STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676270	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Place Four	3505 S Buckner Blvd Bldg 5 Dallas, TX 75227

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49427 Based on observation, interview, and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 1 (Resident #486) of 6 residents reviewed for resident rights. The facility failed to ensure Resident #486's call light was placed within their reach. This failure could place residents at risk of injuries and unmet needs. Findings include: 1. Record review of Resident #486 Comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old male admitted [DATE]. Resident #486 had diagnoses which included traumatic brain injury (brain dysfunction due to injury to head), Methicillin Susceptible Staphylococcus Aureus infection (antibiotic resistant bacterial infection), and anemia (low iron) with a blank BIMS score. Record review of Resident #486's care plan reflected resident was at risk of falls, with the goal to be free of falls dated 05/02/2024 with a target date of 07/31/2024 and interventions to anticipate and meet the resident's needs and ensure call light was within reach and encourage the resident to use it for assistance as needed. Review of care plan reflected Resident #486 had a surgical incision wound due to a previous head injury with the goal for the surgical wound to be healed without complications dated 05/03/2024 with a target date of 07/31/2024. Observation on 05/07/2024 at 3:50 PM of Resident #486 room revealed Family Member seated next to resident's bed and indicated resident was in the restroom and Family Member only spoke Spanish. Observation of call light on floor coiled on the floor next to head of bed and on top of TV stand. Observation and interview on 05/08/2024 at 4:21 PM revealed Family Member sitting in chair next to resident's bed and Resident #486 was walking out of the restroom wearing a white bandage around his head with a large indentation on the right side of his head. Resident #486 wore pajama bottoms, a t-shirt, and slippers. Resident #486's bed was in a low position and call light was coiled on the floor behind the resident's bed. Resident #486 and Family Member indicated they only spoke Spanish and were unable to be interviewed despite attempts to use google translate application. (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: 676270	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/10/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Place Four		STREET ADDRESS, CITY, STATE, ZIP CODE 3505 S Buckner Blvd Bldg 5 Dallas, TX 75227	

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/09/2024 at 10:04 AM revealed Resident #486 sitting in bed with no bandage and with call light coiled on floor beside the head of the bed, Family Member was sitting in a chair next to the bed. Interview on 05/09/2024 at 10:06 AM translated using Language Line Interpreter began with Resident #486 and Family Member. Family Member stated that the call light was always on the floor coiled next to the head of resident's bed and she demonstrated that when she needs to press the call light she walked over, bent down, picked up the call light button and pressed it and then set it back down on the floor. Family Member stated she did not move it herself because she did not want to move something that was not supposed to be moved. Resident #486 stated that if he needed to reach the call light button he would have to bend over to reach it and would probably go walk and get a nurse instead. Resident #486 stated he was a little unsteady when walking. Observation on 05/09/2024 at 11:41 AM revealed Resident Family Member pressed call light at 11:41 AM and set call light down where it was on the floor next the head of Resident #486 bed. Observation on 05/09/2024 at 11:54 AM revealed MDS Coordinator R, entered Resident #486's room and asked if resident needed anything and stated she did not see anything out of place, walked across the room and turned off the call light button, and stated she would get a nurse to come to the room. Observation on 05/09/2024 at 12:00 PM revealed LVN P entered room and stated he did not see anything out of the ordinary. LVN P was asked about resident's call light and he stated that the call light was currently not where it should be and moved call light to resident bed, where it began to slide off. LVN P stated that sometimes a clip is attached to the call light button and was clipped to the pillow or side of bedding to keep within reach of resident. LVN P stated that when the nurse aide or any nurse that checked on or provided care for resident they should always put the call light within reach of the resident before leaving the room. LVN P stated that resident was a fall risk so keeping the call light within reach of resident was important because a resident could be injured when trying to reach a call light or if he needed assistance he would not be able to call for help. Interview on 05/10/2024 at 5:50 PM with ADON C revealed she was the ADON for Resident #486's hall and Resident #486 should have the call light within reach at all times because resident was a fall risk and needed to be able to call for help when needed to prevent possible injuries. Review of the facility's call light policy titled Communication-Call System, dated revised 10/24/2022, reflected The facility will provide a call system to enable residents to alert the nursing staff from their beds and toileting/bathing facilities . Procedure .II. Call cords will be placed within the resident's reach in the residents' room. Review of facility's fall prevention policy titled Fall Evaluation and Prevention, dated revised August 2020, reflected The facility will evaluate residents for their fall risk and develop interventions for prevention . Intervention suggestions for fall prevention . Demonstrate use of nurse call system and ensure call cord within reach at all times.

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F 0580

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 34399

Based on interview and record review, the facility failed to immediately consult with the resident 's physician when there was a significant change in the resident 's physical status and a need to alter treatment significantly for two (Residents #17 and #55) of ten residents reviewed for notification of changes.

1. ADON C failed to notify the physician and responsible party of Resident #17's change of condition of significant weight loss on 04/28/24. Resident #17's physician was not informed of significant weight loss until 05/06/24. The responsible party for Resident #17 was not notified until 05/07/24.

2. ADON C failed to notify the physician and responsible party of Resident #55's change of condition of significant weight loss on 05/04/24.

These failures could place residents at risk for a delay in treatment and diagnosis of new symptoms resulting in serious illness, hospitalization , further decline in the resident's condition, and death.

Findings included:

1. Review of Resident #17's quarterly MDS assessment dated [DATE] reflected Resident #17 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of stroke, heart failure, hypertension, kidney failure, diabetes, dementia, metabolic encephalopathy (brain dysfunction caused by problems with your metabolism), dysphagia (difficulty swallowing that can be caused by various conditions affecting the throat or esophagus), cognitive communication deficit and gastrostomy status. Resident #17 had a BIMS of 11 indicating he was moderately cognitively impaired. Resident #17 had a substantial/maximal assistance to dependent with ADLs. Resident #17 had a feeding tube with 51% or more proportion of total calories received through tube feeding while in the facility.

Review of Resident #17's face sheet dated 05/08/24 reflected Resident #17 responsible party and POA was a resident's family member.

Review of Resident #17's weights from March to May 2024 reflected the following:

- Dated 05/03/24 178 lbs recorded by ADON C

- Dated 04/28/24 179.2 lbs recorded by ADON C

- Dated 04/05/24 224 lbs recorded by previous DON

- Dated 03/07/24 226.9 lbs recorded by previous DON

Review of Resident #17's progress/nutrition notes and assessments from 04/01/24 to 05/06/24 reflected there was no notification to physician or responsible party for change of condition.

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/09/24 at 11:41 AM with Resident #17's Responsible Party revealed she was notified on 05/07/24 about Resident #17's weight loss but the facility did not go into detail about how much weight. She stated she was told they would put some interventions in place but did not tell her what was put in place. She would like to know what interventions the facility put in place to address the weight loss. She was concerned about Resident #17's significant weight loss and would have liked more information from the facility when she was notified about it. 2. Review of Resident #55's quarterly MDS assessment dated [DATE] reflected Resident #55 was a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] to the facility with diagnoses of chronic respiratory failure with hypoxia (occurs when you do not have enough oxygen in your blood), seizures, adult failure to thrive, tracheostomy status and gastrostomy status. Resident #55 had moderately impaired cognitive skills for daily decision making with no BIMS score completed for Resident #55 since he was rarely/never understood per the assessment. Resident #55 was dependent with all ADLs. Resident #55 has a feeding tube with 51% or more proportion of total calories the resident received through tube feeding. Review of Resident #55's weights from 11/6/23 to 05/04/24 reflected the following: - Dated 11/06/23 203 lbs recorded by previous DON - Dated 12/06/23 204 lbs recorded by previous DON - Dated 01/07/24 202.4 lbs recorded by previous DON - Dated 02/04/24 197.9 lbs recorded by previous DON - Dated 03/07/24 197.6 lbs recorded by previous DON - Dated 04/05/24 198.5 lbs recorded by previous DON - Dated 05/04/24 164.4 lbs recorded by previous DON Review of Resident #55's progress/ nutrition notes from 04/01/24 to 05/07/24 reflected there was no notification to physician or responsible party for change of condition. Interview on 05/07/24 at 4:48 PM with ADON C revealed she had not notified Resident #17 or Resident #55's responsible party about the weight loss. Interview revealed she did not inform the physician about the weight loss for Resident #55. Interview on 05/08/24 at 10:38 AM with Regional Nurse Consultant A revealed the QAPI put ADON C as the one responsible for ensuring weights completed and for notifying the physician and the responsible party for any weight loss for residents. She stated ADON C should have notified the physician and responsible party. Interview on 05/08/24 at 1:53 PM with Resident #17's Physician revealed he expected to be notified when residents have weight loss . He stated he was not notified until Monday (05/06/24) for Resident #17's weight loss. He was not notified or aware of Resident #55's weight loss. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility's policy Assessment and Management of Resident Weights last revised December 2023 reflected under procedure V. Significant Weight Change Management A. Significant weight changes will be reviewed by the DON or designated licensed nurse. Significant weight changes are: i. 5% in one (1) month ii. 7.5% in three (3) months iii. 10% in six (6) months B. The DON or licensed nurse will: i. Report weight change in the medical record and on the 24-Hour Report. ii. Notify the physician, resident/RP/family/healthcare decision maker of significant weight changes. iii. Document the notification. iv. Complete a change of condition on residents with significant 1 month 5% or greater weight changes .D. The licensed nurse will notify the physician and resident/RP/family/healthcare decision maker of the dietitian's recommendations as indicated. Review of facility's policy Change of Condition Notification revised June 2020 reflected to ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner .The Facility will promptly inform the resident, consult with the resident's Attending Physician, and notify the resident's legal representative when the resident endures a significant change in their condition cause by, but not limited to: .A significant change in the resident's physical, cognitive, behavioral or functional status . The Licensed Nurse will notify the resident's Attending Physician when there is an .A significant change in the resident's physical, mental or psychosocial status, e.g., deterioration in health, mental or psychosocial status .III. Notifying the Attending Physician A. The Attending Physician will be notified timely with a resident's change in condition. B. Notification to the Attending Physician will include a summary of the condition change and an assessment of the resident's vitals signs and review system focusing on the condition and/or signs and symptoms for which the notification is required .A licensed nurse will document the following: Date, time and pertinent details of the incident and subsequent assessment in the nursing notes. ii. The time the Attending Physician was contacted, the method by which he was contacted, the response time and whether or not orders were received. iii. The time the family/responsible party was contacted.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 42971 Based on observation, interview and record review, the facility failed to provide the necessary services to maintain good personal hygiene to a resident who is unable to carry out activities of daily living for three of six residents (Resident #536, Resident #4, and Resident #32) reviewed for quality of life. 1. The facility failed to provide Resident #536, who required extensive assistance, with timely incontinence care on 05/7/24 from 6:00 a.m. to 2:20 p.m. 2. The facility failed to provide Resident #4, who required extensive assistance, with timely incontinence care on 05/07/24 from 6:00 a.m. to 2:50 p.m. and failed to consistently shampoo resident's hair. 3. The facility failed to ensure Resident #32 had his fingernails cleaned and trimmed. These failures could place residents at risk of skin breakdown, urinary tract infections, and loss of dignity. Findings included: 1. Record review of Resident #536's Face sheet dated 05/09/24 reflected a [AGE] year-old male with an admitted [DATE]. Resident was listed as his own responsible party. Diagnoses included cauda equina syndrome (compression of nerve roots in the lumber spine), malignant neoplasm of the prostate and bone (cancer), neuromuscular dysfunction of the bladder(lack bladder control due to nerve problems) and need for assistance with personal care. Record review of Resident #546's base line care plan completed on 05/07/24 reflected, The resident has an ADL Self Care performance deficit related to impaired balance, cauda equina syndrome, weakness . Interventions .toileting .dependent assist of 2 persons, incontinent care, foley care . In an interview with Resident #536 on 05/07/24 at 10:50 a.m., he stated he admitted to the facility yesterday (05/06/27). Resident had a foley catheter and he stated he had a wound on his bottom. During a medication pass observation on 05/07/24 at 01:15 p.m. while standing in hallway outside of Resident #536's room, an unknown staff member entered Resident #536's room with his lunch tray. Resident #536 told unknown staff member he needed to be changed. Unknown staff member stated she would let his CNA know and left the room. In an interview with Resident #536 on 05/07/24 at 2:05 p.m. he stated no one had come and changed him. He stated he was concerned about his catheter since he had a history of drainage from his catheter and stated he had a bowel movement and needed to be changed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Regional Director of Operations on 05/07/24 at 02:10 p.m. he was informed Resident #536 had requested to be changed at 01:15 p.m. and no one had come and changed him. Regional Director of Operations stated he would send someone right away. In an observation on 05/07/24 at 05/07/24 at 2:20 p.m., CNA K and CNA G donned gowns and entered Resident #536's room to provide incontinence care. Resident stated this was the first time anyone had been in to change him this shift. CNA K stated it was the first time she had been in to provide incontinent care to the resident and stated no one had informed her he needed to be changed. 2. Record review of Resident #4's annual MDS assessment, dated 03/16/24, reflected a [AGE] year-old female with an admitted d of 05/18/21. She had a BIMS score of 12, indicating her cognition was moderately impaired. She had no behaviors documented and had not resisted care. Resident #4 required extensive assistance with toileting and personal hygiene and was always incontinent of bowel and frequently incontinent of urine. Resident #4 was at risk of pressure ulcers with no current skin issues. Her active diagnoses included diabetes, cerebral vascular accident (stroke) and dementia. Record review of Resident #4's Comprehensive Care Plan with a revision date of 03/18/24, reflected, . [Resident #4] has mixed bladder and bowel incontinence related to confusion, dementia, impaired mobility, inability to communicate needs, physical limitations. She is at increased risk for alterations in skin integrity and/pressure ulcer development Has an ADL Self-Care performance deficit .Interventions .Uses disposable briefs .Toilet use .Personal Hygiene .requires extensive assistance (2x) staff participation . In an Interview and observation with Resident #4 on 05/07/24 at 11:20 a.m. Resident was observed lying in bed with a hospital gown on. Hair was noted to be oily, and resident had a musty smell. Resident #4 stated her hair had not been washed in over a month. She stated she wanted it washed. She stated she did not get into the shower because it hurts too much to be lifted with the lift. She stated she gets a bed bath instead of going to the shower. In an Interview with CNA K on 05/07/24 at 1:00 p.m. she stated she was the aide assigned to Resident #4. She stated Resident #4 probably had not had her hair washed in over a month, because the shower bed was too short for the resident. She stated she did not always work the hall Resident #4 was on, and stated she had never washed the resident's hair. In an interview with CNA K on 05/07/24 at 2:45 p.m., she stated she had not provided incontinence care to Resident # 536 or Resident #4. She stated she was headed to Resident #4's room next. She stated she had worked the hall by herself and some of the residents had some behaviors which placed her behind. She stated she had not gotten to Resident #4. She stated the hall trays did not get to the hall until 1:00 p.m. so she had not gotten to do her final rounds before she should have been clocking out. She stated she stayed over to provide care to these two residents and had gotten CNA G to help her since it took 2 people. An observation on 05/07/24 at 2:50 p.m. revealed CNA K and CNA G entered Resident #4's room. Both staff sanitized their hands and put on gloves. Resident #4 stated this was the first time she had been changed this shift but stated that was not typical. She stated CNA K was good about taking care of her. Staff provided incontinence care without issue. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/08/24 at 09:30 a.m. with LVN M she stated she was not aware Resident #536 and Resident #4 were not provided with incontinence care on the 06:00 to 02:00 p.m. shift on 05/07/24. She stated had the aide asked her for help, she would have helped her. In an interview on 05/10/24 at 11:00 a.m. with CNA O she stated she was assigned to the hall where Resident #4 resided. She stated Resident #4 did not get in the shower and took bed baths instead. She stated residents who were bed bound, she just used towels and soap to wash their hair. She stated she had only washed Resident #4's hair once or twice in the times she had taken care of her. She stated she was not sure how often they were supposed to wash residents' hair. She stated she just waited for them to tell her when they wanted it washed. In an interview on 05/10/24 at 11:15 a.m. with the Regional Nurse Consultant A, she stated any resident who was incontinent was to be checked every 2 hours and changed as needed. She stated residents could have a bath or shower anytime they wanted it, but at a minimal, baths and showers were offered three times a week according to the bath schedule. She stated staff should be washing residents' hair during their shower or bed bath days. She stated failing to provide hair care and timely incontinent care could lead to skin breakdown, poor hygiene, and a loss of dignity. She stated the Charge Nurse should be aware of which resident were scheduled for showers or baths and should ensure the care was provided. 3. Record review of Resident #32's Comprehensive MDS assessment dated [DATE] reflected Resident #32 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses included cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), cognitive communication deficit, and contracture of muscle on the left hand. Staff assessed his cognitive status as severely cognitively impaired. The MDS assessment indicated Resident #32 required maximal assistance of 2 persons with toileting and personal hygiene. Record review of Resident #32's Care Plan dated 03/12/24, reflected the following: Focus: [Resident #32} has an ADL self-care performance deficit related to cerebral infarction. Goal: [Resident #32] will maintain current level of function in ADLs through the next review date. Interventions: . Personal hygiene: the resident requires total assistance with personal hygiene care . An observation on 05/07/24 at 09:58 AM revealed Resident #32 was laying in his bed. The nails on both hands were approximately 0.4cm in length extending from the tip of his fingers. The nails were discolored tan and had dark brown colored residue underside. Resident #32 did not answer questions. In an interview on 05/07/24 at 10:59 AM, CNA U stated CNAs were allowed to cut the residents' nails if they were not diabetic. CNA U stated did not see Resident #32's nails this morning. She stated she would do it right then . In an Interview on 05/09/24 at 04:06 PM, ADON D stated nail care should be completed as needed and every time aides wash the residents' hands. The ADON D stated nails should be observed daily. The ADON stated nurses were responsible for trimming the nails of residents who were diabetic, and CNAs could trim other residents' nails. The ADON D stated he expected CNAs to offer to cut and clean nails if they were long and dirty. The ADON D stated he would do the routine rounds to monitor. The ADON D stated residents having long, and dirty nails could be an infection control issue. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Care and Services, dated June 2020, reflected, Residents are provided with the necessary care and services to maintain the highest practicable physical, mental, and social well-being level of in an environment that enhances quality of life in the scope of a long-term care facility. Care and services are provided in a manner that consistently enhance self-esteem and self-worth .The facility will have sufficient staff to provide services to resident with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing as determined by individualized resident assessments and plans of care

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49427 Based on observations, interviews, and record review, the facility failed to ensure that residents received adequate supervision and assistance devices to prevent accidents for 1 (Resident #486) of 6 residents reviewed for quality of care. The facility failed to ensure Resident #486 wore a helmet, as ordered by physician, to prevent possible injury when ambulating. This failure could result in residents to experience accident, injuries, and diminished quality of life. Findings included 1. Record review of Resident #486 Comprehensive MDS dated [DATE] reflected a [AGE] year-old male admitted [DATE]. Resident #486 had diagnoses which included traumatic brain injury (brain dysfunction due to injury to head), Methicillin Susceptible Staphylococcus Aureus infection (antibiotic resistant bacterial infection), and anemia (low iron) and BIMS score was blank. Record review of Resident #486's care plan reflected resident was at risk of falls, with the goal to be free of falls dated 05/02/2024 with a target date of 07/31/2024 and interventions to anticipate and meet the resident's needs and ensure call light was within reach and encourage the resident to use it for assistance as needed. Review of care plan reflected Resident #486 had a seizure disorder due to traumatic brain injury with right sided craniotomy dated 05/07/2024. Review of care plan reflected resident had a surgical incision wound to the head due to a previous head injury with the intervention to wear a helmet at all times date initiated 05/07/2024. Record review of Treatment Administration Record Report for Resident #486 revealed order date of 05/03/2024, discontinue date of 05/07/2024, and updated date of 05/07/2024 for Resident #486 to wear a helmet at all times when out of bed. Observation on 05/07/2024 at 2:51 PM revealed Resident #486 standing at his doorway of his room with a white gauze bandage wrapped around his head with a large indent on the right side of his head as he walked slowly down hallway toward nursing station. Observation and interview on 05/08/2024 at 4:21 PM revealed Family Member sitting in a chair next to resident's bed and Resident #486 was walking out of the restroom wearing a white bandage around his head with a large indentation on the right side of his head and wore pajama bottoms, a t-shirt, and slippers. Resident #486's bed was in a low position and call light was coiled on the floor just behind resident's bed. Resident and Family Member indicated they only spoke Spanish and were unable to be interviewed despite attempts to use google translate application. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Place Four	3505 S Buckner Blvd Bldg 5 Dallas, TX 75227

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/09/2024 at 10:06 AM translated using Language Line Interpreter began with Resident #486 and Family Member revealed resident used to have to wear the helmet all the time when he was in the hospital and now did not have to wear it as often and had been walking around the facility to the nurse's station and outside without wearing the helmet and only remembered wearing the helmet once since being admitted to the facility. Resident #486 stated that when he wore the helmet for a long time he experienced headaches. Interview on 05/09/2024 at 12:00 PM with LVN P revealed he was the charge nurse for Resident #486's hall and worked at facility for about 2 years. LVN P stated that Resident #486 was supposed to wear a helmet whenever he walked or did physical therapy. LVN P stated resident was a fall risk and could have a serious injury if he fell when not wearing the helmet. Interview on 05/09/2024 at 1:38 PM with CNA G revealed she typically worked on Resident #486's hall and had been working at facility for about 3 months. CNA G stated she was not very familiar with Resident #486's and his Family Member was with him most of the time, so she checked on resident periodically throughout her shift and during shift change and when passing meal trays. CNA G stated she had been told in the past by her change of shift nurse that Resident #486 doesn't need much care because his Family Member was present often. CNA G stated on a typical shift she saw the resident walking down the hallway to the nurse's station with his Family Member and did not use a walker or assistive device. CNA G stated resident typically wore a bandage around his head and had staples in his head and did not recall ever seeing resident wearing a helmet when ambulating. CNA G was unable to pull up Resident #486's Kardex during the interview due to the monitor on Resident #486 hall not responding and stated she usually was informed by the nurse during change of shift or her charge nurse about information regarding resident needs and would look at the Kardex when available. Observation and interview with CNA G on 05/09/2024 at 1:46 PM revealed Resident #486 walking from room with Family Member wearing a helmet CNA G stated this was the first time she had seen him wear the helmet. Interview on 05/10/2024 at 12:11 PM with Occupational Therapist Q revealed Resident #486 spoke Spanish, had an accident that resulted in part of his brain and skull removed, broke both of his wrists and it impacted his ability to balance. Occupational Therapist Q stated that if an order from a doctor stated the resident should wear helmet during ambulation then she would be concerned if resident did not wear it due to possible injury if he fell . Interview on 05/10/2024 at 3:00 PM with Regional Nurse Consultant A revealed the resident's care plan and physician orders stated resident was to wear a helmet when out of bed and expected the staff to ensure the orders were followed and care plan implemented. Regional Nurse Consultant A stated the resident not wearing the helmet could result in a serious injury if he fell because resident had a craniectomy and was missing part of his skull which protected his brain, and this information would be communicated verbally through nurse to aide or through the Kardex or Electronic Health Record. Interview on 05/10/2024 at 5:50 PM with ADON C revealed she was the ADON for Resident #486's hall. She stated Resident #486 was a fall risk and the Kardex would be how a CNA would be aware if a resident was supposed to wear a helmet and would expect to see it in the physician orders and care planned. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the facility's policy titled Resident Rights-Accommodation of Needs, date revised 08/2020 reflected the facility's environment is designed to assist the resident in achieving independent functioning and maintaining the resident's dignity and well-being. Review of facility's fall prevention policy titled Fall Evaluation and Prevention, dated revised August 2020, reflected The facility will evaluate residents for their fall risk and develop interventions for prevention . Upon Admission, the nursing staff/interdisciplinary care team should determine if a resident is at risk for falls and develop appropriate interventions based on the evaluation. The goal is to prevent falls if possible and avoid any injury related to falls.

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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** 34918 Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for one of two residents (Resident #38) reviewed for catheter care. The facility failed to ensure CNA H provided catheter care and appropriate perineal care for Resident #38 when she failed to clean the resident's penis, scrotum, and buttocks on 05/08/24. This failure could place residents at risk for the development and/or worsening of urinary tract infections and skin breakdown. Findings included: Record review of resident #38s quarterly MDS assessment, dated 02/12/24, reflected an [AGE] year-old male with an admitted [DATE]. He had a BIMS score of 4 which indicated he was severely cognitively impaired. He was dependent of care for all ADL. He had a foley catheter and colostomy (an opening into the colon from outside of the body). Active diagnoses included dementia, chronic respiratory failure, pressure ulcer stage 4 to sacral (buttocks) area, tracheostomy (a surgical opening in the neck providing a direct airway through the trachea) and quadriplegia (form of paralysis that affects all four limbs). Review of Resident #38's care plan, initiated on 07/17/23, reflected .[Resident #38] has a diagnosis of stage 4 pressure area to sacrum .Resident has a foley catheter in place .Interventions .Foley catheter care per order . Record review of Resident #38's Physician Order Summary report dated 05/09/24, reflected, Foley catheter care every shift and PRN, with a start date of 01/23/24. In an observation on 05/08/24 at 09:10 a.m. the Treatment Nurse was observed providing wound care to Resident #38's sacral wound with the assistance of CNA H. Resident's brief was observed to be soiled with drainage from the sacral wound. After completion of the wound care, the Treatment Nurse instructed CNA H to provide incontinence care and change out the resident's brief. CNA H stated she would need to go get supplies. CNA H removed her gloves and left the room without performing hand hygiene. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 05/08/24 at 9:25 a.m., CNA H donned gown and gloves without performing hand hygiene, prior to entering Resident #38's room. CNA H removed the residents brief and wiped down each groin with the same wipe and then rolled the resident over on his side. CNA H did not provide catheter care, did not clean the penis, and did not clean the scrotum. CNA then rolled the resident on his right side and held him over with one hand while using the other hand to wipe from the base of the wound care dressing toward the resident's scrotum and then front to back toward the resident's anal area. Brief was soiled with brownish drainage from the resident's coccyx wound. CNA H did not clean the scrotum area or the resident buttocks. With the same soiled gloves, CNA H placed a clean brief under the resident and rolled him back onto his back and repositioned the resident and fastened the brief. CNA adjusted the resident's sheet and gathered up the trash. CNA H them removed her gloves and gown and left the room without performing hand hygiene. CNA H walked down to the soiled linen room and deposited the trash. In an interview with the CNA H on 05/08/24 at 9:35 a.m. she stated they were supposed to do catheter care every time they did incontinence care. She stated she did not clean the penis or clean from the tip of the penis down the catheter tube. She stated she did not clean the scrotum or buttocks. She stated she was supposed to perform hand hygiene when she removed her gloves and before she left the room and did not do it. She stated failing to provide proper perineal care and catheter care could lead to urinary tract infections and further skin breakdown. In an interview with Regional Nurse Consultant A on 05/08/24 at 2:00 p.m. she stated staff were to perform hand hygiene before care, when going from dirty to clean and after glove changes and before leaving the room. She stated catheter care was be performed anytime the staff provided incontinence care and staff were to clean the peri area including penis and scrotum for male residents then moving toward the buttocks. She stated by not providing accurate incontinence care it placed residents at risk for urinary tract infections, skin breakdown and overall poor hygiene. She stated she expected the Charge Nurses to make rounds and any staff observed providing care and performing skills incorrectly were to be re-educated as needed. Record review of CNA H's skill checks on 03/20/24 reflected she was competent in hand hygiene, perineal care, and care of indwelling urinary catheter. Record Review of the Facility's policy titled, Catheter- Care of, dated June 2020, reflected, .Daily Catheter Care .Wash hands and put on gloves prior to handling the catheter, drainage system or bag Cleanse the perineum and urinary meatus with soap and water, cleansing wipe, or a perineal rinse as part of am and pm care and after each bowel movement or incontinence episode. Cleanse the perineum from front to back and cleanse the outside of the catheter wiping away from the meatus .remove gloves and wash hands . Record Review of the Facility's policy titled, Perineal Care, dated June, 2020, reflected, .Perineal care is proved as part of resident's hygienic program .Wash hands .put on gloves .Wash the pubic area .For male residents .Wash the penis from the urethral opening or tip of the penis .Wash the scrotum, pay attention to the skin folds, rinse and dry .Turn resident to side .Wash, rinse and dry buttocks and peri-anal area without contaminating perineal area .Remove gloves. Wash hands or use alcohol-based hand sanitizer. Note: Do not touch anything with soiled gloves after procedure (i.e., curtain, side rails, clean linen, call bell, etc.) .put on clean gloves .place soiled linens in proper container .remove gloves .wash hands .

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F 0692

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

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

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 34399

Based on observation, interview, and record review the facility failed to ensure that residents maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise when the facility failed to implement significant weight loss interventions for two (Residents #17 and #55) of seven residents reviewed for significant weight loss, in that:

1. The facility failed to communicate and follow-up on Resident #17's significant weight loss of 44.8 pounds (20%) from 04/05/24 to 04/28/24 to the facility. Resident #17 was weighed on 05/03/24 revealing Resident #17 had lost 46 pounds (21%) for 1 month period from 04/05/24 to 05/03/24. The facility did not notify physician until 05/06/24 and failed to follow physician guidance to notify Dietitian on 05/06/24. The Dietitian was notified by ADON C after surveyor intervention on 05/07/24. The Dietitian failed to observe Resident #17 when she became aware of Resident #17's significant weight loss of 20% for 1 month on 05/07/24 and to follow-up to ensure Resident #17 was receiving enteral feeding as ordered by the physician. The facility failed to monitor Resident # 17 after a feeding change and them he experienced a weight loss.

2. The facility failed to notify the Physician, Dietitian and responsible party regarding resident 55's significant weight loss of 34.1 lbs (17%) from 04/05/24 to 05/04/24. Facility failed to ensure Resident #55 was weighed weekly as per policy for residents dependent on enteral feeding.

These failures could place residents who are completely dependent on staff for their nutrition and hydration at risk for nutritional deficit, weight loss, skin breakdown and overall decline in quality of care, and death.

Findings include:

1. Review of Resident #17's quarterly MDS assessment dated [DATE] reflected Resident #17 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of stroke, heart failure, hypertension, kidney failure, diabetes, dementia, metabolic encephalopathy (brain dysfunction caused by problems with your metabolism), dysphagia (difficulty swallowing that can be caused by various conditions affecting the throat or esophagus), cognitive communication deficit and gastrostomy status. Resident #17 had a BIMS of 11 indicating he was moderately cognitively impaired. Resident #17 had a substantial/maximal assistance to dependent with ADLs. Resident #17 had a feeding tube with 51% or more proportion of total calories received through tube feeding while in the facility.

Review of Resident #17's comprehensive care plan last revised on 01/24/24 reflected Resident #17 requires tube feeding r/t dysphagia and aspiration Resident is NPO at this time . Interventions included to Monitor/document/report to MD PRN . and The resident is dependent with tube feeding and water flushes. See MD orders for current feeding orders.

Review of Resident #17's current physician orders dated 04/09/24 reflected Enteral Feed Order every shift Begin Jevity 1.5 @ 52mls Q/hr times 22/hrs QD to provide 1716 kcals, 73 gm protein and 869 mls free water.

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F 0692

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Review of Resident #17's Nurse Administration Record for April and May 2024 reflected Resident #17 received Enteral Feed Order every shift Begin Jevity 1.5 @ 52mls Q/hr times 22/hrs QD to provide 1716 kcals, 73 gm protein and 869mls free water. The MAR had a check mark from April 10th to May 6th on the day, evening, and night shift . There was a check mark on May 7th for the Day shift. It did not reflect how much feeding Resident #17 received via tube feeding.

Review of Resident #17's Nutrition assessment dated [DATE] by previous Dietitian reflected Resident #17 was npo and received tube feedings with weight history stable with most recent weight on 04/05/24 of 224 lbs via mechanical lift. It reflected to discontinue Jevity1.5 bolus 1 can via 5 times daily and to Begin Jevity 1. 5 @ 52mls Q/hr times 22/hrs QD to provide 1716 kcals, 73 gm protein and 869mls free water. Provide additional 45mls water, via PEG, times 22/hrs QD to provide 990mls water. It reflected Resident #17 had nutritional risk related to diagnosis, history, incontinency, enteral feeding dependency and age

Review of Resident #17's weights reflected the following:

- Dated 05/03/24 178 lbs recorded by ADON C

- Dated 04/28/24 179.2 lbs recorded by ADON C

- Dated 04/05/24 224 lbs recorded by previous DON

- Dated 03/07/24 226.9 lbs recorded by previous DON

Weight loss calculations for Resident #17 reflected the following:

From 4/5/24 to 4/28/24 = 224-179.2 = 44.8 lbs = 20 % weight loss x 1 month

From 4/5/24 to 5/3/24 = 224-178 = 46 = 21% weight loss x 1 month

From 4/5/24 to 5/7/24 = 224-174.6 = 49.4 = 22% weight loss x 1 month

Review of Resident #17's progress/nutrition notes and assessments from 04/01/24 to 05/06/24 reflected there was no notification to physician or responsible party for change of condition.

Review of Resident #17's clinical record from 04/01/24 to 05/06/24 reflected no nutrition assessment or progress note by Dietitian since 04/09/24.

Observation on 05/07/24 at 2:14 PM revealed Restorative Aide and CNA S weighed Resident #17 via mechanical lift reflecting Resident #17 weighed 174.6 lbs.

Interview on 05/07/24 at 2:18 PM with Restorative Aide revealed Resident #17 had his own hoyer sling for use with him only and weighed Resident #17 via mechanical lift each time. She stated she was responsible to weigh all residents including weekly and monthly. She was not aware of any weight loss for Resident #17 but after she weighed the residents she gave her weight documentation to ADON C currently who put in the resident weights in the PCC electronic record. She stated she did not have access to input resident weights herself. She stated she did not have her weight book with her today and left it at home.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/07/24 at 2:51 PM with RN W revealed Resident #17 was tube feeding only for nutrition. She stated she did not really look at resident weights but ADON C and Dietitian were responsible for looking at resident weights. 2. Review of Resident #55's quarterly MDS assessment dated [DATE] reflected Resident #55 was a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] to the facility with diagnoses of chronic respiratory failure with hypoxia (occurs when you do not have enough oxygen in your blood), seizures, adult failure to thrive, tracheostomy status and gastrostomy status. Resident #55 had moderately impaired cognitive skills for daily decision making with no BIMS score completed for Resident #55 since he was rarely/never understood per the assessment. Resident #55 was dependent with all ADLs. Resident #55 has a feeding tube with 51% or more proportion of total calories the resident received through tube feeding. Review of Resident #55's comprehensive care plan last reviewed on 04/05/24 reflected the following: -Date initiated on 12/26/23 - Resident #55 has Tracheostomy r/t Impaired breathing mechanics, Injury. -Date initiated on 12/26/23 and revised on 01/10/24 - Resident #55 requires tube feeding r/t Dysphagia, semi- Coma state, nonverbal, no responsive to stimuli. Interventions included RD to evaluate quarterly and PRN. Monitor caloric intake, estimate needs. Make recommendations for changes to tube feeding as needed. - Dated initiated on 12/26/23 - Resident #55 has potential nutritional problem related to GTUBE, anoxic brain injury. Interventions included Monitor/record/report to MD PRN s/sx of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 3lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Provide G-Tube feedings as ordered. Review of Resident #55's current physician orders dated 02/04/24 reflected Enteral Feed Order every shift Continuous Enteral Feeding: Formula: Jevity 1.5; Rate: 60cc/hr times 22/hrs QD. Review of Resident #55's weights from 11/6/23 to 05/04/24 reflected the following: - Dated 11/06/23 203 lbs recorded by previous DON - Dated 12/06/23 204 lbs recorded by previous DON - Dated 01/07/24 202.4 lbs recorded by previous DON - Dated 02/04/24 197.9 lbs recorded by previous DON - Dated 03/07/24 197.6 lbs recorded by previous DON - Dated 04/05/24 198.5 lbs recorded by previous DON - Dated 05/04/24 164.4 lbs recorded by previous DON Weight loss calculations from 4/05/24 to 5/04/24 = 198.5-164.4= 34.1 = 17.2% x 1 month. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	From 02/04/24 to 05/04/24 = 197.9-164.4=33.5=16.9% x 3 months From 11/03/23 to 05/04/24 = 203-164.4=38.6=19.2% x 6 months Review of Resident #55's Nutrition admission assessment dated [DATE] reflected Resident #55 was npo with weight of 204 lbs via mechanical lift on 12/06/23. Resident #55 has wounds on sacrum deep tissue injury. Resident #55 was on Jevity 1.5 @ 60/hr x 22 hours. Review of Resident #55's progress notes from 04/01/24 to 05/07/24 including nutrition notes reflected no nutrition progress notes for Resident #55. There were no progress notes about significant weight loss or notification to physician or responsible party for change of condition. Interview on 05/07/24 at 3:10 PM with LVN L stated Resident #55 had a history of weight loss in the past, but she was not aware of Resident #55 currently losing weight. She stated that ADON C and Dietitian were mostly responsible for checking and monitoring resident weights. Interview 05/07/24 at 2:35 PM with ADON C revealed on 03/07/24 she started at facility and on 04/24/24 she took over the weights after previous DON left. She stated on 04/28/24 weights were the first time she was responsible for inputting weights. She stated Restorative Aide was responsible for doing weekly and monthly weights for all residents at the facility. She stated at end of the month she printed off weight list and highlight weekly weights giving it to Restorative Aide. She stated once restorative aide is done with getting all weights she turns them into her, she reviews weights and puts resident weights in electronic record system manually. She stated she contacted Regional Nurse Consultant A at this time telling her there were fluctuations in the weights but did not go into detail about the specific residents and weight. She stated she did not know who was the Consultant Dietitian at time since she was just given the responsibility for weights on 04/25/24 so she did not notify Consultant Dietitian about the specific significant weight loss for residents. She stated the facility had a QAPI meeting at end of April 2024 to discuss about questioning weight calculations. She stated she found residents not getting weighed monthly and started weekly weights for Resident #55 since prior to her taking over the weights Resident #55 was not getting weekly weights. She stated residents who were weekly weights should have included g-tube residents and did not know why Resident #55 was not weighed weekly. Follow-up interview on 05/07/24 at 4:48 PM with ADON C revealed they discussed in an IDT meeting about the resident weights having discrepancies but did not specifically mention which residents and the significant weigh loss calculations for the residents. She did not have re-weighs for residents to be completed to verify the accuracy of the resident weights. ADON C stated she notified Dietitian after surveyor intervention earlier in the afternoon today but did not mention specific weight loss percentage asking her to review Resident #17's weights. She stated based on the weights in the PCC system it reflected Resident #55 did have a significant weight loss. She stated she did not document about Resident #17 and #55's significant weight loss or any notification of significant weight loss (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/07/24 at 5:20 PM with Consultant Dietitian revealed she had been recently hired 2 weeks ago started working at the facility. She stated this was her first day in the facility and she was now starting to work on monthly weights which were supposed to be in the PCC system by the 5th of the month and by the 10th of the month she would have reviewed all the weights for all residents. She stated residents who were weekly weighed included residents with g-tube feedings. She stated the ADON or DON should notify me of resident's significant weight loss when became aware of it. She was notified today of Resident #17's significant weight loss and reviewed his weights. She did not go observe Resident #17 or look at Resident #17's enteral feeding pump she only reviewed his weights in the PCC and it looked like Resident #17 was not weighed the same way. She stated she would ask the charge nurse about their enteral feeding to determine if resident getting physician ordered enteral feeding and She stated she reviewed resident weights to monitor weight trends and important to ensure residents getting correct tube feeding as ordered by the physician for residents dependent on enteral feeding. She stated residents dependent on enteral feeding with significant weight loss were at a higher risk for malnutrition and higher risk for skin conditions. She was not aware or notified of Resident #55's significant weight loss. She will review his weights. She looked at his weights in the PCC system showing Resident #55 had a 34.1 lb weight loss for 1 month which was a 17.2 % weight loss. Follow-up Interview on 05/08/24 at 10:15 AM with Restorative Aide revealed she had been weekly weighing Resident #17 and would provide the weights to the previous DON and now the ADON C inputted the weights. She stated when she did her weekly and monthly resident weights she would turn them in within the same day she completed them. She stated Resident #55 was not on her weekly weight list until this week when she did the weekly weights on 05/06/24. She stated she had been doing the resident weights at the facility since beginning of January 2024. She stated Residents #17 and #55 were both weighed via mechanical lift. She was not aware Resident #17's weekly weights were not inputted into PCC but she turned them into the previous DON. She stated on 05/06/24 Resident #17 was weighed via mechanical lift with weight of 172 lbs. Interview on 05/08/24 at 10:38 AM with Regional Nurse Consultant A revealed they did have a QAPI meeting on 04/25/24 about missing weights for residents and were going to weigh all residents weekly for 4 weeks to identify weight trends getting a better idea of resident baseline. She stated the previous DON was responsible for weight management and significant weight loss issues. She stated at the QAPI the facility put ADON C as the one responsible for ensuring weights completed and for notifying the physician and Dietitian about any significant weight loss for residents. She stated they had not been able to find any other resident weights documented to clarify the weights. She stated Restorative Aide was responsible for doing all weights monthly and weekly for residents. She stated ADON C would give the Restorative A a list of residents to be weighed each week. She stated ADON C should have notified the physician and Dietitian on 04/28/24 of any significant weight loss for Resident #17 so interventions could be put in place. She stated ADON C should have documented the significant weight loss notification for residents. She stated she expected g-tube residents to receive the physician ordered enteral feedings. She stated the Dietitian was responsible to calculate nutritional intake including calories to ensure enteral feedings were meeting resident nutritional needs. She stated nurses should make sure setting is correct on enteral feeding and match physician orders along with bags dated and time of started. She stated looking at the history of the feeding g-tube pump would allow the nurse to see what amount of feeding was given since last reset to ensure residents receiving enteral feeding. She stated residents with significant weight loss were at a greater risk for malnutrition and can place residents at risk for skin breakdown. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Brentwood Place Four		STREET ADDRESS, CITY, STATE, ZIP CODE: 3505 S Buckner Blvd Bldg 5 Dallas, TX 75227	

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/08/24 at 1:53 PM with Resident #17's Physician revealed he expected to be notified when residents trigger for a significant weight loss with a day and for the Dietitian to be notified so she can evaluate the weight loss and put nutritional interventions in place for the residents. He stated he was not notified until Monday (05/06/24) for Resident #17's significant weight loss and stated to consult with Dietitian about the significant weight loss to assess Resident #17's weight loss and put Dietitian's nutritional recommendations in place for Resident #17. He stated he expected residents to receive their physician ordered enteral feedings. He stated he expected residents with significant weight loss who are dependent on enteral feedings should be consulted with Dietitian. He was not notified or aware of Resident #55's significant weight loss. Review of facility's policy Assessment and Management of Resident Weights last revised December 2023 reflected To ensure that each resident maintains acceptable parameters of weight and nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible based on the resident's comprehensive assessment. Under procedure I. A facility designee will obtain weight on residents: A. Admissions and re-admissions will be weighed. B. Hospital weight will not serve as admission or re-admission weight. C. Adaptive or assistive equipment used during measurement will be documented. II. If the weight is less than or greater than 5 pounds from the previous weight, immediately re-weigh and have a licensed nurse verify the accuracy of the weight. III. Weights will be entered into the clinical record in a timely manner. V. Significant Weight Change Management A. Significant weight changes will be reviewed by the DON or designated licensed nurse. Significant weight changes are: i. 5% in one (1) month ii. 7.5% in three (3) months iii. 10% in six (6) months B. The DON or licensed nurse will: i. Report weight change in the medical record and on the 24-Hour Report. ii. Notify the physician, resident/RP/family/healthcare decision maker of significant weight changes. iii. Document the notification. iv. Complete a change of condition on residents with significant 1 month 5% or greater weight changes. C. The Registered Dietitian will: i. Complete a nutritional assessment on all residents with a significant weight change; and ii. Document the nutritional assessment and weight management recommendations in the medical record. iii. Notify the facility's IDT team of the nutritional recommendation. D. The licensed nurse will notify the physician and resident/RP/family/healthcare decision maker of the dietitian's recommendations as indicated.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34399 Based on observation, interview, and record review the facility failed to ensure enteral feeding physician orders were followed for two (Residents #17 and #55) of six residents reviewed for enteral tube feeding, in that: 1. The facility failed to verify adequate nutrition was provided via enteral tube feeding or PEG tube (surgical placement of feeding tube in the stomach to provide nutrition, hydration and/or medicines) for Resident #17. 2. The facility failed to notify Consultant Dietitian of Residents #17 and #55's significant weight loss to ensure nutritional interventions were in place. 3. The facility failed to administer enteral feedings for Resident #17 as ordered by the physician. 4. The facility failed to administer enteral feedings to Resident #55 as ordered by the physician. These failures could place residents who are completely dependent on staff for their nutrition and hydration at risk for nutritional deficit, weight loss, skin breakdown and overall decline in quality of care. Findings include: 1. Review of Resident #17's quarterly MDS assessment dated [DATE] reflected Resident #17 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of stroke, heart failure, hypertension, kidney failure, diabetes, dementia, metabolic encephalopathy (brain dysfunction caused by problems with your metabolism), dysphagia (difficulty swallowing that can be caused by various conditions affecting the throat or esophagus), cognitive communication deficit and gastrostomy status. Resident #17 had a BIMS of 11 indicating he was moderately cognitively impaired. Resident #17 had a substantial/maximal assistance to dependent with ADLs. Resident #17 had a feeding tube with 51% or more proportion of total calories received through tube feeding while in the facility. Review of Resident #17's face sheet dated 05/08/24 reflected Resident #17 responsible party and POA was resident's family member. Review of Resident #17's comprehensive care plan last revised on 01/24/24 reflected Resident #17 requires tube feeding r/t dysphagia and aspiration Resident is NPO at this time . Interventions included to Monitor/document/report to MD PRN . and The resident is dependent with tube feeding and water flushes. See MD orders for current feeding orders. Review of Resident #17's current physician orders dated 04/09/24 reflected Enteral Feed Order every shift Begin Jevity 1.5 @ 52mls Q/hr times 22/hrs QD to provide 1716 kcals, 73 gm protein and 869 mls free water. (continued on next page)

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F 0693

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Review of Resident #17's Nurse Administration Record for April and May 2024 reflected Resident #17 received Enteral Feed Order every shift Begin Jevity 1.5 @ 52mls Q/hr times 22/hrs QD to provide 1716 kcals, 73 gm protein and 869mls free water. The MAR had a check mark from April 10th to May 6th on the day, evening, and night shift . There was a check mark on May 7th for the Day shift. It did not reflect how much feeding Resident #17 received via tube feeding.

Review of Resident #17's Nutrition assessment dated [DATE] by previous Dietitian reflected Resident #17 was npo and received tube feedings with weight history stable with most recent weight on 04/05/24 of 224 lbs via mechanical lift. It reflected to discontinue Jevity1.5 bolus 1 can via 5 times daily and to Begin Jevity 1.5 @ 52mls Q/hr times 22/hrs QD to provide 1716 kcals, 73 gm protein and 869mls free water. Provide additional 45mls water, via PEG, times 22/hrs QD to provide 990mls water. It reflected Resident #17 had nutritional risk related to diagnosis, history, incontinency, enteral feeding dependency and age

Review of Resident #17's clinical record from 04/01/24 to 05/06/24 reflected no nutrition assessment or progress note by Dietitian since 04/09/24.

Observation on 05/07/24 at 2:14 PM revealed Restorative Aide and CNA S weighed Resident #17 via mechanical lift reflecting Resident #17 weighed 174.6 lbs.

Observation on 05/07/24 at 2:49 PM revealed Resident #17 was lying with head of bed elevated with Jevity 1.5 at 52 ml/hr with tube feeding revealed dated 05/07/24 at 5:30 AM. Interview with RN W revealed she did not know how to look at Resident #17's history of clock time on the enteral feeding pump. Observation at 2:50 PM with RN W of Resident #17's Enteral pump history with surveyor guidance revealed the following about the last 71 hours of clock time for feed rate set at 52ml/hr with flush 45ml every 1 hour for Resident #17:

- Pump history of last 11 hours - 396 ml feed, 315 ml water flush

- Pump history of last 21 hours - 733 ml feed, 675 ml flush

- Pump history of last 31 hours - 1217 ml feed, 1105 ml flush

- Pump history of last 41 hours - 1717 ml feed, 1555 ml flush

- Pump history of last 51 hours - 2179 ml feed, 1940 ml flush

- Pump history of last 61 hours - 2682 ml feed, 2390 ml flush

- Pump history of last 71 hours - 3092 ml feed, 2730 ml flush

Resident #17's Pump history reviewed for last 71 hours of clock time reflected 3092 ml of formula delivered to Resident #17. However, 52ml/hr x 71 hour = 3692 ml feed. Resident #17 received 600 ml formula deficit -> 900 kcals delivered less in last 71 hours. Resident #17 had a protein deficit for the last 71 hours of 38.2 grams.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/07/24 at 2:51 PM with RN W revealed Resident #17 was tube feeding only for nutrition. She stated her responsibility as a charge nurse was to ensure resident's tube feeding orders match with the pump rate. She did not know if the tube feeding pump needed to be reprogrammed every 24 hours. She did not usually start the tube feeding or take it out on her shift. She stated according to tube feeding it was hung at 5:30 am today for Resident #17. 2. Review of Resident #55's quarterly MDS assessment dated [DATE] reflected Resident #55 was a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] to the facility with diagnoses of chronic respiratory failure with hypoxia (occurs when you do not have enough oxygen in your blood), seizures, adult failure to thrive, tracheostomy status and gastrostomy status. Resident #55 had moderately impaired cognitive skills for daily decision making with no BIMS score completed for Resident #55 since he was rarely/never understood per the assessment. Resident #55 was dependent with all ADLs. Resident #55 has a feeding tube with 51% or more proportion of total calories the resident received through tube feeding. Review of Resident #55's comprehensive care plan last reviewed on 04/05/24 reflected the following: -Date initiated on 12/26/23 - Resident #55 has Tracheostomy r/t Impaired breathing mechanics, Injury. -Date initiated on 12/26/23 and revised on 01/10/24 - Resident #55 requires tube feeding r/t Dysphagia, semi- Coma state, nonverbal, no responsive to stimuli. Interventions included RD to evaluate quarterly and PRN. Monitor caloric intake, estimate needs. Make recommendations for changes to tube feeding as needed. - Dated initiated on 12/26/23 - Resident #55 has potential nutritional problem related to GTUBE, anoxic brain injury. Interventions included Monitor/record/report to MD PRN s/sx of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 3lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Provide G-Tube feedings as ordered. Review of Resident #55's current physician orders dated 02/04/24 reflected Enteral Feed Order every shift Continuous Enteral Feeding: Formula: Jevity 1.5; Rate: 60cc/hr times 22/hrs QD. Observation on 05/07/24 at 3:07 PM revealed Resident #55 was lying in bed with head of bed elevated. Resident #55's enteral feeding pump history of clock time with LVN L revealed the following: -Feed rate: Jevity 1.5 60 ml/hr and feed rate 1540 ml, 662 ml flush. - pump history of last 12 hours - 538 ml feed rate, ml flush - pump history of last 22 hours - 1203 ml feed rate, 1321 ml flush - Pump history of 32 hours - 1745 ml feed, 1981 ml flush - Pump history of 42 hours - 2224 ml feed, 2461 ml flush - Pump history of 52 hours - 2594 ml feed, 2761 ml flush (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Pump history of 62 hours - 3164 ml feed, 3361 ml flush - Pump history of 72 hours - 3705 ml feed, 4021 ml flush Resident #55's Pump history reviewed for last 72 hours of clock time revealed 3750 ml of formula delivered for Resident #55. However, 60ml/hr x 72 hour = 4320 ml of formula. Resident #55 had a 570 ml formula deficit -> 855 kcals delivered less in last 72 hours. Resident #55 had a protein deficit of 36.3 grams in the 72 hour period. Review of Resident #55's Nutrition admission assessment dated [DATE] reflected Resident #55 was npo with weight of 204 lbs via mechanical lift on 12/06/23. Resident #55 was on Jevity 1.5 @ 60/hr x 22 hours. Review of Resident #55's progress notes from 04/01/24 to 05/07/24 including nutrition notes reflected no nutrition progress notes for Resident #55. Interview on 05/07/24 at 3:10 PM with LVN L revealed charge nurse need to clear the pump every 24 hours and before starting new tube feeding each day. She stated the risk for not clearing the enteral feeding pump was unaware of how much feed has been given to the resident and whether it is accurate. Interview on 05/07/24 at 5:20 PM with Consultant Dietitian revealed she had been recently hired 2 weeks ago started working at the facility. She stated this was her first day in the facility. She stated she would ask the charge nurse about their enteral feeding to determine if a resident was getting physician ordered enteral feeding. The Consultant Dietitian stated she needed to ensure residents were getting correct tube feeding as ordered by the physician. Interview on 05/08/24 at 10:38 AM with Regional Nurse Consultant A revealed they did have a QAPI meeting on 04/25/24 about missing weights for residents. She stated she expected g-tube residents to receive the physician ordered enteral feedings. She stated the Dietitian was responsible to calculate nutritional intake including calories to ensure enteral feedings were meeting resident nutritional needs. She stated nurses should make sure setting is correct on enteral feeding and match physician orders along with bags dated and time of started. She stated looking at the history of the feeding g-tube pump would allow the nurse to see what amount of feeding was given since last reset to ensure residents receiving enteral feeding. She stated residents with significant weight loss were at a greater risk for malnutrition and can place residents at risk for skin breakdown. Interview on 05/08/24 at 1:53 PM with Resident #17's Physician revealed he expected residents to receive their physician ordered enteral feedings. Review of facility's policy Tube Feeding/TPN (Total Parenteral Nutrition) revised December 2020 reflected To ensure that the Facility meets the nutritional guidelines and resident's nutritional requirements per physician orders . A physician order is required to administer tube feedings/total parenteral nutrition (TPN). I. The physician's order for tube feedings and TPN are considered diet orders .The physician order and information communicated to the Nutrition Services Department should include: A. Type of formula; B. Amount of formula and fluid; and C. Frequency and amount of feeding. The Dietitian should periodically review residents receiving tube feeding and TPN to ensure nutritional adequacy. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	42971

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F 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide safe and appropriate respiratory care for a resident when needed.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 34918

Based on observation, interview, and record review, the facility failed to ensure that a resident who needed respiratory care, including tracheostomy care, was provided such care, consistent with professional standards of practice for two of two (Resident #20 and Resident # 76) residents reviewed for tracheostomy care.

1. The facility failed to ensure the RT performed hand hygiene during tracheostomy (a surgical opening in the neck providing a direct airway through the trachea) care.

2. The RT failed to maintain sterile technique during the suctioning of Resident #20's trach.

3. The facility failed to ensure LVN L performed hand hygiene during tracheostomy care for Resident #76 and changed her gloves and performed hand hygiene before applying a clean trach drainage sponge around Resident #76's trach stoma.

These failures could place residents at risk for respiratory infections.

Findings included:

1. Review of Resident #20's Admission MDS assessment, dated 05/01/24, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. Staff assessed his cognitive status as severely cognitively impaired. His active diagnoses included acute respiratory failure, cerebrovascular accident (stroke), pneumonia (lung inflammation caused by bacterial or viral infection), and seizure disorder. In Section O-Special Treatments, Procedures, and Programs it revealed he required oxygen therapy, suctioning, and tracheostomy (trach) care during the 14-day look back period.

Review of Resident #20's care plan initiated on 05/02/24 reflected, The Resident has Tracheostomy related to impaired breathing mechanics .Interventions .Ensure that trach ties are secured at all times . Monitor/document respiratory rate, depth and quality. Check and document q shift/as ordered .Suction as necessary .

Review of Resident #20's Physician's orders summary report dated 05/09/24, reflected, .Trach care daily and PRN . with a start date of 04/27/24.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 05/08/24 at 9:40 a.m. revealed the Respiratory Therapist (RT) outside of Resident #20's room. He donned a gown and an N95 mask and gathered an unopened trach kit and entered the resident's room. The RT cleaned the bedside table with a germicidal wipe and placed a box of procedure gloves and the unopened trach kit on top of the bedside table. The RT removed his gloves and put on another pair of gloves without performing hand hygiene and opened the trach kit and removed the sterile drape and placed it on the bedside table for his clean field. He reached into the kit and removed the bottle of saline. The RT removed his gloves and re-gloved with no hand hygiene. The RT reached under his gown to retrieve a pulse oximeter (device used to check O2 saturation) and his stethoscope. The RT placed the pulse oximeter on the resident's finger and listened to his lungs with the stethoscope. The RT removed the pulse oximeter and placed his stethoscope back around his neck. The RT, wearing the same gloves, opened the bottle of normal saline and poured it into the reservoir in the trach kit. The RT removed his gloves and re-gloved with no hand hygiene. The RT stated he needed to suction the resident. The RT reached into the top drawer of the chest of drawers next to the resident's bed and pulled out a tracheal suctioning kit and placed the kit on the clean field. He opened the package and attempted to put on the sterile glove on his right hand. At one point he used his ungloved left hand and tried to get sterile glove on. He then used the hand with the sterile glove (which was half on) and searched the kit. After a few minutes he disposed of the kit and removed the sterile glove and reached into the drawer and retrieved another tracheal suctioning kit. He opened the kit and put on the sterile glove on his right hand and then reached into the box of utility gloves (unsterile) with the hand that had the sterile glove on it and retrieved a utility glove and placed it on his left hand with the hand with the sterile glove, thus making it non-sterile. The RT then picked up the tracheal suctioning catheter by the end that connects to the suctioning machine with his sterile hand (right) and held up the catheter which was dangling and connected it to the suctioning machine. He grabbed the end of the suction catheter with his left hand (un-sterile) and removed the oxygen from the trach and inserted the catheter into the trach and suctioned the resident, which elicited coughing from the resident. He then disposed of the suction catheter, removed his gloves, and re-gloved with utility gloves with no hand hygiene and reached into the trach kit and removed the gauze and the trach dressing. He removed the old trach dressing which had phlegm and placed it on the clean field, next to the clean gauze and trach sponge. The RT then picked up a gauze with the same gloves used to remove the old trach sponge and dipped it in the normal saline and wiped around the trach stoma and repeated the same process twice. He then placed the clean trach sponge under the trach collar wearing the same gloves. The RT then removed his glove and gown and washed his hands. In an interview with the Respiratory Therapist on 05/08/24 at 10:15 a.m. he stated the tracheal suctioning was supposed to be a sterile procedure and he stated he did not do a sterile procedure. He stated he thought there were supposed to be 2 sterile gloves in the tracheal suctioning kit, and it threw him when there was only one. He stated the reason it was supposed to be a sterile procedure was to reduce the risk of introducing infection into the lungs. He stated he should had performed hand hygiene between gloves changes. In an interview with the VP of clinical services on 05/08/24 at 11:00 a.m. she stated tracheal suctioning was considered a sterile procedure and anytime gloves were changed they should be doing hand hygiene. She stated the Regional Director of Respiratory therapy was responsible for skills checking the Respiratory therapist as well as the nursing staff and the DON would be responsible for ongoing oversight of any respiratory therapy care in the facility. She stated the RT would be immediately re-trained. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/8/24 at 11:05 a.m. with the Regional Director of Respiratory Therapy she stated she was responsible for performing the skills checks on the RTs and the nurses for tracheostomy care. She stated she had skills checked the RT and was surprised he had performed so poorly. She stated he must had been very nervous. She stated she was doing re-training and skills check before he resumed care on any of the residents. She stated tracheal suctioning was a sterile procedure and staff should always perform hand hygiene between glove changes. She stated failure to follow proper procedures could lead to lung infections. Record Review of the Respiratory Therapist competency validation dated 04/05/24 reflected he was competent in Tracheostomy suctioning and Tracheostomy care. 2. Review of Resident #76's Comprehensive MDS assessment, dated 04/21/24, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. Staff assessed his cognitive status as moderately impaired. His active diagnoses included acute and chronic respiratory failure, pneumonitis (lung inflammation caused by bacterial or viral infection), and tracheostomy status. In Section O-Special Treatments, Procedures, and Programs it revealed he required oxygen therapy, suctioning, and tracheostomy (trach) care during the 14-day look back period. Review of Resident #76's care plan initiated on 04/23/24 reflected, The Resident has Tracheostomy related to chronic respiratory failure .Interventions .Ensure that trach ties are secured at all times .Monitor/document respiratory rate, depth and quality. Check and document q shift/as ordered . Review of Resident #76's Physician's orders summary report dated 05/10/24, reflected, .Trach care daily and PRN . with a start date of 05/07/24. In an observation on 05/09/24 at 12:25 PM revealed LVN L outside of Resident #76's room. She donned a gown and gloves and gathered an unopened trach kit and entered the resident's room. LVN L cleaned the bedside table with a germicidal wipe. LVN L removed her gloves and put on another pair of gloves without performing hand hygiene and opened the trach kit and removed the sterile drape and placed it on the bedside table for her clean field. She removed and discarded the gloves, and she donned sterile gloves without performing hand hygiene. She opened the bottle of normal saline and poured it into the reservoir in the trach kit. LVN L disconnected the trach tube, and removed and discarded the inner cannula using the left hand. She inserted the sterile cannula using the right hand. She removed the old trach dressing which had phlegm and discarded it, she then picked up a gauze with the same gloves used to remove the old trach sponge and dipped it in the normal saline and wiped around the trach stoma and repeated the same process twice. She then placed the clean trach sponge under the trach collar wearing the same gloves. The LVN L then removed her gloves and gown and washed her hands. In an interview with LVN L on 05/09/24 at 1:14 PM she stated the trach care was supposed to be a sterile procedure. She stated the reason it was supposed to be a sterile procedure was to reduce the risk of infection and pneumonia. She stated she should had performed hand hygiene between gloves changes, and she stated she should had changed gloves before handling the clean sponge. She stated she was nervous. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/9/24 at 12:05 PM with the Regional Director of Respiratory Therapy she stated she was responsible for performing the skills checks on the nurses for tracheostomy care. She stated she had skills checked the LVN L. She stated tracheal care was a sterile procedure and staff should always perform hand hygiene between glove changes. She stated failure to follow proper procedures could lead to lung infections. Record Review of LVN L competency validation dated 05/08/24 reflected she was competent in Tracheostomy care. Record review of the facility's policy, Tracheostomy Care' dated June 2020, reflected, .In addition to routine care, stoma dressing, and trach ties will be changed when wet or soiled .Gather supplies .Wash hands .don gloves .Inspect skin and stoma site for sing or symptoms of infection, skin irritation, or open areas. If there is a tracheostomy dressing, remove the old dressing from around the tracheostomy tube and discard .Clean around the tracheostomy site .with a cotton swab or gauze pad moistened in normal saline .Repeat the cleaning process until wet and dried mucus is removed. Use a clen cotton swab or gauze pad each time .Pat the area dry with a gauze pad .Apply a precut (non-[NAME] dressing) around the insertion site .Suction resident as needed . Record review of the Facility's undated Clinical Competency Validation Tracheostomy Suctioning check list reflected: .2. Gathers supplies, puts on PPE; including gloves. 5. Cleanses hands 6. Apply gloves and clean work surface with disinfectant. 7. Remove gloves and dispose in plastic bag 8. Wash hands and apply clean gloves 10. Attached connecting tubing to suction machine 11. Turns on suction machine and checks equipment for proper working order 12. Removes gloves and cleanses hands 13. Places suction kit on bedside table. Opens wrapper and uses as sterile filed. Opens sterile water. 14 Establishes one sterile and one non-sterile hand. Designates dominant hand as the sterile field. 15. Puts on sterile gloves 16. Leaves sterile catheter in wrapper. With non-sterile hand, attaches connecting tubing to end of catheter. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	17. Places thumb of non-sterile hand over aspiration port and suctions up a small amount of water to test effectiveness of suction pressure. 18.With Sterile hand and without applying suction, inserts catheter into tracheostomy stoma/trach tube until resistance is felt then pulls back 1 cm. 19. With non-sterile hand, applies suction and gently withdraw catheter, slowing rotating catheter with fingertips . 22. With sterile hand, rinses catheter in sterile water and repats procedure until breath sounds are clean no more mucous returns. 23. Detaches suction catheter from connecting tube and discards 25. Removes PPE and cleansed hands 42971

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34399 Based on observations, interview and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food and nutrition services. 1. The facility failed to ensure Dietary Aide ZB wore effective hair restraints to cover his hair and facial hair on 05/07/24 while cleaning dishes and using the dish machine. 2. The facility failed to ensure 1 of 3 freezers were free of ice accumulation on the bottom of freezer. These failures could place residents at risk for food-borne illness and food contamination. Findings included: Observation on 05/07/24 at 10:35 AM with Dietary Aide ZB revealed he did not wear a hair restraint to cover the 2.5 inches of back of hair along with 1/2 inch near his ear not covered with cap. Dietary Aide ZB had facial hair not covered with no facial hair restraint while doing dishes. Interview on 05/07/24 at 10:50 AM with Dietary Aide ZB stated he knew he should have been wearing a hair restraint while doing dishes to cover his facial hair along with covering hair restraint to cover the areas where his cap did not cover. Observation on 05/07/24 at 10:31 AM revealed 1 of 3 freezers had ice accumulation of about 1 inch of inside bottom of freezer. Interview on 05/10/24 at 3:35 PM with the Dietary Supervisor revealed they cleaned up the ice on the bottom of the freezer after it was brought to her attention on 05/07/24 from surveyor. She stated the hose slipped off in the top back of the freezer which allowed water to drip down the back and bottom of the freezer and it froze over. She stated, routinely, kitchen freezers were cleaned weekly and as needed. She stated Dietary Aide ZB had been in-serviced prior about hair restraints. He should wear hair restraint to cover facial hair and restraints. Asked for in-service for dietary aide. She stated she had on-going in-service about hair restraints when entering kitchen. Iinterview on 05/10/24 at 5:20 PM with the Maintenance Supervisor revealed the freezers had gotten ice accumulation before and it had to be emptied out and clean it when it does. He stated he replaced the hose in the back before especially when dietary staff were stacking items in freezer too high on top shelf. Review of facility's dietary staff in-service dated 02/28/24 by Dietary Supervisor reflected about hair nets and beard guards. The in-service included Dietary Aide ZB. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility's policy Nutrition Services Personnel Guidelines revised January 2024 reflected important personnel guidelines followed by Food and Nutrition Services .Dress code .4 .Hair must be fully covered with hairnet or hair bonnet always within the department. The facility did not have a specific policy about freezer maintenance.

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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** 34918 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 diseases and infections for three of sixteen residents (Resident #536, Resident #38, and Resident #32) observed for infection control. 1. The facility failed to ensure that CNA K and CNA G performed hand hygiene while providing incontinence care to Resident #536 on 05/07/24 2. CNA G failed to prevent cross contamination with the residents foley catheter bag. 3. The facility failed to ensure that CNA H changed her gloves and performed hand hygiene while providing incontinence care to Resident #38 on 05/08/24. 4. The facility failed to ensure that CNA U changed her gloves and performed hand hygiene while providing incontinence care to Resident #32 on 05/07/24. These failures could place the residents at risk of cross-contamination and development of infection. Findings included: 1. Record review of Resident #536's Face sheet dated 05/09/24 reflected a [AGE] year-old male with an admitted [DATE]. Resident was listed as his own responsible party. Diagnoses included cauda equina syndrome (compression of nerve roots in the lumber spine), malignant neoplasm of the prostate and bone (cancer), neuromuscular disfunction(lack of bladder control due to nerve problem) of the bladder and need for assistance with personal care. Record review of Resident #536's base line care plan completed on 05/07/24 reflected, The resident has an ADL Self Care performance deficit related to impaired balance, cauda equina syndrome, weakness . Interventions .toileting .dependent assist of 2 persons, incontinent care, foley care . In an interview with Resident #536 on 05/07/24 at 10:50 a.m. stated he admitted to the facility yesterday (05/06/27). Resident has a foley catheter and stated he had a wound on his bottom. During a medication pass observation on 05/07/24 at 01:15 p.m. while standing in hallway outside of Resident #536's room and unknown staff member entered Resident #536's room with his lunch tray. Resident #536 told unknown staff member he needed to be changed. Unknown staff member stated she would let his CNA know and left the room. In an interview with Resident #536 on 05/07/24 at 2:05 p.m. he stated no one had come and changed him. He stated he was concerned about his catheter since he had a history of drainage from his catheter and stated he had a bowel movement and needed to be changed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Regional Director of Operations on 05/07/24 at 02:10 p.m. he was informed Resident #536 had requested to be changed at 01:15 p.m. and no one had come and changed him. Regional Director of Operations stated he would send someone right away. In an observation on at 05/07/24 at 2:20 p.m. revealed CNAs K and CNA G donning gowns and entered Resident #536's room to provide incontinence care. Resident stated this was the first time anyone had been in to change him this shift. CNA K stated it was the first time she had been in to provide incontinent care to the resident and stated no one had informed her he needed to be changed. Staff washed their hands and put on gloves. CNA G unhooked the catheter bag which was 1/4 full of urine and placed it on the bed next to the resident. CNA K unfastened the resident's brief and wiped down each groin and across the resident pubic area with a wipe. She then retrieved a wipe and provided catheter care using the proper technique. The resident was assisted onto his side revealing he had a bowel movement. Observed a dressing on the coccyx dated 05/06/24. The edges of the dressing were peeling up from the bottom. CNA K cleaned the residents perianal area wiping from front to back. CNA K removed her gloves and re-gloved without performing hand hygiene. Staff placed a clean brief under resident and repositioned him back on his back. CNA G tightened the catheter strap on the resident's leg per his request. CNA G then placed the catheter bag on the bed rail and the staff changed the resident's tee shirt. Both staff gathered the dirty clothes and trash, removed their gloves and gowns, and left the room without performing hand hygiene. CNA K was followed to the dirty linen room down the hallway where she deposited the trash and linens. In an interview with CNA K on 05/07/24 at 2:45 p.m. she stated she was supposed to perform hand hygiene before care and anytime she changed her gloves and before she left the room. She stated she failed to perform hand hygiene when she changed her gloves and did not do it before she left Resident #536's room. She stated this could spread germs and infections. In an interview on 05/09/24 at 10:50 a.m. with CNA G she stated she placed the catheter bag in the bed with Resident #536, so it did not get pulled when they were providing care to him. She stated the catheter bag was considered contaminated and by placing it in the bed with him she had contaminated the sheets and the residents. She stated they were supposed to perform hand hygiene before and after care and anytime they changed their gloves and acknowledged they had not done that during care for the resident. She stated this could spread infection to other residents. 2. Record review of resident #38's quarterly MDS assessment, dated 02/12/24, reflected an [AGE] year-old male with an admitted [DATE]. He had a BIMS of 4 which indicated he was severely cognitively impaired. He was dependent of care for all ADL. He had a foley catheter and colostomy (an opening into the colon from outside of the body). Active diagnoses included dementia, chronic respiratory failure, pressure ulcer stage 4 to sacral area, tracheostomy (a surgical opening in the neck providing a direct airway through the trachea) and quadriplegia (form of paralysis that affects all four limbs). Record review of Resident #38's care plan, initiated on 07/17/23, reflected .[Resident #38 has a diagnosis of stage 4 pressure area to sacrum .Resident has a foley catheter in place .Interventions .Foley catheter care per order . Record review of Resident #38's Physician Order Summary report dated 05/09/24, reflected, Foley catheter care every shift and PRN, with a start date of 01/23/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 05/08/24 at 09:10 a.m. the Treatment Nurse was observed providing wound care to Resident #38's sacral wound with the assistance of CNA H. Residents brief was observed to be soiled with drainage from the sacral wound. After completion of the wound care, the Treatment Nurse instructed CNA H to provide incontinence care and change out the resident's brief. CNA H stated she would need to go get supplies. CNA H removed her gloves and left the room without performing hand hygiene. In an observation on 05/08/24 at 9:25 a.m. observed CNA H donned gown and gloves without performing hand hygiene, prior to entering Resident #38's room. CNA H removed the residents brief and wiped down each groin with the same wipe and then rolled the resident over on his side. CNA H did not provide catheter care, did not clean the penis, and did not clean the scrotum. CNA then rolled the resident on his right side and held him over with one hand while using the other hand to wipe from the base of the wound care dressing toward the resident's scrotum and then front to back toward the resident's anal area. Brief was soiled with brownish drainage from the resident's coccyx wound. CNA H did not clean the scrotum area or the resident buttocks. With the same soiled gloves, CNA H placed a clean brief under the resident and rolled him back onto his back and repositioned the resident and fastened the brief. CNA adjusted the resident's sheet and gathered up the trash. CNA H them removed her gloves and gown and left the room without performing hand hygiene. CNA H walked down to the soiled linen room and deposited the trash. In an interview with the CNA H on 05/08/24 at 9:35 a.m., she stated they were supposed to do catheter care every time they did incontinence care. She stated she did not clean the penis or clean from the tip of the penis down the catheter tube. She stated she did not clean the scrotum or buttocks. She stated she was supposed to perform hand hygiene when she removed her gloves and before she left the room and did not do it. She stated failing to provide proper perineal care and catheter care could lead to urinary tract infections and further skin breakdown. Record review of CNA H''s skill checks on 03/20/24 reflected she was competent in hand hygiene, perineal care, and care of indwelling urinary catheter. 3. Record review of Resident #32's Comprehensive MDS assessment dated [DATE] reflected Resident #32 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses included cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), cognitive communication deficit, and contracture of muscle on the left hand. Staff assessed his cognitive status as severely cognitively impaired. The MDS assessment indicated Resident #32 required maximal assistance of 2 persons with toileting and personal hygiene. The MDS assessment indicated Resident #32 was always incontinent of bowel and bladder. Record review of Resident #32's Care Plan initiated 01/04/20, reflected the following: Focus: [Resident #32} is always incontinent of bladder and bowel related to impaired mobility. Goal: [Resident #32] will remain free from skin breakdown due to incontinence and brief use. Interventions: . Check the resident Q2 and as required for incontinence. Wash, rinse, and dry perineum. [NAME] clothing PRN after incontinence episodes . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 05/07/24 at 9:58 AM revealed CNA U and CNA V entered Resident #32's room to provide incontinence care. Both CNAs washed hands and donned gloves CNA V cleaned the front pubic area. The resident was assisted onto his side revealing he had a large bowel movement. CNA V held resident and CNA U cleaned the resident's buttocks area using several wipes. CNA U cleaned her soiled gloves with wipes and continued to clean resident's buttocks. CNA U removed her gloves and re-gloved without performing hand hygiene, she placed a clean brief under resident. Both CNAs repositioned the resident back on his back. Both CNAs gathered the dirty clothes and trash, removed their gloves and gowns, and washed hands. In an interview on 05/07/24 at 10:59 AM, CNA U stated she was supposed change her gloves when they get soiled and when she went from dirty to clean. She stated she supposed to perform hand hygiene between change of gloves. CNA U stated failing to provide proper care exposed the resident to infections. In an interview with the Regional Nurse Consultant A on 05/08/24 at 2:00 p.m. she stated staff were to perform hand hygiene before care, when going from dirty to clean and after glove changes and before leaving the room. She stated catheter care was be performed anytime the staff provided incontinence care and staff were to clean the peri area including penis and scrotum for male residents then moving toward the buttocks. She stated by not providing accurate incontinence care it placed residents at risk for urinary tract infections, skin breakdown and overall poor hygiene. She stated she expected the Charge Nurse's to make rounds and any staff observed providing care and performing skills incorrectly were to be re-educated as needed. Record review of the facility's policy titled, Hand Hygiene, dated June 2020, reflected, The Facility considers hand hygiene the primary means to prevent the spread of infections Facility staff .must perform hand hygiene procedures in the following circumstances including but not limited too .Wash hands with soap and water . after removing personal protective equipment PPE and before moving to another resident in the same room or exiting the room .Before putting on sterile gloves for the purpose of performing procedures for which aseptic techniques is required .Alcohol -based hand hygiene products can and should be used to decontaminate hands .Immediately upon entering a resident occupied area .regardless of glove use . Immediately upon exiting a resident occupied area .Hand hygiene is always the final step after removing and disposing of personal protective equipment .The use of gloves does not replace hand hygiene procedures . 42971

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 49427 Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for one of one laundry room reviewed for environment. 1. The facility failed to properly dispose and maintain the lint accumulation in the facility dryers in a timely manner. 2. The facility failed to properly maintain sanitary handwashing area in the laundry room hand washing station and for the laundry employee restroom. This failure could put residents at risk for an unsafe and unsanitary environment. Findings included: Observation on 05/09/2024 at 9:00 AM of facility's laundry room revealed there were three (3) dryers that were in use at that time. Observation of the lint collector area beneath two (2) dryers revealed a layer of thick lint about 2 inches thick accumulated on the top of lint trap and on the bottom of the lint trap. Observation of third dryer revealed a thick accumulation of lint about 2 inches thick on the top side of the lint filter and a clump of lint about 6 inches wide and 12 inches long on the floor of the lint collection area of the dryer. Interview on 05/09/2024 at 9:05 AM with the Housekeeping Supervisor stated they did not know if there was a lint trap cleaning log and they log and immediately began to get a broom to clean the lint build up. The Housekeeping Supervisor stated that the lint trap should be cleaned out after each use and at the beginning or end of every shift and the amount of buildup looked like it wasn't cleaned out for at least one shift. Observation on 05/09/2024 at 9:14 AM of laundry room revealed folding area with sign, undated, on wall that stated Attention Laundry Staff . Team leaders . The dryer's bottom lint trap should be cleaned out every 2 hours. And a document, undated, titled Laundry Staff Duties that stated .3. Every 2 hours will clean lint from dryers. Interview on 05/10/2024 at 5:30 PM with the Laundry Supervisor revealed he saw the lint trap build up when it was brought to his attention yesterday by the Housekeeping Supervisor and that it was an unacceptable amount of buildup. The Housekeeping Supervisor stated the expectation was for staff to check lint traps at the beginning of each shift and every 2 hours and remove any build up. The Laundry Supervisor stated risk to residents when lint traps are not cleaned regularly was a sanitary and fire hazard and an in-service had been started with all laundry staff. 2. Observation and interview on 05/09/2024 at 9:00 AM of facility laundry room revealed hand washing sink that with a bag of hand washing soap laying on the top of sink next to the faucet handle. The Housekeeping Supervisor stated the soap bag did not work with the soap dispenser and employees were squeezing the bag to get soap to wash their hands. The Housekeeping Supervisor stated this was sufficient to wash their hands but not ideal. (continued on next page)

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/09/2024 at 9:04 AM of facility's restroom for laundry employees revealed there was no soap in soap dispenser and dispenser was missing the front panel and an unlabeled bottle with a pump sitting on the back of the toilet with a pink liquid filled about a quarter full. The Housekeeping Supervisor stated that was hand sanitizer. Interview on 05/09/2024 at 9:04 AM with the Housekeeping Supervisor stated that staff were able to wash their hands at the main hand washing station, but it was not ideal. The Housekeeping Supervisor stated he would let the Maintenance Supervisor know and there were not any maintenance requests for the laundry room sink or restroom. The Housekeeping Supervisor stated no staff mentioned the concern to him. Review of the maintenance log on 05/09/2024 at 1:00 PM revealed no maintenance requests for sink in laundry room or employee laundry room restroom. Interview on 05/10/2024 at 5:15 PM with the Maintenance Supervisor revealed he had seen the handwashing station in the laundry room and was not aware until 05/09/2024 that there was no soap in the laundry employee restroom. The Maintenance Supervisor stated the soap dispenser at both laundry room sinks required soap in a box and the bags of soap did not work for that type of soap dispenser. The Maintenance Supervisor stated staff had not informed him of the problem and had been using the bags of soap and leaving them on the sink.The Maintenance Supervisor stated it was not ideal but staff could technically wash their hands with soap and did not have sanitary concerns. The Maintenance supervisor stated he planned to replace the soap dispensers. Review of the facility's laundry safety policy titled Laundry-Safety, dated August 2020, reflected laundry should be handled in a safe manner to prevent injury or spread of infection . Procedure .I. Laundry Safety .G. All machines and appliances are checked daily to make sure they are clean, operating correctly, free of defects . and all defects are reported to Housekeeping Supervisor . J. Hands are washed thoroughly before and after any cleaning or laundry task. Review of facility laundry supply and storage policy titled Laundry-Supply & Storage, dated August 2020, reflected .I. Laundry areas should have, at a minimum: .B. Handwashing and toilet facilities easily accessible to laundry personnel . Procedure I .E. after each use of the washing machine or dryer, and at least daily.