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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676279	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crown Point Health Suites	6640 Iola Avenue Lubbock, TX 79424

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42515 Based on observations, interviews, and record reviews, the facility failed to ensure each resident was treated with respect, dignity, and care for each resident in a manner and in an environment that promotes the maintenance or enhancement of their quality of life, recognizing each resident's individuality and the facility failed to protect and promote the rights of the resident for 3 of 19 residents (Resident #18, Resident #136, and Resident #145) reviewed for resident rights in that: 1. CNA D and CNA E provided peri care for Resident #18 and failed to close the blinds. 2. The facility failed to provide a privacy cover for Resident #136's urinary catheter bag. 3. CNA A failed to provide full privacy while assisting Resident #145 to the toilet. These failures could place residents at risk for diminished quality of life and loss of dignity and self-worth. The findings included: Resident #136 Record review of the admission record for Resident #136, dated 02/05/25, revealed an 87--year-old female admitted to the facility on [DATE] with the following diagnoses: acute respiratory failure (breathing problems), influenza due to identified novel influenza a virus (flu infection), and retention of urine (condition that makes it hard to empty bladder). Record review of Resident #136's order summary report, dated 02/03/25, revealed an order: Urinary catheter present, size 16 French foley, every shift related to retention of urine with a start date of 02/03/25. Observation on 02/03/25 at 9:56 AM revealed Resident #136 lying in bed and a urinary catheter tubing noted hanging on the side of the bed with a urinary drainage bag secured to the bottom of the bed. No privacy cover was noted over the urinary drainage bag and clear, yellow urine was noted in the drainage bag and could be seen from the hallway. (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/03/25 at 9:57 AM, Resident #136 stated she did not know if her urinary catheter bag was supposed to be covered. Resident #136 stated she would like for the drainage bag to be covered because she did not want everyone to see her urine. Observation on 02/03/25 at 12:18 PM revealed Resident #136 in bed and a foley catheter bag was noted hanging on the side of the bed. No privacy cover was noted over the urinary drainage bag and clear, yellow urine was noted in the drainage bag and could be seen from the hallway. Resident #145 Record review of the admission record for Resident #145, dated 02/03/25, revealed a [AGE] year-old male who was admitted to the facility on [DATE] with the following diagnoses: metabolic encephalopathy (brain disorder), urinary tract infection (bladder infection), and type 2 diabetes mellitus (blood sugar problems). Record review of the comprehensive MDS assessment, dated 01/06/25, revealed Resident #145 had a BIMS score of 08, indicating Resident #145's cognition was moderately impaired. Observation on 02/03/25 at 10:09 AM, CNA A was observed assisting Resident #145 to the toilet in his room. The door to the room and the bathroom was open and Resident #145's buttocks could be seen from the hallway. Interview on 02/03/25 at 10:11 AM, CNA A stated she should have closed the door when assisting Resident #145 to the bathroom. CNA A stated she did not shut the door because it was hard to shut the bathroom door with the small space. CNA A stated she had been trained to shut the doors and provide privacy to the residents when providing care. CNA A stated a potential negative outcome to the resident was she thought everyone could see him and no privacy. Resident #18 Record review of Resident #18's face sheet dated 02/05/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: high blood pressure, atherosclerotic heart disease (damage or disease in the heart's major blood vessels), hyperlipidemia (a condition in which there are high levels of fat particles in the blood), depression, dysphagia (difficulty swallowing), abnormal weight loss, acid reflux, osteoporosis (a condition in which bones become weak and brittle), occlusion and stenosis of carotid artery (plaques accumulate in the walls of the arteries and cause them to narrow or become so thick they completely block the flow of blood), epileptic seizures, aphasia (the inability or refusal to swallow), stroke, apraxia (difficulty with skilled movements even when a person has the ability and desire to do them), congestive heart failure, atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial movement), dementia, anxiety, esophageal obstruction (abnormal narrowing of esophagus). Record review of Resident #18's admission MDS dated [DATE] revealed a BIMS score left blank and incomplete. Record review of Resident #18's care plan, dated 05/05/24, stated Resident #18 had bowel incontinence. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 02/04/25 at 11:56 AM, CNA D and CNA E provided peri care to Resident #18 with the blinds open for the entire procedure. CNA D and CNA E had removed Resident #18's brief and proceeded in providing peri care while the blinds were open, facing a street where cars were parked, and the bed facing the window. Resident #18 was unable to be interviewed due to being nonreviewable. During an interview on 02/04/25 at 12:10 PM, CNA D stated that she did not pay attention to the blinds being open. CNA D stated that she should have closed the blinds to provide privacy, but she was nervous. CNA D stated that she had been trained in privacy by in-services, every couple of weeks. CNA D stated that the negative potential outcome for not providing privacy is that it may embarrass the resident. During an interview on 02/04/25 at 4:51 PM, LVN D (ADON) stated that his expectations for staff was to provide privacy, knock on doors, have good communication, and close the blinds. LVN D (ADON) stated that training had been provided to the staff through in-services, every six weeks. LVN D (ADON) stated that the negative potential outcome was that it could have caused the resident to be exposed and become embarrassed. During an interview on 02/05/25 at 10:47 AM, the DON stated she expected all staff to provide privacy bags for all urinary catheter bags. The DON stated she expected the staff to provide privacy when assisting residents to the bathroom. The DON stated the staff had been trained to place urinary bags in a privacy bag and making sure the residents were covered [during care] and got the privacy they needed. The DON stated the resident had a potential risk for being uncomfortable. During an interview on 02/05/25 at 10:56 AM, the ADM stated the facility always wanted to preserve the resident's dignity in regard to care. The ADM stated she expected staff to close the door, close the curtains and ensure nothing can be seen from the hallway while providing care to the residents. The ADM stated it was important that the staff did not make the resident feel exposed. The ADM stated the staff had been trained to make sure the residents felt protected with their privacy and dignity. During an interview on 02/05/25 at 12:17 PM, the DON stated that she would expect staff to provide privacy. The DON stated that training was a part of peri care, audits, and training. The DON stated that the negative outcome was it may make the resident feel uncomfortable. Record review of the facility policy titled, Dignity, with a revised date of February 2021, reflected the following: Policy Statement: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self- esteem. Policy Interpretation and Implementation 1. Residents are treated with respect and dignity . 11. Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43150 Based on observations, interviews, and record review, the facility failed to ensure that each resident has a right to personal privacy and confidentiality of his or her personal medical records for 14 of 14 resident was reviewed for privacy (Resident #25 and 12 residents listed in the 24-hour report book, Resident#7, #8, #10, #11, #15, #36, #44, #56, #58, #186, #187, #188). 1. CNA F failed to protect residents personal care information by leaving the 24-hour report book open on a table in the hallway on Emerald Hall. 2. MA B failed to protect Resident #25 name and medication information by writing the resident's information on a sticky note and dropping it in the living area on Emerald Hall. These failures could place residents at risk of having medical information personal, or care instructions exposed to others and misuse of personal information. Findings Included: Resident #25: Record review of an Admission Record for Resident #25 showed an [AGE] year-old male with an admitted [DATE] with diagnoses of systolic and diastolic congestive heart failure, osteoarthritis, shortness of breath, type 2 diabetes, neuropathy, upper respiratory infection, chronic kidney disease, hyperkalemia, acid reflux, sick sinus syndrome. Record review of a Quarterly MDS assessment dated [DATE] for Resident #25 indicated a BIMS score of 13 meaning Resident #25 was cognitively intact. Record review of an order summary report for Resident #25, dated 1/20/25 with a start date of 1/21/25 revealed: Losartan Potassium Oral Tablet 100 MG (Losartan Potassium) Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION. During an observation on 02/03/25 at 11:50 AM, a 24-hour report book was found on Emerald Hall on a table that was visible for others to see. No staff members were observed by the book. The book was open to the page that was dated 02/03/25 and had 13 residents listed on the page with personal care documented. The page disclosed if the named resident was incontinent, had hospice, had oxygen therapy, feeder, or were a fall risk. During an interview on 02/03/2025 at 12:10 AM, CNA F stated that the staff always leave the book on the table in the hall, so it was available for them to see what resident care needs were. CNA F stated that was just how they have always done it. CNA F stated that she had been trained in privacy through in-services, monthly. CNA F stated that other people could see the information and it may make the resident feel uneasy other people knowing their care needs. Record review on 02/03/2025 at 12:15 AM, 24-hour report book that was left open in the hall on a table, read: (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #7: room [ROOM NUMBER] A, limited X1, continent, O2 at all times. Resident #8: room [ROOM NUMBER] B, Limited X1, continent, O2 at night, shower done. Resident #11: room [ROOM NUMBER], Total X2 (Hoyer), ostomy bag, foley, Feeder. Resident #186: room [ROOM NUMBER], Extensive X1, continent BM, Foley. Resident #56: room [ROOM NUMBER], Extensive X1, incontinent, fall risk, shower done. Resident #10: room [ROOM NUMBER], Incontinent. Resident #15: room [ROOM NUMBER], Total X2 (Hoyer), Incontinent, O2 at night, hospice, shower done. Resident #187: room [ROOM NUMBER], Total X2, Incontinent, New. Resident #58: room [ROOM NUMBER], Extensive X1, continent. Resident #36: room [ROOM NUMBER], Extensive X1, foley, continent with BM. Resident #188: room [ROOM NUMBER], Total X2 (Hoyer), Incontinent. Resident #44: room [ROOM NUMBER], Extensive X2, Incontinent, O2 all the time, hospice. CNA F, CNA G, and LVN E During an observation on 02/03/25 at 2:08 PM, while Surveyor was making observations MA B had her medication cart parked by the living area and she had left the cart, while she was walking, she had dropped a blue sticky note that was found by the Surveyor that read: Resident #25's name, Potassium 20 meq. The blue sticky note was picked up by Surveyor. The Surveyor had seen MA B walking toward the cart and it was brought to MA B's attention. MA B observed the sticky note and identified it as her sticky note. During an interview on 02/03/25 at 2:16 PM, MA B stated that the blue sticky note that was found on the floor was her sticky note. MA B stated that she must have accidentally dropped it when she was walking toward the hall. MA B stated that she should not have written down the personal information of a resident. MA B stated that it will not happen again. MA B stated that she had been trained in HIPAA and privacy, through in-services, every few months. MA A stated that it could make a resident feel violated. During an interview on 02/05/25 at 12:05 PM, the Administrator stated that she would expect staff to preserve resident privacy in to regards to medical records. The Administrator stated that the training the staff have been provided regarding protecting health information. The Administrator stated that the negative outcome would be disclosing PHI to those who do not need access to the information. Record Review of facility provided policy, Labeled, Confidentiality of Information and Personal Privacy, date Revised in October 2017, stated: (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Statement: Our facility will protect and safeguard resident confidentiality and personal privacy. 1. The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records. 2. The facility will strive to protect the resident's privacy regarding his or her: a. accommodations b. medical treatment c. written and telephone communications. d. personal care e. visits f. family and group meetings 4. Access to resident personal and medical records will be limited to authorized staff and business associates. 7. Release of resident information, including video, audio, or computer stored information, will be managed in accordance with resident rights and privacy policies.

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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** 42515 Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder or had a urinary catheter received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 5 Residents (Resident #136) reviewed for incontinence care in that: The facility failed to position Resident #136's catheter tubing in a manner to prevent infections. This failure had the potential to affect residents by placing them at an increased risk of urinary tract infections. Findings include: Record review of the admission record for Resident #136, dated 02/05/25, revealed an 87--year-old female admitted to the facility on [DATE] with the following diagnoses: acute respiratory failure (breathing problems), influenza due to identified novel influenza a virus (flu infection), and retention of urine (condition that makes it hard to empty bladder). Record review of Resident #136's order summary report, dated 02/03/25, revealed an order: Urinary catheter present, size 16 French foley, every shift related to retention of urine with a start date of 02/03/25. Observation on 02/03/25 at 12:18 PM revealed Resident #136 in bed and a foley catheter bag was noted hanging on the side of the bed. The drainage tubing at the bottom of the catheter bag was unsecured and the end of the tubing was touching the floor. Interview on 02/03/25 at 12:19 PM, Resident #136 stated she did not know why the catheter tubing was touching the ground. Resident #136 stated she could not remember when her urinary drainage bag was last emptied. Interview on 02/03/25 at 12:21 PM, LVN A stated Resident #136's catheter tubing should not be touching the ground. LVN A stated she was not sure exactly why the catheter tubing was touching the floor and stated it probably happened when the CNA's emptied out the urine from the bag. LVN A stated the facility has trained the staff to keep urinary catheter tubing off the floor. LVN A stated the resident was at risk for getting an infection with the catheter tubing touching the floor. Interview on 02/05/25 at 10:47 AM, the DON stated she expected staff to keep the urinary catheter drainage tubing clipped and secured to the bag. The DON stated the staff were trained on keeping the urinary catheter tubing clicked in [secured] and she did not know why Resident #136's catheter tubing was touching the floor. The DON stated there was a potential risk to the resident for infection or it could also be a tripping hazard. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/05/25 at 10:56 AM, the ADM stated she expected the staff to not let the urinary catheter drainage tubing touch the ground. The ADM stated staff had been trained on securing catheter tubing and she did not know why Resident #136's catheter tubing was touching the ground. The ADM stated the resident had a potential risk for infection. Record review of the facility policy and procedure titled, Catheter Care, Urinary, with a revised date of August 2022 revealed the following: Purpose: The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. Infection Control: .2. Be sure the catheter tubing and drainage bag are kept off the floor

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49305 Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored properly for 1 of 4 medication carts (Ruby House medication cart), reviewed for medication storage. The medication cart assigned to [NAME] House contained a loose pill. This failure could place residents at risk of not receiving prescribed medications as ordered and place the facility at risk of drug diversions. The findings included: On 02/04/25 at 8:51 AM an observation of the medication cart for [NAME] House was conducted with MA A. A loose pill was found in the bottom drawer of the medication cart. MA A placed the pill in a dispensing cup and took it to ADON A for identification. ADON A identified the medication as Buspar 5 mg (1 tablet). ADON A destroyed the loose pill and documented the destruction according to facility protocol. During an interview on 02/04/25 at 9:03 AM, MA A stated there should not be loose pills on the medication cart. She stated she was not sure why the medication cart contained a loose pill. She stated it was her responsibility to check the cart for loose medications. MA A stated the medication cart was usually spot checked weekly by ADON A for proper medication storage and cleanliness. MA A stated a potential negative outcome of loose medications on the cart would be that a resident may miss a dose of medication. During an interview on 02/04/25 at 9:17 AM, ADON A stated there should not be loose pills on the medication cart. He stated staff were trained on proper medication storage through periodic in-services conducted by nursing administration. He stated he conducted spot checks of medication carts weekly, and it was the responsibility of the nursing staff to assure the carts did not contain loose medications. ADON A stated a potential negative outcome of loose medications on the cart would be lost medications or harm to the resident if they did not receive medications as order by the physician. During an interview on 02/05/25 at 11:35 AM, the DON stated she was not aware that there was a loose pill on the medication cart for [NAME] House. She stated there should not be loose medications on the medications cart and medications should be stored properly at all times. The DON stated staff were trained on proper medication storage through periodic in-services and through weekly cart audits conducted by the facility ADON's. She stated it was the responsibility of nursing administration to assure staff were trained on proper medication storage. The DON stated a potential negative outcome of loose pills on the medication cart would be drug diversions and residents not receiving ordered medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/05/25 at 11:42 AM, the ADM stated she was not aware that there was a loose pill on the medication cart for [NAME] House. She stated nursing administration was responsible to assure staff were trained on proper medication storage. The ADM stated her expectation was that staff would adhere to the facility policy for proper medication storage at all times. She stated a potential negative outcome for failure to properly store medications would be not preserving the integrity of the medication through proper storage. Record review of the facility-provided policy titled, Medication Labeling and Storage; revised February 2023 revealed: Policy Interpretation and Implementation Medication Storage 1. Medications and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received . 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. . 5. Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.

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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. 42515 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 4 of 4 kitchens (Kitchen A, Kitchen B, Kitchen C, and Kitchen D) reviewed for dietary services. 1) The facility failed to keep drawer and oven handles clean in Kitchen A. 2) The facility failed to keep refrigerator and freezer handles clean in Kitchen A and Kitchen C. 3) The facility failed to keep the microwave clean in Kitchen B. 4) The facility failed to properly store food refrigerator and freezer in Kitchen A and Kitchen B. 5) The facility failed to keep the ice machines clean in Kitchen A and Kitchen D. 6) The facility failed to properly store plates and bowls in Kitchen A and Kitchen C. These failures could place residents at risk for food contamination and foodborne illness. The findings include: Observation during a kitchen tour in Kitchen A on 02/03/25 at beginning at 10:27 AM revealed 2 freezer handles, 2 fridge handles, 3 storage drawer handles and 2 oven handles that had dry, sticky substances on the inside handle, a small bag in the freezer was noted to have a waffle with a thick amount of ice/frost stuck to the waffle, a gallon-sized zip-lock bag of chicken fried steak, dated 01/15/25 and a gallon-sized zip-lock bag of catfish nuggets, dated 12/23 in the freezer that was open and not properly sealed. A silver bowl was in the refrigerator with a light brown, thick batter and was dated 2/3/25 but had no label. 4 stacks of regular bowls, 1 stack of small plates, and 3 stacks of small bowls were sitting next to the stove right side up with no covering. The ice machine was noted to have a thick amount of white, green and yellow dried substances close to where the ice comes out of the machine. Interview on 02/03/25 at 10:33 AM, [NAME] A stated the unlabeled batter in the refrigerator was pancake mix that was made that morning. [NAME] A stated he did not know that the pancake batter had to be labeled with a name and stated the thought the date was all that was needed to be labeled. [NAME] A stated stacks of bowls and plates were usually covered by a plastic bag and did not know why the dishes were uncovered. Observation during a return visit to Kitchen B on 02/04/25 beginning at 8:44 AM revealed a large bag of mozzarella cheese, dated 01/13/25 in the refrigerator and the bag was opened and not properly sealed. The kitchen microwave was noted to have dry, hard substances on the door, door handle, open button, numbered buttons and on the side of the microwave next to the buttons. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Crown Point Health Suites		STREET ADDRESS, CITY, STATE, ZIP CODE 6640 Iola Avenue Lubbock, TX 79424	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/04/25 at 8:46 AM, [NAME] C stated the bag of mozzarella cheese was not sealed properly because she had just used some and was in a hurry and did not seal the bag all the way when putting it back. [NAME] C stated the microwave probably got dirty during the breakfast meal. [NAME] C stated she had been trained on keeping kitchen items clean and food sealed properly in the refrigerator. [NAME] C stated a potential negative outcome to the residents was the food could loose it's freshness or they could get sick. Observation during a return visit to Kitchen C on 02/04/25 at 8:50 AM revealed 2 freezer handles and 2 refrigerator handles with a thick layer of dry, hard substances stuck to the inside handles. 2 stacks of small bowls, 1 stack of regular plates, and 2 stacks of big bowls were observed sitting next to the stove Interview on 02/04/25 at 8:53 AM, the DM stated she thought the freezer handles and the refrigerator handles were cleaned the night before. The DM stated she did not know why the dishes were uncovered next to the stove and stated the cook probably just uncovered them. During an observation on 02/04/25 at 12:14 PM, [NAME] D was observed carrying 4 plates (2 in each hand) of spice cake to residents in the dining room on Emerald Hall. [NAME] D had stuck his right thumb in one of the plates of cake and proceeded in delivering the cake to a resident. During an interview on 02/04/25 at 12:20 PM, [NAME] D stated that he was carrying all the plates at once to hurry and deliver the cake to the residents. [NAME] D stated that he does not normally help deliver the food. [NAME] D stated that he did accidentally had touched the icing on the cake. [NAME] D stated that he did not know why he went ahead and delivered the cake to the resident. [NAME] D stated that he had been trained in infection control through in-services, every other month. [NAME] D stated that the negative outcome would be spread of germs. During an interview on 02/04/25 at 12:32 PM, the DM stated that she did see [NAME] D carrying 4 plates of cake (2 on each side) and does not train the staff to do that. The DM stated that she would start an in-service immediately. The DM stated the staff gets nervous when State was in the building. The DM stated that she will make sure that all staff are trained with washing their hands. The DM stated that the negative outcome would be the transfer of germs. Observation during a return visit to Kitchen D on 02/05/25 at 8:57 AM revealed a thick layer of a white, green and yellow/brown dried substance on the ice machine where the ice comes out of the machine. Interview on 02/04/25 at 8:59 AM, [NAME] B stated he did not know when the ice machine was last cleaned. [NAME] B stated the kitchen staff had been trained on keeping the ice machine clean. [NAME] B stated a potential negative outcome to the residents was they could get sick. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/05/25 at 9:51 AM, the DM stated it was a goal in the kitchen to always succeed and to fix any mistakes and do better. The DM stated she did not know why some food items were not sealed properly in Kitchen A or Kitchen B. The DM stated sometimes the zip-lock bags the facility uses were hard to seal. The DM stated she did not know the dishes were not stored properly in Kitchen A or Kitchen C. The DM stated the staff had been trained to keep the dishes covered when they were stored or to store them upside down. The DM stated she did know why some kitchen items were not cleaned in Kitchen A, Kitchen B, Kitchen C or Kitchen D. The DM stated all of the kitchen staff had been trained on kitchen cleanliness. The DM stated the residents had a risk of getting sick from food not being stored properly or kitchen items not being clean. Interview on 02/05/25 at 10:56 AM, the ADM stated she expected the food to be sealed in the kitchen with no freezer burn on foods and the kitchen items cleaned. The ADM stated the kitchen staff had been trained on storing food and food items and kitchen cleanliness. The ADM stated the kitchens were always being monitored by the DM and the dietician, so she did not know how these failures occurred. The ADM stated a potential negative outcome to the residents with food not being sealed properly was the food integrity was not being preserved. The ADM stated a potential negative outcome to the residents with kitchen items not being cleaned or food items not being stored properly was a possibility for contaminates to spread or food-borne illness that could cause harm. Record review of the facility's policy and procedure title, Food Receiving and Storage with a revised date of November 2022, reflected the following: Food shall be received and stored in a manner that complies with safe food handling practices . Refrigerator/Frozen Storage 1. All foods stored in the refrigerator or freezer are covered, labeled and dated Record review of the facility's policy and procedure titled, Sanitation with a revised date of November 2022, reflected the following: Policy Statement: The food service area is maintained in a clean and sanitary manner. Policy Interpretation and Implementation: 3. All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions. 10. Ice machines and ice storage containers are drained, cleaned and sanitized per manufacturer's instructions

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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** 42515 43150 Based on observation, interview and record review, the facility failed to maintain an infection control program designed to provide a safe, comfortable, and sanitary environment to help prevent the development and transmission of communicable diseases for 6 of 16 residents (Resident #12, Resident #13, Resident #52, Resident #65, Resident #145, and Resident #299) and 7 of 7 staff (RN A, LVN B, CNA A, CNA B, CNA C, and MA A, reviewed for infection control. 1. LVN B failed to follow policy and procedure for handwashing while providing wound care for Resident #12. 2. RN A failed to follow policy and procedure for handwashing while providing wound care for Resident #13. 3. MA A failed to sanitize hands between residents during medication administration for Resident #65 and Resident #52. 4. CNA A failed to wear the proper PPE when providing direct care to Resident #145 who was on Enhanced Barrier Precautions (EBP). 5. CNA B and CNA C failed to follow policy and procedure for handwashing while providing peri care for Resident #299. These failures could place residents at risk for spread of infection and cross contamination. Findings included: Resident #12 Record review of Resident #12's face sheet dated 02/05/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: pressure ulcer of sacral region, STAGE 4, pressure ulcer of right hip, pressure-induced deep tissue damage of left heel, pressure-induced deep tissue of right heel, pressure-induced tissue damage of right ankle, muscle weakness, unsteadiness on feet, abnormalities of gait and mobility, dysphagia (difficulty swallowing), protein-calorie malnutrition, hyperlipidemia (a condition in which there are high levels of fat particles in the blood), dementia, atherosclerotic heart disease (damage or disease in the heart's major blood vessels), osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wears down) left knee. Record review of Resident #12's admission MDS dated [DATE] revealed a BIMS score left blank and incomplete. Record review of Resident #12's order summary report, dated 01/08/25, revealed an order: New guest to the facility with the primary diagnosis/conditions for stage IV pressure ulcer to the sacrum. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #12's order summary report, dated 01/08/25, revealed an order: Enhanced barrier precautions are in use related to wounds with a start date of 1/08/25. The interventions are listed as: follow facility policy and procedures for use of EBP, clean hands before entering and when leaving room, don appropriate PPE, dispose of PPE in receptacle in room, use appropriate PPE for enhanced barrier precautions, per facility policy and guidance (gloves, gown, face protection as needed for risk of splash or spray), use enhanced barrier precautions per facility during instances of high contact care such as; dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs/assisting with toileting, device care or use, wound care During an observation on 02/05/25 at 9:23 AM, LVN B washed hands for 9 seconds before providing wound care for Resident #12 and used the same paper towel to dry her hands to turn off the faucet. During wound care for Resident #12, LVN B washed her hands for 6 seconds before rinsing hands under the water. LVN B grabbed two clean paper towels and dried hands then used the same paper towel to dry hands to turn off the water faucet. After providing wound care for Resident #12, LVN B washed her hands for the 15 seconds stated in the policy and used a seperate paper towel to dry her hands and a clean paper towel to turn off the faucet. During an interview on 2/5/25 at 9:49 AM, LVN B stated that the policy stated that she should wash her hands for 20 seconds. LVN B stated that she understands why it was important to follow policy and procedures for hand washing. LVN B stated that she was nervous. LVN B stated that she had been trained in hand washing through in-services, once a month. LVN B stated that the negative potential outcome for not following policy for washing hands would be that wounds would have the potential for getting infected and spread of infections and germs. Resident #13 Record review of Resident #13's face sheet dated 02/05/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses: peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), acquired absence of right leg above knee, pressure ulcer of the right heel(stage 3), benign prostatic hyperplasia (age related prostate gland enlargement that can cause urination difficulty), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), major depressive disorder, dementia, stroke, aortic aneurysm (is a bulge or ballooning in the wall of the aorta, the body's main artery that carries blood from the heart), low blood-pressure, anemia (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin), chronic kidney disease (longstanding disease of the kidneys leading to renal failure), vitamin d deficiency, hyperlipidemia (a condition in which there are high levels of fat particles in the blood), insomnia, high blood pressure, cardiac arrythmias (irregular beating of the heart, whether irregular, too fast, or too slow), acid reflux, unsteadiness on feet, anorexia (an eating disorder causing people to obsess about weight and what they eat. Record review of Resident #13's admission MDS dated [DATE] revealed a BIMS of 8 meaning Resident #13 was mildly impaired. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 02/02/25 at 10:29 AM, RN A provided wound care for Resident #13. RN A proceeded in washing her hands before starting the wound care procedure. RN A turned on water faucet in Resident #13's bathroom. RN A put three squirts of soap in her hands and lathered using friction for 5 seconds and then put her hands under the water, using friction, and singing happy birthday while rinsing her hands. RN A used 3 clean paper towels to dry hands and discarded in the trash. RN A used a clean paper towel to turn off the water faucet and discarded in the trash. During wound care for Resident #13, RN A removed her gloves and discarded in the trash. RN A used hand sanitizer and then placed on clean gloves. RN A went to Resident #13's restroom to wash her hands. RN A put two squirts of soap in her hands and lathered using friction for 4 seconds. RN A put her hands underneath the water using friction and began to sing while rinsing hands. RN A used three clean paper towels to dry her hands and discarded in the trash. RN A used a clean paper towel to turn off the water faucet and discarded in the trash. RN A put on clean gloves. After placing a bandage on Resident #13's ankle, RN A removed dirty gloves and discarded in the trash. RN A used hand sanitizer and put on clean gloves. After providing wound care for Resident #13, RN A removed gloves and discarded in biohazard bag. RN A went to resident's bathroom to wash hands. RN A turned on the water faucet. RN A put two squirts of soap in hands and began to use friction for 4 seconds. RN A put her hands underneath the running water after the 4 seconds, using friction and rubbing hands together, under the water, while singing, Happy Birthday. RN A grabbed three clean paper towels to dry her hands and discarded in the trash. RN A grabbed one clean paper towel to turn off water faucet and discarded in the trash. During an interview on 02/05/25 at 11:04 AM, RN A stated that she had been in-serviced for handwashing through coaching, memo format, annual competency checks, upon hire and quarterly. RN A stated that the negative outcome of not following policy and procedures for handwashing would be the spread of infections, slow down the healing time, make wounds worse, and could severely impact health. Resident #65 Record review of Resident #65's face sheet dated 02/05/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: congestive heart failure (condition in which the heart does not pump adequately), iron-deficiency anemia (condition in which the blood lacks adequate healthy red blood cells), gastric ulcer (sore in the lining of the stomach), ulcer of the esophagus (sore in the lining of the tube that connects the throat to the stomach), anorexia (abnormal lack of appetite), macular degeneration (eye disease that causes vision loss) and peripheral vascular disease (circulatory condition that causes reduced blood flow to the limbs). Record review of Resident #65's admission MDS dated [DATE] revealed a BIMS score of 14, which indicated the resident was cognitively intact. During an observation of medication pass on 02/04/25 at 08:35 AM, MA A prepared medications for Resident #65 and administered her medications. MA A did not sanitize her hands after medication administration for Resident #65. Resident #52 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #52's face sheet dated 02/05/25 revealed an [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: Alzheimer's disease (a progressive disease that destroys mental functions), osteoporosis (a bone disease that decreases bone mass), protein-calorie malnutrition (a nutritional status in which reduced nutrients cause changes in body composition), muscle weakness, gastro-esophageal reflux disease (digestive disease in which stomach acid irritates the lining of the food pipe), major depressive disorder (mental health disorder characterized by persistently depressed mood) and anxiety (feelings of fear, dread or uneasiness). Record review of Resident #52's annual MDS dated [DATE] revealed a BIMS score of 15, which indicated the resident was cognitively intact. During an observation of medication pass on 02/04/25 at 08:42 AM, MA A prepared medications for Resident #52 and administered her medications. MA A did not sanitize her hands before or after medication administration. During an interview on 02/04/25 at 08:58 AM, MA A stated she did not sanitize her hands between the medication pass for Resident #65 and Resident #52. She stated, I got side tracked and wasn't thinking and made a careless mistake. She stated she was trained on proper hand hygiene through quarterly in-services and annual recertification skills checks. MA A stated a potential negative outcome for failure to properly sanitize hands during medication administration was cross-contamination. Resident #145 Record review of the admission record for Resident #145, dated 02/03/25, revealed a [AGE] year-old male who was admitted to the facility on [DATE] with the following diagnoses: metabolic encephalopathy (brain disorder), urinary tract infection (bladder infection), and type 2 diabetes mellitus (blood sugar problems). Record review of the comprehensive MDS assessment, dated 01/06/25, revealed Resident #145 had a BIMS score of 08, indicating Resident #145's cognition was moderately impaired. The MDS further revealed Resident #145 had an indwelling catheter. Record review of Resident #145's order summary report, dated 02/03/25, revealed an order: Enhanced barrier precautions are in use related to suprapubic indwelling catheter. Every shift with a start date of 12/31/24. Record review of Resident #145's care plan, Dated Initiated was 12/31/24, revealed: Focus: I required Enhanced Barrier Precautions (EBP) due to: Indwelling medical device: Urinary Catheter. Goal: I will not have complications from staff use of enhanced barrier precautions through the review date. Interventions: Follow facility policy and procedures for use of EBP, use enhanced barrier precautions per facility policy during instances of high-contact care, such as dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs/assisting with toileting, device care or use, wound care. During an observation on 02/03/25 at 10:06 AM, CNA A walked into Resident #145's room putting on a pair of clean gloves. Signage observed next to Resident #145's room stating: Enhanced Barrier Precautions. No gown was observed to be used when CNA A was in Resident #145's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 02/03/25 at 10:09 AM, CNA A was observed assisting Resident #145 to the toilet in his room. CNA A was observed wearing gloves only, no gown was observed to be used by CNA A. During an interview on 02/03/25 at 10:11 AM, CNA A stated Resident #145 was on EBP, and a gown and gloves should be worn when providing direct care to the resident. CNA A stated she should have been wearing a gown when helping Resident #145 to the toilet. CNA A stated she had been trained on the proper PPE to wear in EBP rooms and the resident was at risk for cross-contamination when not wearing the proper PPE. Resident #299 Record review of Resident #299's face sheet dated 02/05/25 revealed an [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following a stroke, protein calorie malnutrition, type 2 diabetes, muscle weakness, dysphagia (difficulty swallowing), unsteadiness on feet, abnormalities of gait and mobility, aphagia (inability or refusal to swallow), magnesium deficiency, hypokalemia, anemia, hyperlipidemia, high blood pressure, atherosclerotic heart disease, atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), acid reflux, angiodysplasia small vascular malformation of the gut) of colon without hemorrhage, osteoporosis (a condition in which bones become weak and brittle), cardiac murmur (is a whooshing or swishing sound that occurs when blood moves abnormally over heart valves), edema (inflammation), presence of prosthetic heart valve. Record review of Resident #299's annual MDS dated [DATE] revealed a BIMS score of 11, which indicated the resident was cognitively mildly impaired. Record review of Resident #299's order summary report, dated 01/14/25, revealed an order: bladder incontinence related to impaired mobility secondary to stroke with left hemiparesis (weakness on the left side of the body) with a start date of 1/14/25. During an observation on 2/4/25 at 11:41 AM, CNA B and CNA C provided peri care to Resident #299. CNA B did not wash her hands but did use hand sanitizer prior to putting on clean gloves. CNA C did not use hand sanitizer or wash her hands prior to putting gloves on to provide peri-care for Resident #299. After providing peri care and disposing of the trash, CNA C came back after disposing trash to wash hands. CNA C turned on the water and placed three squirts of soap in hands. CNA C used friction for 7 seconds and then rinsed hands. CNA C grabbed three clean paper towels to dry her hands. CNA C used the same paper towel that she dried her hands with to turn off the faucet. CNA C discarded the paper towel in the trash. CNA B turned on the water faucet and used two squirts of soap. CNA B began to lather soap in hands with friction for 10 seconds and then rinsed hands under water. CNA B used two clean paper towels to dry her hands and then used the same paper towel that she used to dry her hands to turn off the water faucet. CNA B discarded the paper towel in the trash. During an interview on 02/04/25 at 4:38 PM, CNA C stated that the policy for handwashing stated that she should wash her hands for 20 seconds. CNA C stated that she was unsure how long she washed her hands. CNA C stated that she had been trained in infection control through in-services. CNA C stated that she was not sure how often the training was because she had only been in the facility for a week. CNA C stated that the negative potential outcome for not following handwashing procedure per policy was that could cause spread of infections, sickness, and if severe enough, death. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/04/25 at 4:50 PM, CNA B stated that the policy for hand washing stated she should wash hands for 20 seconds. CNA B stated she was not used to someone watching her and it had made her nervous. CNA B stated that she had been trained in infection control through in-services, monthly and as needed. CNA B stated that the negative outcome for not following the hand washing policy could be the spread of infections. During an interview on 02/05/25 at 10:47 AM, the DON stated she expected staff to follow EBP with providing care that was close contact with residents currently on EBP. The DON stated the staff have been trained on EBP with in-services. The DON stated she did not know why CNA A did not follow EBP for Resident #145. The DON stated the EBP were in place for some residents to prevent infection. The DON stated the resident was at risk for infection with EBP not being followed. During an interview on 02/05/25 at 10:56 AM, the ADM stated she expected staff to follow the policy and procedures for EBP. The ADM stated the staff have been in-serviced on EBP and there was a sign on the door in clear language regarding EBP. The ADM stated she did not know why the staff did not follow EBP and stated they got confused. The ADM stated the purpose of EBP for some residents was to protect the residents from the staff from getting an infection. During an interview on 02/05/25 at 11:35 AM, the DON stated she was not aware that staff were not observing proper hand hygiene during medication administration. She stated the DON, Infection Preventionist, and administrative staff were responsible to assure staff were trained on proper hand hygiene during medication administration. The DON stated staff were trained on hand hygiene through quarterly in-servicing, periodic skills checks, computer-based training and annual recertifications. She stated a potential negative outcome for failure to practice proper hand hygiene during medication administration was the spread of infection. During an interview on 02/05/25 at 11:42 AM, the ADM stated she was not aware that staff were not observing proper hand hygiene during medication administration. She stated the Infection Preventionist, and nursing administration were responsible for assuring staff were trained on proper hand hygiene during medication administration. She stated her expectation of staff for proper hand hygiene was to sanitize hands appropriately and to adhere to policies and procedures for proper hand hygiene. The ADM stated a potential negative outcome for failure to practice proper hand hygiene during medication administration was the spread of infection. During an interview on 02/05/25 at 12:17 PM, the DON stated that she expects staff to use the proper hand washing techniques. The DON stated that she does provide competency checks and in-services for hand washing, upon hire, quarterly and as needed. The DON stated that the negative potential outcome for not following hand washing procedures is the spread of infection. During an interview on 02/05/25 at 12:38 PM, the Administrator stated that she expects staff to follow policy and procedure for hand washing. The Administrator stated that the staff is provided training through in-services upon hire and quarterly. The Administrator stated that the negative potential outcome for residents and staff is the spread of infection. Record review of the facility-provided policy titled, Administering Oral Medications, revised October 2010, revealed: Purpose (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The purpose of this procedure is to provide guidelines for the safe administration of oral medications. Steps in the Procedure 1. Wash your hands. . 9. Prepare the correct dose of medication. . 21. Remain with the resident until all medications have been taken. . 23. Perform hand antisepsis. Record review of the facility provided policy, titled, Handwashing/Hand Hygiene, date of October 2023, stated: Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Administrative Practices to Promote Hand Hygiene: 1. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. Indications for Hand Hygiene: 1. Hand hygiene is indicated: a. immediately before touching a resident. b. before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device). c. after contact with blood, body fluids, or contaminated surfaces. d. after touching a resident. e. after touching the resident's environment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676279	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2025
NAME OF PROVIDER OR SUPPLIER Crown Point Health Suites		STREET ADDRESS, CITY, STATE, ZIP CODE 6640 Iola Avenue Lubbock, TX 79424	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. before moving from work on a soiled body site to a clean body site on the same resident; and g. immediately after glove removal. 3. Wash hands with soap and water: a. when hands are visibly soiled; and b. after contact with a resident with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella, and C. difficile. 4. Single-use disposable gloves should be used. a. before aseptic procedures. b. when anticipating contact wit blood or bodily fluids; and c. when in contact with a resident, or the equipment or environment of a resident, who is on contact precautions. 5. The use of gloves does not replace hand washing/ hand hygiene. Washing Hands 1. Wet hands first with warm water, then apply an amount of product recommended by the manufacturer to hands. 2. Rub hands together for at least 15 seconds, covering all surfaces of the hands and fingers. 3. Rinse hands with water and dry thoroughly with a disposable towel. 4. Use towel to turn off the faucet. 1. Apply generous amount of product to palm of hand and rub hands together. 2. Cover all surfaces of hands and fingers until hands are dry. 3. Rub hands together for a minimum of 15 seconds. 4. Follow manufactures' directions for volume of product to use. Record review of the facility provided policy, titled, Wound Care, date of October 2010, stated: Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Steps in the Procedure: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676279	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Establish clean field on resident's overbed table. Place all items to be used during procedure on the clean field. Arrange the supplies so they can be easily reached. 2. Wash and dry your hands thoroughly. 3. Position resident. Place disposable cloth next to resident (under the wound) to serve as a barrier to protect the bed linen and other body sites. 4. Put on exam glove. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. 6. Put on gloves. Gowns will only be necessary if soiling of your skin or clothing with blood, urine, feces, or fluids into your eyes or mouth is likely. 8. Pour liquid solutions directly on gauze sponges on their papers. 9. Wear exam gloves for holding gauze to catch irrigation solutions that are poured directly over the wound. 10. Wear sterile gloves when physically touching the wound or holding a moist surface over the wound. 11. Place one (1) gauze to cover all broken skin. Wash tissue around the wound that is usually covered by the dressing, tape, or gauze with antiseptic or soap and water. 12. Remove dry gauze. Apply treatments as indicated. 13. Dress wound. Pick up sponge with paper and apply directly to area. [NAME] tape with initials, time, and date and apply dressing. Be certain all clean items are on clean field. 15. Discard disposable items into the designated container. Discard all soiled laundry, linen, towels, and washcloths into the soiled laundry container. Remove disposable gloves and discard into designated container. Wash and dry your hands thoroughly. 17. Reposition the bed covers. Make the resident comfortable. Use supportive devices as instructed. 18. Place the call light within easy reach of the resident. 19. Use clean field saturated with alcohol to wipe overbed table. 20. Return the overbed table to its proper position. 21. Wipe reusable supplies with alcohol as indicated. Return reusable supplies to resident's drawer in treatment cart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676279	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2025
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	22. Take only the disposable supplies that are necessary for the treatment into the room. Disposable supplies cannot be returned to the cart. 23. Wash and dry your hands thoroughly. 24. If the resident desires, return the door and curtains to the open position and if visitors are waiting, tell them that they may now enter the room. Record review of the facility provided in-services, titled, Infection Control, date of 02/03/35, signed by 6 staff members including Kitchen Cook, stated: Summary of Subject Matter: When carrying any type of food to pass to guest, we are to put it on tray or carts to pass out. We will never pass out 2 at a time on each hand. Prevent infection control. Wash hands. Record review of the Centers for Disease Control website (www.cdc.gov) article titled Clinical Safety: Hand Hygiene for Healthcare Workers, dated February 27, 2024, reavealed: Know how to wash hands with soap and water . 3. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. 49305