care Performance Deficit r/t CVA [cerebrovascular accident], impaired mobility, with interventions that include Oral Hygiene: Dependent x 1 staff member. Record review of Resident #67's oral hygiene log for October 2024 revealed there was no oral hygiene documented as being done on the following days: 10/4/2024, 10/7/2024, 10/11/2024, 10/15/2024, 10/25/2024, 10/28/2024 and 10/29/2024. Interview on 10/28/2024 at 9:41 a.m. with Resident #67's RP revealed she visited often, and was concerned because it did not appear that Resident #67's teeth were being brush daily, noting her teeth did not appear clean sometimes when she visited. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with LVN H on 10/31/2024 at 9:37 a.m., LVN H stated she also was one of the MDS Nurses and helps with training of staff. She reviewed the oral hygiene log for Resident #67 for October 2024 and confirmed that n/a ,(non-applicable), was recorded on the 7 days with no oral hygiene recorded as being completed. LVN H was not able to explain why n/a would be documented for oral hygiene, unless there was a medical reason the resident could not brush her teeth, and stated that oral hygiene should be conducted at least daily, and documented in POC (Point of Care). LVN H reviewed the record and stated the CNA who documented the n/a on Resident #67's on the dates in question on the oral hygiene log was CNA F. Interview with CNA F on 10/31/2024 at 10:00 a.m. revealed he had been working at the facility for about 3 years and stated he did brush Resident #67's teeth every day, but instead of using a toothbrush, he used a sponge stick, because the toothbrush seemed to hurt her, and she would pull away. He stated he used a sponge stick to swab Resident #67's teeth every day when he was on duty, but he documented it as n/a because he did not use a toothbrush. He stated that the log they document tasks performed changed a few months back and he realized now he entered the completed oral hygiene task in wrong section of the log. During an interview with the DON on 10/30/2024, the DON stated oral hygiene should be done at least daily, but ideally both am & pm. She stated staff should be documenting all tasks completed and any refusals. She stated that if not documented, the task could be considered as not being done. Record review of facility policy titled Charting and Documentation revised 5/2007 revealed that The resident's clinical record is a concise account of treatment, care, response to care, signs, symptoms and progress of the resident's condition.

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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** 34788 Based on observation, interview, and record review, the facility failed to 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 disease and infection for 3 of 15 residents (Residents #67, #49 and #6) reviewed for infection control, in that: 1. While providing incontinent care for Resident #67, CNA D did not change her gloves or wash her hands after touching the privacy curtain before starting to provide care. 2. While observing LVN I perform an accu-check test on Resident #49, a used lancet (a sharp pointed medical instrument used to puncture the skin to obtain a small amount of blood for testing) was observed on Resident #49's bedside table that was parallel next to her bed, within her reach and lying next to some candy wrappers. 3. While preparing to administer eye drops to Resident #6, MA J took off the lid to the eye dropper, obtained a tissue from the box next to the resident's bed and wiped the top of the eye dropper in a back and forth turning motion, rubbing the tissue across the tip of the eye dropper several times These deficient practices could place residents at-risk for infection due to improper care practices. These findings included: 1. Record review of Resident #67's face sheet, dated 10/31/2024, revealed an admitted [DATE] with diagnoses which included: Dysphagia (difficulty swallowing), Hypertension (High blood pressure), Type 2 diabetes mellitus (high level of sugar in the blood), Hypothyroidism (under active thyroid), Cerebral infraction (Stroke). Record review of Resident #67's MDS Annual assessment, dated 09/25/2024, revealed the resident had a BIMS score of 4 indicating severe cognitive impairment. Resident #67 required extensive assistance to total care, had an indwelling catheter and, was always incontinent of bowel. Record review of Resident #67's care plan revealed a care plan initiated 11/12/2022 with a problem of has an indwelling Foley catheter 16F (French) with 30cc balloon related to obstructive uropathy and a goal of Will remain free from catheter related trauma/UTI through review date. Observation on 10/30/24 10:12 a.m., revealed while providing catheter/incontinent care for Resident #67, CNA D touched the privacy curtain with her gloved hands. She did not change her gloves or wash her hands, then, started to provide care for Resident #67. During an interview on 10/30/2024 at 10:40 a.m., CNA D verbally confirmed the privacy curtain was considered dirty as part of the environment around the resident and she should have changed gloves and sanitize her hands. She revealed she forgot. She confirmed receiving training on infection control within the year (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 10/31/2024 at 9:20 a.m., the DON verbally confirmed the staff should have changed her gloves and sanitize her hands prior to start providing care for the resident. She confirmed it could cause a risk of cross contamination and infection for the resident. She confirmed they provided training on infection control at least once a year and as needed. She confirmed they checked the skills of the staff annually and as needed with the assistance of her ADONS. Record review of the facility's incontinent care evaluation, undated, revealed wash hands before care, after each gloves change, before reapplying gloves. 33866 2. Record review of Resident #49's face sheet, dated 10/31/2024, revealed an admitted [DATE] with diagnosis which included: cerebral infarction (stroke); Hemiplegia and Hemiparesis (paralysis or weakness on one-side of the body) following cerebral infarction affecting left non-dominant side; Type 2 diabetes mellitus (high level of sugar in the blood); and glaucoma (disease that damage the eye's optic nerve). Record review of Resident #49's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 10 indicating moderate cognitive impairment. Resident #49 was assessed as having diabetes Mellitus, and glaucoma. Record review of Resident #49's Care Plan initiated 6/20/2020 with a focus area for Diabetes Mellitus, and a goal to have no complications related to diabetes through the review date. Record review of Resident #49's Order Summary dated 10/31/2024 revealed an order for Humalog Kwik Pen Subcutaneous solution Pen-Injection 100 unit/ml (Insulin Lispro) as per sliding scale .subcutaneously before meals and at bedtime related to Type 2 Diabetes Mellitus with other circulatory complications. Observation on 10/30/2024 at 07:05 a.m. revealed that after LVN I administered an accu-check test on Resident #49, she picked up with her gloved hands the used lancet she had just used, and then reached over to pick up another used lancet that was located on Resident #49's bedside table, next to some candy wrappers and within Resident #49's reach. During an interview on 10/30/2024 at 7:09a.m., LVN I stated the lancet should not have been left out on Resident #49's bedside table, and it appeared to have been left out by someone conducting an earlier accu-check. She stated a lancet is considered a sharps, and should be disposed of correctly in sharps container, not left out in open and that is why she picked it up. Interview with Medical Records Specialist K who was also monitoring the accu-check being performed, confirmed that the used lancet should not have been left out on the bedside table, and without proper disposal posed a safety and infection control concern. Review of facility policy titled Infection Control - Sharps Disposal dated 6/2016, revealed under Procedure: 1. Contaminated sharps shall be discarded immediately or as soon as feasible into designated containers. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of Resident #6's face sheet dated 10/31/2024 revealed an initial admitted [DATE] with re-admission on 10/10/2024 and diagnoses which included: Congestive Heart Failure (condition where heart does not pump as it should); Primary open-angle glaucoma bilateral (condition causing increased pressure in eye); Glaucomatous Optic Atrophy (damage to optic nerve affecting vision) bilateral and dementia (loss of cognitive functioning). Record review of Resident #6's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 10 indicating moderate cognitive impairment. Record review of Resident #6's Care Plan Initiated 11/11/2020 revealed a focus area of impaired vision r/t glaucoma, wears prescription glasses and a goal to have no indications of acute eye problems through review date and interventions which I included Administer medications as ordered by physician. Record review of Resident #6's Order Summary dated 10/31/2024 revealed an order for Ofloxacin Ophthalmic Solution 0.3%. Instill 1 drop in both eyes three times a day related to Glaucomatous Optic Atrophy Bilateral. Observation on 10/30/2024 at 3:51p.m. revealed that while administering medications to Resident #6, MA J opened the top of the eye drops (Ofloxacin Ophthalmic Solution 0.3%) and then obtained a tissue from a box next to Resident #6's bed, and wiped the top of the eye dropper in a back and forth turning motion, rubbing the tissue across the tip of the eye dropper several times. During an interview with MA J on 10/30/2024 at 3:51p.m., MA J stated she did not know why she wiped the top of the eye dropper with a tissue, explaining she was nervous and just did it. MA J stated she knows she is not supposed to touch the tip of the eye dropper to any surface, as this may contaminate the eye drops. Interview with the DON on 10/30/2024 at 4:32p.m. revealed that she confirmed that the surface of the eye dropper should not touch any surface, as this may contaminate the eye drops. Further interview with DON revealed that MA J had been trained on medication administration of eye drops and infection control, and she provided Competency Testing with MA J completed 10/07/2024 which showed MA J showed competency with medication administration to include administration of eye drops. Record review of American Academy of ophthalmology article titled How to Put in Eye Drops dated 05/05/2023, revealed instructions which included: Remove the cap of the eye drop medication but do not touch the dropper tip. Further review reveals the dropper tip could pick up bacteria from fingers or other surfaces and contaminate the bottle of medication.