STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676290	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spjst Rest Home 1	1810 Old Granger Road Taylor, TX 76574

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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50872 Based on observations, interviews, and record review, the facility failed to ensure each resident was treated with respect and dignity by contracted staff for 1 (Resident # 69) of 1 resident reviewed for resident rights. The facility failed to ensure contracted staff did not check vital signs (blood pressure, heart rate, and temperature) while at the dining room table during meal service. This deficient practice placed the resident at risk of a decline in their sense of dignity and self-worth. Findings included: Review of Resident #69's undated face sheet revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included depression, dementia (memory, thinking, difficulty), dysphagia (difficulty swallowing), and anxiety. Review of Resident #69's Quarterly MDS dated [DATE] revealed Resident #69 had a BIMS score that was not completed but, indicated the resident could not understand and could not make self-understood. An observation of the 100-hall dining room lunch service on 10/15/24 at 01:07 PM revealed RN Q, approached the table with Resident #69 and another female resident. RN Q started assessing Resident #69, including putting a blood pressure cuff on Resident's left wrist while the resident was attempting to eat a hamburger with her right hand. An interview with LVN F on 10/17/2024 at 01:50 PM revealed that she had training on resident rights and dignity. She stated that all assessments on residents including checking vital signs should be done in the resident's room. She further stated that any type of assessment, including checking vital signs, could be a dignity issue and if she had witnessed this event, she would have asked RN Q to wait until the resident was done eating, then take her to her room [for further assessment]. A phone interview with RN Q on 10/17/24 at 03:08 PM revealed that she had been trained on resident rights. She stated, It was a big mistake, but I was in a hurry .as a hospice nurse I don't need to check her vitals if she appears comfortable. She further stated that checking vital signs while the resident was eating in the dining room could affect the resident's dignity. (continued on next page)

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 - Few	An interview with the ADM on 10/17/24 at 3:12 PM revealed staff, including contracted staff like hospice, had been trained on resident rights. He stated hospice was another set of eyes to monitor a resident. He stated that all assessments were to be performed in the resident's room and it could affect the resident's dignity/privacy if done in the dining room during a meal. An interview with the DON on 10/17/24 at 3:55 PM revealed all contracted staff were expected to respect the resident's rights. She stated residents should be taken to their room after they were done eating for any assessment. She stated that doing any assessment in the dining room while they were eating could be inaccurate due to movement and it could affect the resident's dignity. Record review of the Facility Policy on Quality of Life-Dignity dated August 2009 revealed each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Staff shall promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment process. Record review of undated Resident's [NAME] of Rights revealed 19.206-The facility ensures the resident's right to privacy in the following areas: 1. Medical treatment. The facility provides privacy to each resident during examinations, treatments, case discussions, and consultations. Staff treats these matters confidentially. 2. Personal care.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45070 Based on observations, interviews, and record review, the facility failed to ensure the residents' right to privacy during personal care for 1 of 3 residents (Resident #230) reviewed for privacy. The facility failed to ensure IP M provided privacy during peri care for Resident #230, by closing the door and fully drawing the privacy curtain. This failure could place residents at risk of having their bodies exposed to the public, resulting in low self-esteem and a diminished quality of life. The findings included: Record review of Resident #230's face sheet on 10/16/24 revealed a [AGE] year-old male who was initially admitted to the facility on [DATE]. His diagnoses were, constipation, nausea with vomiting, gastro-esophageal reflux disease (acid reflex), and generalized anxiety disorder. Record review on 10/16/24 of Resident #230's care plan dated 10/01/24 reflected the resident had alteration in his bowel elimination and constipation. The relevant intervention was monitoring bowel movements every shift and record. Record review on 10/16/24 of Resident #230's initial MDS assessment, dated 10/04/24 revealed a BIMS score of 13 indicating intact cognition. Further review of the MDS revealed Resident #230 was occasionally incontinent with bowel and bladder. During an observation on 10/16/24 at 9:30am IP M provided peri care to Resident #230 while he was lying in his bed. IP M did not close the door and drew the privacy curtain fully, of Resident #230's room during the entire process. If anybody passed by the hallway to Resident #230's room, they would see Resident #230's exposed body. During an interview on 10/16/24 at 10:00am Resident #230 stated he did not notice if the door and privacy curtain were closed properly. He said it would be embarrassing if anyone from the public observed him while receiving perineal care. During an interview on 10/16/24 at 9:50am IP M stated, by not closing the door and the curtain, the privacy and dignity of Resident #230 were compromised as anyone passed by the room could see resident's exposed body. When asked about the training she received on resident's rights, IP M stated she was fully aware of the resident's right to have privacy and received in-service on resident's rights at least once a year. During an interview on 10/17/24 at 4:35pm the DON stated privacy must be provided during nursing care and the door to Resident #230's room should have been closed completely by IP M. She said the training was an ongoing process and resident rights were one of them. The DON stated that the facility ensured all the new hires went through skill checks. Every nursing staff also had to complete an annual evaluation to ensure their nursing skills and knowledge including competency in privacy/confidentiality. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/24 at 3:30 pm the ADM stated that residents' privacy should be maintained during nursing care by closing the room door, pulling the curtains, and making sure the window blinds are closed. During the review of facility's policy Quality of Life -Dignity revised in August 2009, reflected: Staff shall promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 3 of 10 residents (Resident #38, Resident #48, Resident #58 , and Resident #73) reviewed for care plans. 1. The facility failed to ensure the comprehensive care plans for Resident #38 and Resident #58 included ADLs. 2. The facility failed to ensure the comprehensive care plans for Resident #48 and Resident #73 included diagnosis of mental illness. This failure could affect residents by placing them at risk of not receiving appropriate physical and psychosocial care. Findings included: Resident #38 Record review of Resident #38's Face Sheet , not dated, reflected a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with a diagnoses of vascular dementia, unspecified, without behavioral disturbance, and Alzheimer's disease, unspecified (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest task). Record review of Resident #38's Quarterly MDS Assessment, dated 07/24/2024, reflected Resident #38 was not capable of completing brief interview for mental status related to Resident #38 was rarely or never understood. Resident #38 was dependent on staff for the following: personal hygiene, dressing, bathing, shower transfer, and toileting hygiene. Resident #38 required moderate assistance (staff does less than half the effort) with oral hygiene. She required supervision with eating. Resident #38 required maximal assistance (helper does more than half the work) with transfers. Record review of Resident #38's Comprehensive Care Plan, revised on 09/24/2024, reflected Resident #38 ADLs was not care planned. Signed by the ADON. Resident # 48 Record review of Resident # 48's Face Sheet, not dated, reflected a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with a diagnosis of delusional disorders (a mental illness- condition that causes a person to have false beliefs that are not based on reality), major depressive disorder (a mental illness- persistently depressed mood and long-term loss of pleasure or interest in life, often with other symptoms as disturbed sleep, feelings of guilt or inadequacy, and suicidal thoughts). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #48's MDS Annual Assessment, dated 09/03/2024, reflected Resident #48 had a BIMS score of one indicating Resident's cognition was severely impaired. Resident #48 was assessed to have a diagnosis of the following diagnoses: major depressive disorder, recurrent, severe with psychotic symptoms (mental illness- psychotic is a collection of symptoms that cause a person to lose touch with reality) and delusional disorders. Resident #48 was taking high-risk medications such as : anti-depressant (a common prescription medications that can help treat depression), and anti-psychotic (medications that treat psychosis-related conditions and symptoms). Record review of Resident #48's physician order, dated 10/16/2024, reflected Resident #48 had an order for Seroquel (quetiapine) 25 mg one tablet once a day for diagnosis of delusional disorders (order date 09/12/2024). Resident #48 had an order for Sertraline 100 mg one tablet every day for major depressive disorder, recurrent, severe with psychotic symptoms on 09/12/2024. Record review of Resident #48's Comprehensive Care Plan, dated 09/25/2024 reflected Resident #48's diagnosis of delusional disorders and major depressive disorders was not documented on the care plan. Signed by the ADON. Resident # 58 Record review of Resident # 58's Face sheet reflected a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses vascular dementia, unspecified severity, with anxiety (symptoms changes in personality, behavior, and mood, such as depression, agitation, and anger. Vascular dementia is a type of dementia that occurs when blood flow to the brain is interrupted, damaging brain cells and impairing thinking, memory, and behavior), cerebrovascular disease, unspecified (condition that affect blood flow to your brain. Conditions include stroke, brain aneurysm, and brain bleed), and age-related physical debility (a symptom of frailty symptoms: weakness, fatigue, slowness, poor balance, decreased physical activity, and cognitive impairment). Review of Resident #58's quarterly MDS assessment dated [DATE] reflected Resident #58 was assessed to have a BIMS score of 00 indicating severe cognitive impairment. Resident #58 was assessed to be dependent on staff for the following: personal hygiene, dressing, bathing, and toileting hygiene. Review of Resident #58's comprehensive care plan, revised on 10/13/2024 reflected ADLs was not care planned. Resident #58 had cognitive loss. She had impaired decision-making ability related to severe cognitive impairment. Intervention: Avoid use of restraints. Allow Resident #58 practice problem solving techniques. Resident #73 Record review of Resident #73's Face Sheet, not dated, reflected a [AGE] year-old male admitted to the facility on [DATE] with a diagnoses of delusional disorders (a mental illness- condition that causes a person to have false beliefs that are not based on reality). Record review of Resident #73's Quarterly MDS, dated [DATE] reflected Resident #73 had a BIMS score of 8 reflected his cognition was moderately impaired. Resident #73 had active diagnoses of delusional disorders. Resident #73 was assessed to be taking antipsychotic medication. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #73's Physician Orders, dated 10/2024 reflected Resident #73 was ordered Sertraline 25 mg. one tablet daily for delusional disorders on 06/28/2024. Resident #73 was ordered Quetiapine 25 mg. one tablet daily in the evening. (5:30 PM). Record review of Resident #73's Comprehensive Care Plan, dated 09/25/2024, reflected Resident #73's diagnosis of delusional disorders was not documented on the care plan. Signed by the ADON. In an interview on 10/16/2024 at 10:45 AM MDS Coordinator stated ADLs including the following personal hygiene, transfers, toileting, showers, eating abilities, dressing, repositioning in bed and type of ambulation was required to be on the comprehensive care plan. She stated if a resident had a mental illness such as delusional disorder or major depression it was to be also care planned. The MDS Coordinator stated the staff would not know the type of physical or mental care a resident needed if it was not care planned and there was a possibility a resident may become injured if the improper ADL care was given to a resident. She stated if the resident did not have any recent delusions or depression these diagnoses there was a risk for symptoms. The MDS Coordinator stated there were risks for symptoms of these diagnoses and the symptoms and medications needed to be care planned. She stated all staff was to follow the care plan to know what type of care each resident needed. The MDS Coordinator stated she and the ADON was responsible for care plans. She stated she had been in serviced on care plans but did not recall the date and time. In an interview on 10/17/2024 at 10:47 AM The ADON stated a care plan was expected to be developed for any resident with a diagnoses of delusional disorder and major depression. She stated if any resident was on anti-psychotic medications or anti-depressants for a diagnoses these medications were expected to be an intervention on the mental illness care plan. She stated delusional disorder and major depression was a mental illness. The ADON stated if a resident was experiencing any symptoms of delusions or major depression, the staff would not know what type of interventions the resident required. She stated a resident may need a special intervention to use only for that resident. The ADON stated if the staff did not have access to the specific intervention for a resident, the resident may not receive the proper care when the resident was delusional and/or had major depression. The ADON stated all residents care plans was expected to have the ADLs on their care plans. She stated it would be difficult for the staff to know what type of ADL care to give if they did not know the resident and reviewed a resident's care plan and the ADLs was not documented. The ADON stated she and the MDS Coordinator was responsible for care plans. She stated if a staff name was on the care plan the staff was the one documenting on the care plan when the staff had care plan meetings. She stated she had been inserviced on care plans but did not recall the date or time. In an interview on 10/17/2024 at 11:11 AM CNA E stated she knew about care plans and what is documented on the care plan was the type of care a resident needed. She stated if any type of mental issues it was not documented it would be difficult to know the care a resident needed. CNA E stated if it was a new resident and the ADLs was not documented on the care plan, she would ask the nurse supervisor. In an email on 10/17/2024 at 11:48 PM requested the Comprehensive Care and in an interview on 10/17/2024 at 1:20 PM requested the Comprehensive Care Plan Policy. This was not provided at time of exit.

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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** 40884 Based on observations, interviews, and record review, the facility failed to ensure residents unable to conduct activities of daily living (ADLs) received the necessary services to maintain good grooming and personal hygiene for four of eight residents (Resident # 31, Resident #38, Resident #43, and Resident #58) reviewed quality of life. 1. The facility failed to ensure Resident #31's facial hair was removed. 2. The facility failed to ensure Resident # 38's, Resident #43's and Resident #58's nails were cleaned and smooth around the edges. These failures could place residents at risk for poor hygiene, dignity issues, and decreased quality of life. Findings included: Resident #31 Record review of Resident # 31's Face Sheet, undated, reflected a 75 -year-old female admitted on [DATE] and readmitted on [DATE] with a diagnoses of Alzheimer's disease, unspecified (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest task), unspecified lack of coordination (the inability to control the position of one's limbs or posture), and unspecified osteoarthritis (a joint disease that occurs when the cartilage in a joint breaks down over time- joint pain, stiffness, and restricted movement). Record review of Resident #31's Quarterly MDS Assessment, dated on 07/25/2024, reflected the resident had a BIMS score of 0 indicating her cognition was severely impaired. Resident #31 required staff to complete more than half the effort with personal hygiene, dressing, and bathing. Record review of Resident #31's Comprehensive Care Plan , revised on 09/25/2024 , reflected Resident #31 had ADL self -care performance deficit related to impaired memory. Intervention: Resident #31 required assistance with showers and with personal hygiene. Observation on 10/15/2024 at 9:12 AM revealed Resident #31 was sitting in her wheelchair in the dining area with other residents. She had facial hair on the right side, middle and underneath her chin. The hair was approximately 1 inch long. Observation on 10/16/2024 at 8:40 AM revealed Resident # 31 was sitting in her wheelchair in the dining area with other residents. The facial hair on and underneath her chin had not been removed. Interview on 09/17/2024 at 9:13 AM with Resident #31 she was not interview able. Resident #38 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #38's Face Sheet , not dated, reflected a 87 -year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses of vascular dementia, unspecified, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a chronic condition that occurs with the brain doesn't receive enough blood flow, which damages brain tissue and impairs thinking, and memory) and Alzheimer's disease, unspecified (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest task). Record review of Resident #38's Quarterly MDS Assessment, dated 07/24/2024, reflected Resident #38 was not capable of completing brief interview for mental status related to Resident #38 was rarely or never understood. Resident #38 was dependent on staff for the following: personal hygiene, dressing, bathing, and toileting hygiene. Record review of Resident #38's Comprehensive Care Plan, revised on 09/24/2024, reflected Resident #38 ADLs was not care planned. Resident #38 had a communication problem related to Alzheimer's and Dementia disease. Intervention: monitor/ document for nonverbal indicators of discomfort or distress, and follow-up as needed. Observation on 10/15/2024 at 9:22 AM revealed Resident #38 was in her room lying in bed. Resident # 38 had blackish/ brownish substance underneath the forefinger, ring finger and middle fingernails on her right hand. Her fore fingernail and her ring fingernail were not smooth around the edges. An attempted interview on 10/15/2024 at 9:24 AM with Resident #38 revealed she was not interview able. Resident #43 Record review of Resident # 43's Face Sheet dated, not dated, reflected a [AGE] year-old male admitted on [DATE] with diagnoses of Alzheimer's disease with late onset (developed in people at the age of 65 and older- a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest task), osteoarthritis left shoulder (occurs when the cartilage in the shoulder joint wears down), and age related physical debility (a symptom of frailty such as weakness, inactivity, and depression). Record review of Resident #43's Quarterly MDS Assessment, dated 09/22/2024, reflected the resident had a BIMS score of 0 indicating his cognition was severely impaired. Resident # 43 required more than the helper's assistance with personal hygiene. Resident #43 required moderate assistance helper does half the assistance with the following: upper and lower dressing and toileting hygiene. Record review of Resident #43's Comprehensive Care Plan dated, 09/25/2024, reflected Resident #43 had impaired memory and inattention related to diagnosis of Alzheimer's and BIMS score of 0. Intervention: Administer medication as ordered. Assess Resident #43 overall cognitive function and memory. Resident #43 had an ADL self-care performance deficit. Intervention: Resident #43 required assistance with personal hygiene. Observation on 10/15/2024 at 9:43 AM revealed Resident #43 was sitting in his wheelchair watching tv in the common area of the memory care unit. He had blackish substance underneath all fingernails on his right hand. Resident #43's middle finger, ring finger and fore fingernails on his right hand was rough around the edges. (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 attempted interview on 10/15/2024 at 9:45 AM Resident #43 was not interview able. Resident # 58 Record review of Resident # 58's Face sheet reflected a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses vascular dementia, unspecified severity, with anxiety (symptoms changes in personality, behavior, and mood, such as depression, agitation, and anger. Vascular dementia is a type of dementia that occurs when blood flow to the brain is interrupted, damaging brain cells and impairing thinking, memory, and behavior), cerebrovascular disease, unspecified (condition that affect blood flow to your brain. Conditions include stroke, brain aneurysm, and brain bleed), and age-related physical debility (a symptom of frailty symptoms: weakness, fatigue, slowness, poor balance, decreased physical activity, and cognitive impairment). Review of Resident #58's quarterly MDS assessment dated [DATE] reflected Resident #58 was assessed to have a BIMS score of 00 indicating severe cognitive impairment. Resident #58 was assessed to be dependent on staff for the following: personal hygiene, dressing, bathing, and toileting hygiene. Review of Resident #58's comprehensive care plan, revised on 10/13/2024 reflected ADLs was not care planned. Resident #58 had cognitive loss. She had impaired decision-making ability related to severe cognitive impairment. Intervention: Avoid use of restraints. Allow Resident #58 practice problem solving techniques. Observation on 10/15/2024 at 9:55 AM revealed Resident #58 was in her room lying in bed Resident #58's right hand forefinger, middle finger, and ring fingernails were not even around the edges and also had a blackish substance underneath the nails. In an attempted interview on 10/15/2024 at 9:58 AM Resident #58 was not interview able. In an interview on 10/17/2024 at 10:26 AM, RN D stated the nurses and the CNAs were responsible for nail care. She stated the nurses were responsible to trim and clean all residents' nails with a diagnosis of diabetes (a disease in which the body's ability to produce or respond to the hormone insulin was impaired) . RN D stated it was the CNA's responsibility to clean and trim all other residents' nails. She stated if there was a blackish substance underneath the residents' nails, there was a possibility the substance had bacteria underneath the residents' nails. She stated if a resident swallowed the bacteria there was a possibility a resident may become extremely ill with stomach issues such as diarrhea or vomiting. RN D stated she was not aware of, Resident #43, Resident #58 or Resident #38 refused nail care. She stated if resident has rough nails there was a possibility the resident may scratch themselves or other residents. She stated there was a possibility the resident may develop a skin tear. RN D stated if a female resident had facial hair on their chin, there was a possibility the resident may become embarrassed with their appearance and may isolate themselves in their room. (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 09/17/2024 at 10:47 AM, the ADON stated it was a joint effort between the CNAs and the nurses to complete nail care on the residents. She stated the nurses was responsible for residents with diagnosis of diabetes. The ADON stated nail care was given during showers and as needed. She stated if a resident had blackish substance underneath their nails there was a possibility the substance may be some type of bacteria. The ADON stated a resident may have symptoms of vomiting, nausea, or diarrhea. She stated if a resident had rough edges around the tip of the nails a resident could scratch their eye or develop a skin tear if the resident scratched themselves. She stated if a female resident had facial hair there was a possibility the female resident may not want to leave their room due to embarrassment of the hair on their face. The ADON stated it was the nurse supervisor to monitor personal hygiene on residents. In an interview on 10/17/2024 at 11:11 AM, CNA E stated the nurses completed all diabetic fingernails and the CNAs were responsible for all other residents' nails. She stated the CNAs were responsible to complete nail care such as trimming, filing, and cleaning the nails. CNA E stated if a resident's nails needed to be cleaned, trimmed, or filed, and it was not their shower day, the staff were expected to do any type of nail care as needed. She stated if a resident had blackish substance underneath their nails, it was probably some type of bacteria. She stated if a resident swallowed bacteria it was a potential the resident may become ill with major stomach problems such as diarrhea. CNA E stated she had given care to Resident #43, Resident #58, and Resident #38 , and she was not aware of them refusing nail care. CNA E stated if a female resident had facial hair on their chin, a resident may become embarrassed over their appearance and there was a possibility the resident may isolate themselves in their room. CNA E stated it was the CNAs or nurses' responsibility to remove facial hair from the female's chin in the resident's room or during showers. CNA E stated she was not aware of any female resident refusing to allow staff to remove unwanted facial hair from their face. She stated if a resident had nails not filed correctly and had rough edges around the fingernails, there was a possibility the resident may scratch themselves or another resident. She stated she had been in-service on personal hygiene, however, did not recall the date of the in-service. Record review of the facility's Policy on Care of Fingernails revised October 2010 reflected The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. Review the resident's care plan to assess any special needs of the resident. Nail care includes daily cleaning and regular trimming. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. The following information should be recorded in the resident's medical record: 1. The date and time that nail care was given. 2. The name and title of the individual (s) who administered the nail care. 3. The condition of the resident's nails and nail bed, including: a. Redness or irritation of skin of hands. b. Breaks or cracks in skin. c. Bluish or dark color of nail beds. d. Ingrown nails; (continued on next page)

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	676290	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spjst Rest Home 1	1810 Old Granger Road Taylor, TX 76574

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. Bleeding; and or f. Pain 4. Any difficulties in cutting the resident's nails 5. Any problems or complaints made by the resident with his/her hands. 6. If the resident refused the treatment, the reasons why and the intervention taken. 7. The signature and title of the person recording the data.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 40884 Based on interview and record review, the facility failed, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for 12 of 12 residents on the secure unit. The facility failed to provide activities on the secured unit as scheduled on 10/05/24, 10/06/24, 10/12/24, and 10/13/24, These failures placed residents at risk of boredom, depression, increased behaviors, and diminished quality of life. Findings include: Record review of the Activity Calendar for the month of October 2024 revealed the following scheduled activities: *10/05/24 10:00 AM: Coffee Social, 11:00 AM Sensory Station, 2:00 PM: TV TIME, 3:00 PM: Coffee Social, 4:00 PM: Resident Activity Choice. *10/06/24 10:00 AM: Coffee Social, 11:00 AM: Sensory Station, 2:00 PM: Grandbaby Love, 2:30 PM Corn Hole/Basket toss, 4:00: PM Resident Activity Choice. *10/12/24 10:00 AM: Coffee Social, (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11:00 AM Sensory Station, 2:00 PM: TV TIME, 3:00 PM: Coffee Social, 4:00 PM: Resident Activity Choice. *10/13/24 10:00 AM: Coffee Social, 11:00 AM: Sensory Station, 2:00 PM: Grandbaby Love, 2:30 PM Corn Hole/Basket toss, 4:00: PM Resident Activity Choice. Record Review of the resident participation records from 10/05/24 to 10/13/24 revealed activities did not occur on 10/05/24, 10/06/24, 10/12/24, and 10/13/24. In an interview on 10/17/2024 at 9:29 AM CNA C stated she did work sometimes on the weekends. She stated no one had in-service her on how to document on the participation records. She stated she did not know if the other staff worked on the memory care unit had been in-service by the activity staff. CNA C stated it was difficult sometimes to do activities with residents on weekends. She stated there was a lot to do on the memory care unit with all the residents giving ADL care. She stated she does talk to the residents on weekends and during the week. She will sit with them when they watch tv and talk to the residents but she was never told during the week to document on any type of participation record of activity being done during the week or weekends. CNA C stated she did not remember if she worked 10/05/2024 - 10/06/2024. In an interview on 10/17/2024 at 9:40 AM the Activity Director A stated anytime an activity was conducted with the residents she expected the activity to be documented on the participation record including on the memory care unit. She stated attendance records were the same as participation records. She stated if any residents attended an activity or had an in-room activity it was to be documented. Activity Director A stated she had not in-serviced all of the staff on the secure unit about documenting activity programs on the weekends. She stated if residents on the secure unit was not receiving routine activities there was a potential the residents may have a decline in cognition, increase social isolation, increase behaviors, etc. She stated it was her and the Activity memory care Coordinator duty to ensure the residents on the secure unit received activities according to the calendar and every day. She stated she had been the Activity Director at this facility more than 5 years. Activity Director A stated sometimes the activities on the calendar changes. She stated they do not make the changes on the current activity calendar on the memory care unit. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/17/2024 at 10:08 AM the Activity Memory Care Coordinator B stated she does leave activity items out for the staff to use on the weekends. She stated she did not recall if all the staff on the secure unit had been in-serviced on how to document on the participation record and how to do the activities on the memory care unit calendar. She stated if it was not documented on the memory care participation records of any resident attending an activity, the activity for that day did not occur on the memory care unit. Activity Memory Care Coordinator B stated if the residents did not receive routine activities every day there was a potential a resident may become bored, wander, become restless and/or have a decline in cognition. She stated it was her responsibility to ensure the residents received activities on the memory care unit and the Activity Director A was her supervisor. She stated she had been an employee at the facility approximately 1 year. She stated attendance records were the same as participation records. Record review of the Facility Policy on Documentation, Activities, revised December 2009, reflected The Activity Director/ Coordinator is responsible for maintaining appropriate departmental documentation. Recordkeeping is a vital part of the activity programs. The following records, at a minimum, are maintained by Activity Department personnel: a. Activity Assessment b. Attendance records. Record review of the Facility Policy on Group Programs and Activities Calendar, revised April 2009, reflected Group activities are available in this facility and an activities calendar is completed to inform residents, families, and staff of the activity opportunities available. Both large and small group activities are part of our activity programs. The activities calendar states all activities available for the entire month, which may also include scheduled room visits. Modifications, time changes, cancellations or substitutions are reflected on all large, posted calendars.

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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** 50872 Based on observations, interviews and record reviews the facility failed to ensure that proper care practices related to catheterization were maintained for one of one resident(s) reviewed for catheter care, as indicated by: 1. The foley catheter bag of Resident #70 was laying on the floor. These failures can place the resident at risk for infection, urethral (the tube that carries urine from the bladder exit the body) tears or dislodging the catheter. Record review of Resident #70's undated face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included but were not limited to retention of urine (inability to urinate), hypertension (high blood pressure), and muscle weakness. Record review of Resident #70's annual MDS dated [DATE] revealed a BIMS score of 4 indicating severe cognitive impairment. Record review of Resident #70's Care Plan dated 9/13/2024 reflected the resident was at risk for impaired urinary elimination related to recent urinary tract infection and antibiotic use, as well as a history of urinary retention (inability to urinate). The resident has a foley catheter for this diagnosis. The relevant interventions included: 1. Report signs/symptoms of UTI (acute confusion, urgency, frequency, bladder spasms, nocturia, burning, pain, difficulty urinating, low back/flank pain, malaise, nausea/vomiting, chills, fever, foul odor, concentrated urine, blood in urine). An observation on 10/15/24 at 07:51 AM revealed Resident #70 sitting in a recliner with the foley catheter bag on the floor under the bedside table legs. An observation on 10/15/24 at 08:41 AM revealed Resident #70 remained in the recliner and the foley catheter bag was on the floor to the right side of the recliner. An observation on 10/17/24 at 09:53 AM revealed Resident #70 sitting in a recliner with eyes closed. The foley catheter bag was laying on the floor in a dignity bag. An interview on 10/17/24 at 10:48 AM with CNA O revealed that she was responsible for ensuring all foley catheter bags are anchored below the level of the bladder but off the floor and have a dignity bag. An interview on 10/17/24 at 01:50 PM with LVN F revealed that if a foley catheter were on the floor then it should be picked up and put in a dignity bag. She stated that if a foley catheter bag were to touch the floor it could cause an infection. An interview on 10/17/24 at 03:55 PM with the DON revealed her expectation for foley catheters were to be kept at the lowest point possible without touching the floor. She stated that not doing so could cause contamination, cause a fall risk, or possible even be forcefully removed causing injury. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 10/17/24 at 03:12 PM with ADM revealed foley catheters should be hung on the bed and if it touches the floor, it could cause cross contamination.

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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** 50872 F695 Based on observation, interviews, and record reviews, the facility failed to ensure professional standards of practice for respiratory care were followed. For all residents reviewed for respiratory care as indicated by: 1. The nasal cannula of Resident #34 and the CPAP of Resident #32 were not in a bag when unused. 2. The oxygen concentrator filters of Resident #32 and Resident #24 were covered in dust. These failures could place the residents at risk of infection. Findings included: Record review of Resident #34's undated face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to Alzheimer's disease (a brain disorder that causes memory loss), venous insufficiency (the veins have trouble sending blood from arms and legs to the heart), congestive heart failure (the heart is unable to pump blood well enough to meet the body's need). Record review of Resident #34's quarterly MDS dated [DATE] revealed a BIMS score of 3 indicating significant cognitive impairment. An observation on 10/15/24 at 07:54 AM revealed Resident #34 lying in bed sleeping. A nasal cannula was laying across the top of the oxygen concentrator and not in a bag. An observation on 10/15/24 at 10:37 AM revealed Resident #34 lying in bed sleeping. A nasal cannula was laying across the top of the oxygen concentrator and not in a bag. An observation on 10/17/24 at 09:55 AM revealed Resident #34 sitting up in bed watching tv. A nasal cannula was laying across the top of the oxygen concentrator and not in a bag. Record review of Resident #32's undated face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to chronic respiratory failure with hypercapnia (difficulty breathing with high levels of carbon dioxide in the blood), chronic congestive heart failure (the heart is unable to pump blood well enough to meet the body's needs), paroxysmal atrial fibrillation (irregular heart rhythm), and obstructive sleep apnea(repeated breathing interruptions during sleep). Record review of Resident #32's quarterly MDS dated [DATE] revealed a BIMS score of 15 indicating no cognitive impairment. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #32's Care Plan dated 12/26/2022 and edited on 9/4/2022 reflected I have altered respiratory status/difficulty breathing related to my diagnosis of acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia and obstructive sleep apnea (adult). I have an order yet refuse to use my CPAP machine while in bed or during naps. Interventions include: 1. CPAP ordered per home settings. 2. Oxygen settings: O2 via NC PRN (as needed) to maintain O2 > 90% An observation on 10/15/24 at 11:16 AM revealed Resident #32 lying in bed watching tv. The oxygen concentrator filter was covered in dust. Also observed Resident #32's CPAP on the floor near the oxygen concentrator with mask in a bag. An observation on 10/17/24 at 10:34 AM revealed Resident #32 remained in bed watching tv. The oxygen concentrator filter continued to be covered in dust. Also observed Resident #32's CPAP remained on the floor near the oxygen concentrator with mask in bag. Record review of Resident #24's undated face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to vascular dementia (brain damage caused by impaired blood flow that has caused memory issues), chronic obstructive pulmonary disease (an ongoing lung disease that causes damage to the lungs), cerebral infarction due to thrombosis (blood flow was reduced or stopped to a portion of the brain due to a blood clot), and congestive heart failure (the heart is unable to pump blood well enough to meet the body's needs). Record review of Resident #24's MDS dated [DATE] revealed a BIMS assessment was not completed. Record review of Resident #24's Care Plan dated 8/5/2024 reflected Resident has shortness of breath and low oxygen sats related to COPD. Interventions included: 1. Administer oxygen at 2 liters via nasal cannula while awake and bipap while asleep. Observe oxygen precautions. 2. Keep room cool and free of irritants (smoke, dust, cleaning agents). Record review of Resident #24's orders from 10/17/2024 revealed orders clean concentrator filter monthly, once a day on the 5th of the month 11:00 PM-07:00 AM and Clean concentrator filter when it appears gray or dirty PRN, as needed. An observation on 10/16/24 at 09:46 AM revealed Resident #24 lying in bed sleeping. The oxygen concentrator filter was covered in dust. An observation on 10/17/24 at 09:50 AM revealed Resident #24 sitting up in bed. Oxygen concentrator continued with dust covering the filter. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 10/17/24 at 10:48 AM with CNA O revealed the nurses were responsible for cleaning the oxygen concentrator filters. The oxygen tubing was to be kept in a bag when not in use or needs to be thrown away and a new one obtained. She stated that if a resident were to use the nasal cannula after it was just laying on top of the oxygen concentrator, it could cause the resident to develop a staph infection in their nose. An interview on 10/17/24 at 01:50 PM with LVN F stated there was an order to clean the back of all oxygen concentrators on the 11 PM-7 AM shift once a month. She stated that nasal cannulas were to be stored in a bag when not in use and all CPAP machines were supposed to be kept on the bedside table, and the mask was to be kept in a bag. If the CPAP machine was stored on the floor, it could get wet and be an electrical hazard or a fall risk. Also, if oxygen concentrator filters were covered in dust, it could be filtering unclean air and cause illness. An interview on 10/17/24 at 03:55 PM with the DON revealed she expected for the oxygen concentrator filters to be checked monthly by maintenance. She further stated that using an oxygen concentrator with a dirty filter could increase the risk of breathing in fungal spores and bacteria. She expected all nasal cannulas to be stored in a bag when not in use. The DON stated if a nasal cannula was not stored in a bag, it could increase the risk of inhaling microbes. She expected CPAP machines to be stored on the bedside table. She stated that storing a CPAP machine on the floor could cause a bug to enter the machine, could cause an infection, or even cause a tripping hazard. An interview on 10/17/24 at 03:12 PM with ADM revealed all nasal cannulas to be stored in bags when not in use and all CPAP machines to be stored on the resident's nightstand. He stated if the concentrator filters weren't cleaned, then the concentrator doesn't work sufficiently. Also, if the nasal cannulas and CPAP machines were not stored properly then it can cause contamination. Review of facility's policy titled Cleaning and disinfection of Resident care Items and Equipment revised in October 2018 reflected: Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50872 Based on observations, interviews, and record review, the facility failed to ensure drugs and biologicals were stored and labeled in accordance with currently accepted professional principles for 2 of 2 medication storage rooms and 1 of 3 medication carts. A) The facility failed to ensure expired supplies were removed from the medication storage room for Halls 100 and 200 including 1 box of Colostomy (a surgical opening for the colon in the abdomen) supplies that expired 2/5/2018, 3 bisacodyl suppositories that expired 8/2024, and chlorhexidine wipes that expired 7/2/2023. B) The facility failed to ensure expired supplies were removed from the medication storage room for halls 300 and 400 including a foley catheter insertion tray with expiration date of 5/31/2023 and Normal Saline IV flush with expiration date 4/30/2023. C) The facility failed to ensure that all medication were secured in the medication cart when it was unattended by CMA N. These failures could place residents at risk of contamination causing illness, decreased effectiveness of medication, and risk of injury to other residents if medications left out were consumed. Findings included: A. Observation on 10/16/2024 at 3:10 PM of the medication storage room for Halls 100 and 200 with LVN G in attendance revealed Colostomy (a surgical opening for the colon in the abdomen) supplies that expired 2/5/2018, 3 bisacodyl suppositories that expired 8/2024, and chlorhexidine wipes that expired 7/2/2023. B. Observation on 10/16/2024 at 4:50 PM of the medication storage room for Hall 300 and 400 with LVN S in attendance revealed 1 vanilla pudding that expired on 7/28/2024, 8 Luer slip disposable syringes that expired 8/6/2024, and a closed IV catheter system (needle to start an IV) that expired 2/28/2022. In an interview on 10/17/2024 at 3:43 PM the DON stated a pharmacist checked 1 medication room and 2 medication carts each month rotating around. She stated all nurses were trained to look at expiration dates of supplies and medication prior to use and if the medication or supplies were expired to not use them. Expired supplies were to be thrown away and medications were to be given to the ADON for destruction. The DON stated that using expired medications and supplies could cause a harmful effect or have a decrease in effectiveness. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/17/2024 at 3:12 PM the ADM stated the pharmacist came out in July-ish and checked for expirations in the medication carts and medication rooms. He stated, I've taken expired medications myself they just might not be as effective. Review of Resident #54's undated Face Sheet reflected he was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of hyperlipidemia (high amount of cholesterol in the blood), anxiety (feeling of dread, fear, and uneasiness), and CVA with right sided weakness (a conditions where blood flow to a part of the brain is stopped causing right sided weakness). A. Observation on 10/16/2024 at 08:57 AM revealed MA N locked the medication cart and walked down 200-hall out of line of sight of the medication cart. 3 medication cards with medications remained on top of the cart face down. The card on top indicated it contained Lisinopril 20mg (a medication to lower blood pressure). B. Observation on 10/16/2024 at 09:10 AM revealed MA N locked the cart and walked into a room and out of line of sight of the medication cart with Resident #54. The 3 cards of medication remained on top of the cart face down. In an interview on 10/17/2024 at 10:10AM MA N stated she has been working at the facility for about 5 years. MA N stated she later realized she left the medication cards on top of the medication cart unattended. She stated that anyone could have walked up to the cart and taken the medications. MA N stated it could be very bad. Review of a facility policy and procedure titled Storage and Expiration Dating of Medications, Biologicals dated 2008 and revised in June 2023 reflected, 3.3 The community should ensure all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room, inaccessible by unauthorize staff, residents, and visitors. 4. The community should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier. Review of grievances indicated no complaint or concerns voiced by residents about expired supplies, food, or medication being given/used.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 42600 Based on observations, interviews, and record reviews the facility failed to ensure food was prepared in a form designed to meet individual needs for 6 of 6 residents (Resident #14, Resident #18, Resident #24, Resident #63, Resident #70, and Resident #75) reviewed for pureed diets. Cook K failed to ensure food prepared for residents receiving a pureed diet was in the proper consistency for this diet. This failure could place residents who received pureed diets at risk of not having nutritional needs met by consuming foods that could cause poor intake, choking and decreased meal intakes. Findings included: Observation on 10/15/2024 at 12:59 PM revealed pureed peas were served on plate and appeared to have a watery consistency. The pureed peas appeared to easily pour out of the serving spoon. During an interview on 10/15/2024 at12:59 PM, DA T stated that she thought the texture of the peas should be a little thicker. Observation on 10/16/2024 at 10:50 AM revealed the chicken base contained included instruaction revealed to add 1 teaspoon to 1 cup of boiling water. Observation on 10/16/2024 at 11:59 AM revealed chicken base separated from water in measuring cup. Further observation revealed [NAME] K added more water to the measuring cup. [NAME] K did not measure additional chicken base to add and did not measure the water added. Observation revealed [NAME] K added mixture while she pureed fried chicken. Observation and interview on 10/16/2024 at 12:03 PM revealed [NAME] K transferred the pureed chicken into serving dishes. Further observation revealed small pieces of unblended chicken in the mixture. [NAME] K stated the texture of the chicken puree was smooth. [NAME] stated again that the texture was smooth. During an interview on 10/16/2024 at 12:03 PM [NAME] K stated that the texture of the chicken puree was smooth. [NAME] K stated the puree texture should be thick like mashed potatoes and stated again that the texture was smooth and there were no chunks. During an interview on 10/16/2024 12:04 PM the DM stated there were small chunks in the chicken puree. DM stated that the cook needed to puree the chicken again. The DM stated the puree should be smooth like baby food and not have any chunks. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spjst Rest Home 1	1810 Old Granger Road Taylor, TX 76574

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/24 at 03:01 PM RD V stated he visited the facility twice a month. RD V stated once a month there was a quality check on how the regular texture food was prepared and that the staff was using the correct ingredients. RD V stated he had no issues with food preparation. RD V stated he observed preparation of pureed food about every 4 to 5 months and was unsure of the exact timeframe. He stated pureed food should be smooth with no lumps. He stated if a fork was put through the pureed food, the food should not easily fall through the fork. RD V stated pureed fried chicken should be smooth. RD V stated when making pureed food the staff typically want to use high calorie liquids. RD V was not sure how to make broth with the chicken base. During an interview on 10/17/24 at 01:40 PM [NAME] K stated the pureed food was supposed to be a smooth texture with no grains or chunks. [NAME] K stated she should be able to put a fork through it and it slowly drops off the fork to ensure the resident do not choke. [NAME] K stated she could add chicken broth, beef broth and milk when she made pureed food. [NAME] K stated for pureed vegetables she could use water from the cooked vegetables. [NAME] K stated she was unsure about the amount of water she needed to make the chicken or beef broth with the chicken or beef bases. [NAME] K stated she measured 1/2 to a teaspoon of chicken base to mix into the water to make broth. [NAME] K stated they are not allowed to use just water for puree because it takes the taste away from the food. [NAME] K stated she should not add water to the measuring cup without adding additional chicken base and stated that if she did it could take away from the flavor. During an interview on 10/17/24 02:00 PM the DM stated she has been the dietary manager for about 2 years. The DM stated pureed food texture should not lose its form and should be smooth almost like consistency of mashed potatoes. The DM stated the pureed food should not just fall out of serving spoon. The DM stated depending on the diet the resident could choke if it was the incorrect texture. The DM stated for pureed foods the liquid you could add depended on the type of food that was being prepared. The DM stated vegetables juice from cooked vegetables could be added, chicken or beef broth to their respective meats could be added. The DM stated she did not think cooks should add more water to existing mixture and stated she expected cooks to mix base and water according to the instructions. The DM stated if the cooks did not follow the instructions on the chicken base, it could be too watery which would affect the flavor of the food. The DM stated the last in-service complete on pureed food may have been last year, but she was unsure. During an interview on 10/17/24 at 02:14 PM [NAME] L stated he has worked at the facility for 4 days. [NAME] L stated he received training on how to make pureed food. [NAME] L stated pureed food was supposed to be smooth and stated that someone could choke if there were chunks. [NAME] L stated pureed food should not be watery. [NAME] L stated if he were to scoop it, it should not just fall through the fork or out of the serving spoon. [NAME] L stated that staff can add milk but you cannot add water because it may not have the correct calories. During an interview on 10/17/24 at 03:11 PM the ADM stated he was unsure if pureed food was supposed to have chunks in it or what the texture was supposed to be. Record review of communication form dated 08/26/2024 revealed a dietician recommendation that sometimes pureed meats have some chunks in them. Review of undated facility list of residents with altered diets revealed Resident #14, Resident #18, Resident #24, Resident #63, Resident #70, and Resident #75 recieved pureed meals. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Therapeutic Diets dated October 2017 revealed a 'therapeutic diet' is considered a diet order by a physician, practitioner, or dietician as part of treat for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet. Examples included an altered consistency diet.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42600 Based on observation, interview and record review, the facility failed to store and prepare food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitization. 1. The facility failed to ensure food in the freezer, refrigerator and dry storage room were properly stored, dated and labeled. 2. The facility failed to ensure kitchen staff performed hand hygiene while preparing food. 3. The facility failed to maintain kitchen equipment in clean operating condition. 4. The facility failed to ensure refrigerators in satellite kitchens maintained appropriate temperatures. 5. The facility failed to ensure clean dishes were stored away from food preparation area and cleaning cloths were stored away from food preparation areas. These failures could place residents who were served from the kitchen at risk of food-borne illness. Observation of the freezer on 10/15/2024 at 7:06 AM revealed an undated package of molded raspberries . Observation of the dry storage on 10/15/2024 at 7:07 AM revealed jalapenos with a label that revealed refrigerate after opening with an open date of 10/7/2024. Observation of the freezer on 10/15/2024 at 7:11 AM revealed undated Ozempic (a prescription injectable medication used to treat type 2 diabetes in adults). Observation on 10/15/2024 at 7:16 AM revealed ice maker in satellite kitchen had rust and white build up on dispenser and rust on tray. Observation on 10/15/2024 at 7:17AM revealed thermometer reading 50 degrees in satellite kitchen refrigerator. There were lemon glycerin swab sticks in freezer of satellite kitchen. Further observation revealed instructions to protect from freezing. Observation on 10/15/2024 at 7:19 AM revealed drinking cups stored in cabinets of satellite kitchen-stained brown at bottoms. Observation on 10/15/2024 at 7:20 AM revealed four plastic containers of various kinds of cereal stored in cabinet of satellite kitchen with no label or date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 10/15/2024 at 11:07 AM revealed a non-functioning hand sanitizer dispenser in the satellite kitchen. Observation on 10/15/2024 at 7:23 AM revealed satellite kitchen refrigerator temperature read 70 degrees. Observation on 10/15/2015 at 12:38 PM revealed DA T wore gloves while serving dining service. Further observation revealed that DA T opened refrigerator with gloves on and proceeded to serve without changing gloves or performing hand hygiene. DA T proceeded to open Ziploc bag of small potato chips and did not perform hand hygiene before returning to serve. Observation on 10/16/2024 at 12:07 PM revealed [NAME] K prepared pureed food over exposed clean bowls. Further observation revealed clean bowls were uncovered. Observation on 10/16/2024 at 12:11 PM revealed [NAME] L touched his face mask with his gloves. [NAME] L was observed then touching the cooking utensil without performing hand hygiene. Observation on 10/16/2024 12:14 PM revealed [NAME] L removed his left glove and grabbed a thermometer. [NAME] L proceeded to put on the same used glove and did not perform hand hygiene and proceeded to take the temperature of the fried chicken. Observation on 10/16/2024 12:17 PM revealed a small red and green filled with a liquid on food preparation table while [NAME] L prepared food. Observation on 10/16/2024 at 12:19 PM revealed [NAME] K grabbed used spoon from food preparation area and added scoop of chicken base paste into measuring cup. [NAME] K proceeded to add water to existing left-over water in measuring cup. She proceeded to mix the chicken base with used spoon. Observation on 10/16/2024 at 12:21 PM revealed [NAME] K grabbed wet rag from water bucket on food preparation area and proceeded to clean food preparation area while blending pureed rice. Observation revealed clean bowls open and under food preparation area. [NAME] K placed rag into green bucket and did not perform hand hygiene before she continued to prepare puree. Observation on 10/16/2024 at 12:23 PM revealed [NAME] K grabbed blending mechanisms with her bare hands and removed it from the blender and scrapped it with the spatula. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/17/24 at 01:40 PM [NAME] K stated has worked at the facility for four years. [NAME] K stated she should wash her hands before preparing food, if she were to leave the food preparation area, she would grab what she needs, leave the supply and wash her hands before she begins prepping food again. [NAME] K stated clean dishes were supposed to be stored on the halls and plates as well but in the warmers. [NAME] K stated cups are stored in a container and stored upside down on halls. [NAME] K stated small dessert bowls were supposed to be covered with something over them so nothing could get on them. She stated the bowls were not covered that day and food could have gotten on them. [NAME] K stated the temperature for the freezer should be below 20 degrees and the refrigerator should stay around 36 degrees. [NAME] K stated in the satellite kitchens the refrigerator should be 32 degrees and the freezer should be 10 degrees. [NAME] K stated the freezers in the satellite kitchens usually do not go below zero. [NAME] K stated only food should be stored in the freezer in the kitchen and Ozempic should not be stored in there. [NAME] K stated if the food label stated refrigerator after opening then the food item should not be stored in dry storage because it was perishable. [NAME] K stated everyday fruits and vegetables are checked daily. [NAME] K stated if they were bad, they were thrown out. [NAME] K stated the staff that served the halls was responsible for cleaning and sanitizing the ice makers in the satellite kitchen. [NAME] K state there should not be white calcium build up or rust on the ice makers. [NAME] K stated any food stored in the satellite kitchens should have a label and expiration date. During an interview on 10/17/24 at 02:00 PM the DM stated she has been the dietary manager for about 2 years. The DM stated the cooks were responsible for checking temperatures of the refrigerator and freezers in main kitchen. The DM stated whoever goes to the satellite kitchen to serve in the hall for breakfast and dinner are responsible for checking the temperature in the refrigerator and freezers. The DM stated the temperature should be 41 or below for the refrigerator and the freezer was supposed to be at 32 or below. The DM state if staff saw temperate above what was supposed to be, they should have taken out any food and brought to the main kitchen. It was important to maintain the correct temperature, so it does not reach danger zone. The DM stated if the refrigerator or freezer was outside the correct temperature, it could cause microorganisms to grow which could make anyone who consumed the food stored in there sick. The DM stated staff were not supposed to store personal items in any of the refrigerators or freezer and only food for the residents should be stored. The DM stated food should have the date it was opened and a date to use by date. The DM stated if the label on the items has to refrigerate after opening, she would not expect that to be stored in dry storage. The DM stated hand hygiene should be performed when you come into the kitchen, change duties, and before you put gloves on and take gloves. The DM stated if staff removed a glove, they should not put it back on. The DM stated staff should not touch their face mask when they are cooking. The DM stated it could make someone sick or could cause cross contamination if not performing hand hygiene correctly. The DM stated cleaned dishes should be stored on the halls and food should not be prepared over clean dishes. The DM stated this could cause cross contamination and physical contamination if you prepare food over dishes that are cleaned. The DM stated that the ice make in satellite are maintained by maintenance and they were responsible for cleaning them. The DM stated ice makers should not have rust on them. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/17/24 at 02:14 PM [NAME] L stated he had worked at the facility for four days. [NAME] L stated that anything that was opened should have a date on it with oldest in front and newest in back. [NAME] L stated the cooks were responsible for labeling but anyone can label food when its opened. [NAME] L stated that cooks were responsible for labeling food in the satellite kitchens. [NAME] L stated that cleaned dishes were supposed to be stored upside down to dry and then stored downward. [NAME] L stated that food should not be prepared over cleaned dishes. [NAME] L stated if you were preparing food over clean dished staff could drop food it could dirty clean dishes. [NAME] L stated the temperature for freezer should be below 32 degrees and the refrigerator should be 68 degrees. [NAME] L state this is for the satellite kitchens as well. He stated the cooks were responsible for checking the temperatures and writing it on the log. [NAME] L stated hand hygiene should be performed all the time. [NAME] L stated you should wash your hands after touching a face mask and when change gloves. [NAME] L stated gloves should not be reused and if they were it could cause cross contamination and could spread germs and cause someone to get sick. [NAME] L stated if staff are cooking and needed to grab something else hand hygiene should be performed in between grabbing them item and starting to cook again. During an interview 10/17/24 at 03:11 PM the ADM stated the DM was responsible for checking labeling in kitchen. He stated they were supposed to do it as shipment comes in. The ADM stated that an opened date were supposed to be put on any food that was opened. The ADM stated that the facility goes through a lot of cereal and not having a label when the cereal was put in the satellite kitchens or opened would not hurt. The ADM stated temperature for the refrigerator was supposed be at 40 degrees or below and the freezer was supposed to be at 0 degrees or below. The ADM stated that this was the same for the satellite kitchen. The ADM stated that the kitchen staff was responsible for checking the satellite kitchen. The ADM stated that if the temperature is above what it should be the food would have to be disposed of. The ADM stated that he expected for hand hygiene in the kitchen to be performed before staff touched food and after they touched anything else. The ADM stated staff were not supposed to reuse gloves in the kitchen. The ADM stated reusing gloves could cause cross contamination. The ADM stated that staff should wash their hands after touching their face masks in the kitchen. Review of facility policy titled Handwashing/Hand Hygiene dated August 2015 revealed all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. Further review revealed to use alcohol-based hand rub or soap after removing gloves, before donning gloves, before and after eating or handling food. Review of facility policy titled Refrigerators and Freezers dated December 2014 revealed this facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. Acceptable temperature ranges are 35 degrees Fahrenheit to 40 degrees Fahrenheit for refrigerators and less than 0 degrees Fahrenheit for freezers. The food service supervisor will take immediate action if temperatures are out of range. Supervisors will inspect refrigerators and freezers monthly for presence of rust, excess condensation and any other damage. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of facility policy titled Food Receiving and Storage dated July 2014 revealed food shall be received and stored in a manner that complies with safe food handling practices. Non-refrigerated foods, disposable dishware and napkins will be stored in a designated dry storage unit and kept clean. Functioning of refrigeration will be monitored at designated intervals throughout the day by food and nutrition services manager or designed. Food items and snacks kept on the nursing units must be maintained at temperate of 41 degrees Fahrenheit or below and labeled with a use by date. Further review revealed toxic substances and drugs will not be stored in the kitchen area or in storerooms for food.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on observation, interview and record review, the facility failed to have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption in personal refrigerators for 1 of 1 residents. 1. The facility failed to conduct and/or document the temperature and contents of Resident #22's personal refrigerator. This deficient practice could place residents at risk for food-borne illness. Findings included: Review of undated face sheet for Resident #22 reflected an [AGE] year-old male admitted to the facility on [DATE]. His diagnoses include acquired absence of right leg below knee (below knee amputation), need for assistance with personal care, muscle weakness (lack of muscle strength), and major depressive disorder (a serious mental disorder that affects how a person feels, thinks, and acts). Review of Resident #22's quarterly MDS dated [DATE] reflected a BIMS score of 14 which indicated no cognitive impairment. Review of Resident #22's orders dated 10/17/2024 reflected assistance x 1 is required for toileting, transfers and eating. Observation and interview on 10/15/2024 at 1:40 PM revealed Resident #22 attempted to put a jar of peppers in his personal refrigerator. Further observation revealed the following: *Several uncovered drinks, *2 tomatoes that were shriveled with large black spots, *Dried food *Brown and yellow liquid spilled on bottom shelf and door of the personal refrigerator. *2 halves of a banana, *A bottle of mayonnaise with a best by date of [DATE], and * No thermometer was observed in the personal refrigerator. Resident #22 stated he did not know who, if anyone, checked his personal refrigerator. During an interview on 10/17/2024 with CNA O at 10:48 AM stated the refrigerators should be checked by dietary staff. CNA O stated if the personal refrigerators were not checked routinely by staff, then the resident could consume products and could end up with food borne illnesses. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/2024 at 1:50 PM LVN F stated she was unsure of who was supposed to check personal refrigerators. She stated if the personal refrigerators were not checked on a regular basis that the food can spoil and can cause food borne illness if consumed by residents. During an interview on 10/17/2024 at 3:12 PM the ADM stated housekeeping was supposed to check all personal refrigerators for spoiled food, but he was unsure of the frequency. The ADM stated he was unsure if personal refrigerator temperatures were being monitored at all. The ADM stated if a resident were to consume spoiled food, they could get food poisoning. During an interview on 10/17/2024 at 3:55 PM the DON stated there was not a policy for personal refrigerators at this time. She said that housekeeping was to clean and check temperatures daily in personal refrigerators for those residents with a low BIMS and incapable of checking the refrigerators themselves. She also stated that if the refrigerators were not checked it could lead to food spoilage, gastritis (an inflammation of the lining of the stomach) and illness if the food were to be ingested by the residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on observations, interviews, and record review, the facility failed to maintain an infection and prevention control program that included, at a minimum, a system for preventing and controlling infections for all the residents reviewed for infection control, as indicated by: 1. LVN F, LVN I, and CMA N did not clean and disinfect the blood pressure monitor while using it on Resident #11, Resident #1, Resident #54, Resident #50, Resident #5, Resident #25, and Resident #46. 2. LVN F did not perform hand sanitizing before preparing medications and handling blood pressure monitor. 3. IP M handled clean items with soiled gloves while providing peri care to Resident #230 These failures could place the residents at risk of transmission of disease and infection. Findings included: Record review of Resident #230's face sheet on 10/16/24 revealed a [AGE] year-old male who was initially admitted to the facility on [DATE]. His diagnoses were, constipation, nausea with vomiting, gastro-esophageal reflux disease, and anxiety disorder, Record review on 10/16/24 of Resident #230's care plan dated 10/01/24 reflected the resident had alternation in his bowel elimination and constipation. The relevant intervention was monitoring bowel movements every shift and record. Record review on 10/16/24 of Resident #230's initial MDS assessment, dated 10/04/24 revealed a BIMS score of 13 indicating his cognition was intact. Further review of the MDS revealed Resident #230 was occasionally incontinent with bowel and bladder. During an observation on 10/16/24 at 9:30am IP M provided peri care to Resident #230 while he was lying in his bed. IP M did not change her soiled gloves before handling the clean wet wipe packet. IP M washed her hands and donned gloves. She removed some wet wipes from the packet for using at that time. She then opened the diaper and cleaned the front and back of Resident #230 with the wipes. When she needed more wipes, without changing the soiled gloves, she handled the wet wipe packet, removed more wipes, and continued to clean. She changed the old diaper with the new one. After the completion of the task, she left the contaminated wet wipe packet with remaining wipes stored on the side table and left the room. During an interview on 10/16/24 at 9:50am IP M stated she was an LVN and the IP at the facility. She stated she understood the mistake that she did not change the dirty gloves while handling clean items. She stated, though peri care was done by CNA's, she gave helping hands to them so that resident did not have to wait for long. She stated she was in a hurry and missed many steps in the procedure for peri care. She said such omissions leads to spreading diseases. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of Resident #50's face sheet on 10/16/24 revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses were acute congestive heart failure, shortness of breath, hypertensive heart, chronic kidney disease, and hyperlipidemia (excessive fat in blood). Record review on 10/16/24 of Resident #50's care plan dated 08/08/24 stated Resident #50 required monitoring as she was on diuretics for congestive heart failure. Record review on 10/16/24 of Resident #50's quarterly MDS assessment dated [DATE] revealed a BIMS score of 15, indicating her cognition was intact. Record review of Resident #25's face sheet on 10/16/24 revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses were hyperlipidemia (excessive fat in blood), dizziness, giddiness, pain, and hypertension. Record review on 10/16/24 of Resident #25's care plan dated 09/05/24 reflected the resident was at risk for decreased cardiac output related to reduced myocardial contractility. The relevant intervention was giving anti-hypertensive medications as ordered and monitoring the side effects such as orthostatic hypotension (low blood pressure) and increased heart rate. Record review on 10/16/24 of Resident #25's quarterly MDS assessment, dated 09/03/24 revealed a BIMS of 11 indicating a moderate level of cognition. An observation on 10/16/24 at 8:25am, revealed LVN F failed to sanitize the blood pressure monitor before using it on Resident #25, in between Resident #25 and Resident #50, and after Resident #50. LVN F took the blood pressure monitor from the top of the med cart and without sanitizing it, she took the blood pressure of Resident #25. LVN F then moved on to Resident #50 and took her blood pressure with the same blood pressure monitor without sanitizing it. After completing the measurement on Resident #50, without cleaning the blood pressure monitor, she kept it on the top of the med cart. During an interview on 10/16/24 at 8:45am, LVN F stated she was working at the facility for about [AGE] years. She said it was essential to minimize the risk of spreading contagious diseases by sanitizing the blood pressure cuff in between the residents. LVN F stated she was aware of the importance of sanitizing medical equipment, and she received training; however, did not know exactly when it was. Record review of Resident #5's face sheet on 10/16/24 revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses were dementia, congestive heart failure, atrial fibrillation (irregular heartbeat), and hypothyroidism (low thyroid hormone). Record review on 10/16/24 of Resident #5's care plan dated 07/25/24 reflected the resident was at risk for fluid retention and activity intolerance related to congestive heart failure. The relevant intervention was administering diuretics as ordered and monitoring effectiveness and notify the provider of side effects/no changes in edema. Record review on 10/16/24 of Resident #5's quarterly MDS assessment, dated 10/04/24 revealed a BIMS score of 10 indicating moderate cognitive impairment. (continued on next page)

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	676290	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spjst Rest Home 1	1810 Old Granger Road Taylor, TX 76574

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of Resident #46's face sheet on 10/16/24 revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses were altered mental status, pain, cerebral infarction (stroke), hyperlipidemia (high fat level in blood), and hypertension. Record review on 10/16/24 of Resident #46's quarterly MDS assessment, dated 07/11/24 revealed a BIMS score of 05 indicating her cognition was severely impaired. The MDS indicated hypertension as one of her active diagnoses. Record review on 10/16/24 of Resident #46's care plan dated 10/03/24 had not indicated for the management of hypertension. During an observation on 10/17/24 at 8:50am LVN I did not sanitize the blood pressure monitor before, in between and after using it on Resident #5 and Resident #46. She took the monitor from the med cart and measured the blood pressure of Resident #5 who was sitting in the dining area. After taking the blood pressure of Resident #5, she approached Resident #46 and applied the same monitor without sanitizing. After the completion, she kept it above the med cart and started dispensing medication for the residents. During an interview on 10/17/24 at 9:05am, LVN I stated she was working at the facility for about a month. LVN I said she was concentrating on administering medications for the residents and forgot to sanitize the blood pressure cuff before and after using it on Resident #5 and Resident #46. She stated it was important to follow infection control protocol and sanitize the blood pressure cuffs before using it on the residents. She added, this was essential to minimize the risk of spreading contagious diseases. LVN I stated she was aware of the importance of sanitizing medical equipment and received training on this during her 3 day orientation training when she started working at the facility. Review of the in-service records from 06/01/24 to 10/17/24 revealed there was no in-services on sanitizing medical devices. 2. Observation on 10/16/2024 at 7:48 AM revealed LVN F coughed and grabbed a blood pressure cuff and proceeded to enter a resident room without performing hand hygiene. Observation on 10/16/24 07:52 AM revealed LVN F prepared medications and did not perform hand hygiene prior to preparing these medications. Further observation revealed hand sanitizer was on the medication cart. Observation on 10/16/24 at 08:00 AM revealed LVN F coughed and proceeded to prepare medications for resident without performing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/17/24 at 10:05 AM LVN F stated that hand hygiene should have been performed before and after direct care with patients. LVN F stated that hand hygiene should have been performed before medication pass and periodically during medication pass. LVN F stated that hand hygiene should have also been performed before trays were passed during meals. LVN F stated that if staff coughed or blew their nose, they should have used hand sanitize after. LVN F stated that if staff blew their nose and did not wash their hands and pass medications it could cause cross contamination and an infection control issue which could get the resident sick. LVN F stated she received training on hand hygiene and infection control but does not recall how long ago. LVN F stated that hand hygiene was reviewed monthly during in-services. LVN F stated that blood pressure cuffs were supposed to be sanitized before use of each patient and before the next. During an interview on 10/17/24 at 09:50 AM CNA O stated she has worked at the facility for a few years. CNA O stated staff should perform hand hygiene before, during and after resident care, and it depended on what the staff was doing. She stated that if staff go from one room to another, hand hygiene should be performed. CNA O stated that if staff worked with the resident, they should perform hand hygiene before they worked with another resident. During an interview on 10/17/24 at 09:53 AM CMA O stated that when she passed medications she knocked, introduced herself, washed her hands, and then prepared medication. She stated she used hand sanitizer after she prepared the medication and after she administered the medication, she washed her hands again. CMA O stated it was not okay to skip hand sanitizer and not wash hands because it was contamination. CMA O stated if she needed to blow her nose, she should wash her hands so that way nothing was contaminated. During an interview on 10/17/24 at 09:59 AM CNA T stated that she has worked at the facility for a few months. CNA T stated she has not had any training for hand hygiene. CNA T stated that staff were supposed to perform hand hygiene before and after working with residents. She stated that hand hygiene should have been performed before putting on gloves and after taking gloves off. She stated that if staff touched their face or blow their nose, they were supposed to wash their hands. 3. Record review of Resident #11's face sheet dated 10/17/2024 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included but were not limited to cerebral palsy (a condition that affects movement and posture caused by damage to the brain, most often before birth), hypertension (high blood pressure), and chronic pain. Review of Resident #1's face sheet dated 10/17/2024 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to diabetes mellitus (a disorder in which the body has high blood sugar levels for prolonged periods of time), cerebral infarction (a conditions where the blood flow to the brain is compromised), hypertension (high blood pressure), and hypothyroidism (a condition where the thyroid gland does not produce enough hormones). Review of Resident #54's Face Sheet dated 10/17/2024 reflected he was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of hyperlipidemia (high amount of cholesterol in the blood), anxiety, and CVA with right sided weakness (a conditions where blood flow to a part of the brain is stopped causing right sided weakness). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation on 10/16/24 at 08:59 AM revealed CMA N sanitized her hands, then took blood pressure cuff off top of medication cart and wiped it down with a sanitizing wipe, and then walked into Resident #54's room. She applied the wrist blood pressure cuff to resident #54's wrist and checked his blood pressure. She took the blood pressure cuff off his wrist and proceeded to return it to the medication cart in the hallway. She set the blood pressure cuff down on top of the cart, sanitized her hands, then began documenting Resident #54's vital signs in the computer and pulling medication to administer. She proceeded to administer Resident #54's medication. An observation on 10/16/24 at 08:28 AM revealed CMA N pushed the medication cart down the hall and outside of Resident #11's room. She sanitized her hands, then picked up the blood pressure cuff off the top of the medication cart and approached Resident #11. She applied the blood pressure cuff to Resident #11's wrist and checked Resident # 11's blood pressure. CMA N removed the blood pressure cuff from Resident #11's wrist and returned it to the medication cart in the hall. CMA N laid the blood pressure cuff down on top of the medication cart, sanitized her hands, and proceeded to document the vital signs in the computer, then pull the medication for Resident #11. She administered the medication to Resident #11. CMA N sanitized hands and pushed medication cart down call to Resident #1's room. An observation on 10/16/24 at 08:39 AM revealed CMA N picked up the blood pressure cuff off the top of the medication cart and approached Resident #1. She proceeded to apply the blood pressure cuff to Resident #1's wrist. She then checked Resident # 1's blood pressure. CMA N then returned to the medication cart in the hallway and sat the blood pressure cuff on top of the cart. She sanitized her hands and proceeded to document the vital signs for Resident #1. CMA N then pulled medications for Resident #1. She administered the medications to Resident #1 and returned to the cart and sanitized her hands. An interview on 10/17/24 at 10:10 AM with CMA N, revealed she had been employed at this facility about 5 years off and on. CMA N acknowledged only sanitizing blood pressure cuff a total of 1 time between 3 residents whom she assessed blood pressure. She further stated that not sanitizing the wrist blood pressure cuff between using on different residents could cause contamination. An interview on 10/17/24 at 01:50 PM with LVN F revealed blood pressure cuffs were to be cleaned between residents. She stated not cleaning the blood pressure cuffs between residents can cause cross contamination. An interview on 10/17/24 at 03:55 PM with the DON revealed her expectation for checking vital signs during medication administration included disinfecting any shared vital sign machines including blood pressure cuffs. She stated failing to disinfect the blood pressure cuff between residents could result in infection. The DON stated it was her expectation that all the staff at the facility should follow infection control protocols while providing care to residents that included peri care. She said the staff were monitored for infection control compliance through annual skill checks and regular and frequent observation by the DON and the IP. She stated the staff with deficient practices were retrained and reevaluated for their skills and proficiency in controlling the infections at the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview on 10/17/24 at 03:12 PM with ADM revealed the blood pressure cuff should be disinfected between resident use, and it could pass an infection between residents if not done. The ADM stated he was not aware that the hand sanitizer dispenser in the satellite kitchen was not functional. He said hand sanitizing in the kitchen was important since the food for all the residents were dispatched from there and improper infection control practices could lead to spreading diseases to all the residents at the facility. Review of facility's policy titled Cleaning and disinfection of Resident care Items and Equipment revised in October 2018 reflected: Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard. The purpose of this procedure is to provide guidelines for disinfection of non-critical resident care items. . 1.The following categories are used to distinguish the levels of sterilization/ disinfection necessary for items used in resident care. a. Critical items consist of items that carry a high risk of infection if contaminated with any microorganism. Objects that enter sterile tissue (e.g., urinary catheters) or the vascular system (e.g., intravenous catheters) are considered critical items and must be sterile. b. Semi-critical items consist of items that may come in contact with mucous membranes or non-intact skin (e.g., respiratory therapy equipment). Such devices should be free from all microorganisms, although small numbers of bacterial spores are permissible. (Note: Some items that may come in contact with non-intact skin for a brief period of time (e.g., hydrotherapy tanks, bed side rails) are usually considered non-critical surfaces and are disinfected with intermediate-level disinfectants.) c. Non-critical items are those that come in contact with intact skin but not mucous membranes. (1)Non-critical resident-care items include bedpans, blood pressure cuffs, crutches and computers. (2) Most non-critical reusable items can be decontaminated where they are used (as opposed to being transported to a central processing location). d. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment) . Review of facility's policy titled Influenza, prevention and control seasonal revised in August 2014 reflected: Infected Healthcare Workers: 1. The Infection Preventionist and/or designee will monitor and manage ill healthcare personnel. Staff who develop fever and respiratory symptoms will be: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a. Instructed not to report to work, or if at work, to stop resident-care activities, don a facemask, and promptly notify their supervisor and the Infection Preventionist and/or designee before leaving work. b. Reminded that adherence to respiratory hygiene and cough etiquette after returning to work is always important. (1) If symptoms such as cough and sneezing are still present, staff will wear a facemask during resident-care activities. (2) The importance of performing frequent hand hygiene (especially before and after each resident contact and contact with respiratory secretions) will be reinforced . Standard Precautions: 1. During the care of any resident, all staff shall adhere to standard precautions, which are the foundation for preventing transmission of infectious agents in all healthcare settings. Hand hygiene: a. Staff will perform hand hygiene frequently, including before and after all resident contact, contact with potentially infectious material, and before putting on and upon removal of personal protective equipment, including gloves. b. Hand hygiene in healthcare settings will be performed by washing with soap and water or using alcohol-based hand rubs. If hands are visibly soiled, soap and water, not alcohol-based hand rubs, will be used. c. Supplies for performing hand hygiene are available throughout the facility. 45070 50872

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on observation, interview and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for one of one facility reviewed for environment. The facility failed to conduct and/or document the servicing of residents in room air-conditioning/heating units which resulted in the smoking of Resident #7's unit. This deficient practice could place residents at risk of a diminished quality of life due to exposure to an environment that is unpleasant, unsanitary, and unsafe. Findings included: Review of Resident #7's face sheet revealed an [AGE] year-old man admitted on [DATE] and diagnoses included: malignant neoplasm of prostate (cancerous tumor that forms in the prostate gland), chronic obstructive pulmonary disease (chronic lung disease that limits airflow and causes ongoing respiratory symptoms), unspecified asthma (chronic disease in which the bronchial airways in the lungs become narrowed and swollen and make it difficult to breathe), atherosclerotic heart disease (condition that occurs when plaque builds up in the arteries, hardening them and limiting blood flow to the heart), and unspecified combined systolic heart failure (caused by other conditions that weaken the heart muscle). Review of Resident #7's quarterly MDS dated [DATE] revealed a BIMS score of 14 which indicated no cognitive impairment. Review of Resident #7 active diagnoses revealed resident had a diagnosis of asthma and/or COPD. During an interview on 10/15/24 at 11:30 AM Resident #7 stated that the unit in his room started to smoke earlier this week. Resident denied seeing a fire but stated that there was a lot of smoke. Review of provider investigation report dated 10/14/2024 revealed CNA H smelled smoke coming from Resident #7's room. Further review revealed when CNA H opened the door the air conditioning/heating unit was smoking in the room. During an observation on 10/16/2024 at 11:17 AM, MD J turned on the unit that smoked on 10/14/2024. There were no fire but smoke was smelled coming from that unit. During an interview on 10/17/24 at 10:37 AM CNA H stated the incident happened between 9:30 AM and 10:00 AM on 10/14/2024. CNA H stated she smelled a smokey smell and described it as when you first turn on heater for first time in the year. CNA H stated there was a lot of smoke in the room of Resident #7 and the smoke came out of the room when she opened the door. CNA H stated t she turned the unit off, removed the resident and pulled the fire alarm. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/15/24 at 08:34 AM MD J stated he started cleaning all the air conditioning and heating units recently and was unsure of the dates. He stated the unit was cleaned but when the resident turned on the heat it started to smoke and smolder. MD J stated they cleaned the unit again and a small piece of dirt was found in it. MD J stated all units are being recleaned. During an interview on 10/16/24 at 11:17 AM MD J stated the 200 hall in-room units were cleaned about three weeks ago. The front screen was removed along with the screen inside and the units were vacuumed inside to remove any debris. MD J stated he did not log or document when the units are cleaned and stated they are cleaned every 6 months in March and October. MD J stated he knows when to clean the units based on memory. During an interview on 10/17/24 at 10:28 AM the ADM stated the maintenance department started cleaning the bottom tray of the units again after the smoke. The ADM stated the units had been cleaned already prior to the smoke but they were cleaned again this week. The ADM stated there was no documentation the units had been cleaned previously or what units had been cleaned again. During an interview on 10/17/24 at 03:07 PM the ADM stated that the in-room units were all cleaned by the end of last week. The ADM stated that he was unsure how often they were being cleaned. The ADM stated that he would not necessarily expect maintenance to document that they were cleaned. The ADM stated that MD J has worked at the facility for [AGE] years and he just trusts that they are cleaned to ensure that it would not happen again. The ADM stated that when the units were cleaned the bottom trays were removed and taken out along with the filers. He stated that the believed the filters were cleaned monthly and the bottom trays annually. The ADM stated that there is no facility policy regarding maintenance of air-conditioning and heating units.