STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676295	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Epic Nursing & Rehabilitation	3210 W Hwy 22 Corsicana, TX 75110

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50444 Based on observation, interview, and record review the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 6 (Resident #71) residents reviewed for Respiratory Care. 1. The facility failed to ensure Resident #71's handheld mouthpiece (device through which medication is inhaled) for his nebulizer (turns liquid medication into a mist) was properly stored when not in use on 02/19/2025. These failures could place the residents at risk for respiratory infection and not having their respiratory needs met. Findings include: 1. Record review of Resident #71's Face Sheet, dated 02/19/2025, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. Resident #71 had diagnoses which included influenza (contagious respiratory infection) and acute (sudden onset) cough. Record review of Resident #71's Quarterly MDS (assesses functional capabilities and health status of residents) Assessment, dated 01/21/2025, reflected the resident was cognitively intact with a BIMS (tool used to identify cognitive impairment) score of 15. Section I of the Quarterly MDS Assessment did not indicate Resident #71 was treated for a pulmonary (lung related) diagnosis. Record review of Resident #71's Comprehensive Care Plan, dated 01/28/2025, reflected activity intolerance related to imbalance between supply oxygenation needs and one intervention was to observe for signs and symptoms of respiratory issues. Record review of Resident #71's Physician's Order, dated 02/10/2025 reflected an order for albuterol sulfate 2.5 mg /3 mL (0.083 %) solution for nebulization 1 inhalation Four Times A Day. During an observation and interview on 02/19/25 at 9:46 AM, Resident #71's nebulizer mouthpiece was placed on a bag of chips on the resident's nightstand. The handheld mouthpiece was not stored in a bag. Resident #71 stated he did not remember seeing the mouthpiece bagged. (continued on next page)

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

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 02/19/25 at 3:50 PM, Resident #71's handheld mouthpiece was placed on top of the nebulizer and was not bagged. LVN A came into Resident #71's room and stated all respiratory items were supposed to be stored in a bag when not in use and she had not noticed it was not in the bag. She stated it was important to store the mouthpiece in a bag to keep it clean and prevent the resident from getting an infection. She stated she was going to take care of it. During an interview on 02/20/25 at 9:00 AM, the ADON stated Resident #71's handheld mouthpiece should have been stored in a bag unless the resident was using it. She stated sometimes the bags get moved or misplaced. She stated the resident did not need to put something in his mouth that had touched other items and gotten dirty. She stated it was important to keep it covered to prevent bacteria and the risk of infection. Review of facility's policy Oxygen Administration, revised October 2010, did not reflect how to store respiratory items when not in use.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 49459 Based interviews and record reviews, the facility failed to maintain the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week, for 8 days of the 6-month review period, reviewed for RN coverage. The facility failed to ensure the facility maintained the required RN coverage for 8 days between April - June 2024. This failure could place residents at risk of not having their nursing and medical needs met and receiving improper care. Findings included: Review of CMS PBJ staffing reports reflected the facility triggered for no RN hours for FY Quarter 3 2024 (April 1 - June 30), revealed the facility did not have the required Registered Nurses coverage of at least 8 consecutive hours a day for the following dates: 04/07/24 no hours recorded. 05/04/24 no hours recorded. 05/05/24 no hours recorded. 05/18/24 no hours recorded. 05/19/24 no hours recorded. 06/01/24 no hours recorded. 06/15/24 no hours recorded. 06/16/24 no hours recorded. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/19/25, at 2:15 PM with the DON who stated when asked what does the facility do when there was not a licensed nurse available in a 24-hour period? The DON stated the managers including myself would come in. When asked how can this impact residents in the facility? She advised; neglect they would not get the care that they need. They would not get the life and quality care that they deserve. Does the facility have an RN to serve as the DON on a full-time basis? She advised yes. Does the facility ensure that the DON services as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents? Yes, but still covering the 8 hours for both days. What does the facility do when there is not an RN available to work the required 8 consecutive hours on the weekend? They would contact me, and I would come in. She advised since she is on salary it is not keyed into the payroll system to reflect her working. She stated she has a paper form that she turns in when or if she had been called in on the weekends. When asked how does the facility provide care to residents that require an RN if one is not available to work on the weekend? They would call me in. When asked what is the facility doing to address a lack of RN coverage on weekends? We just hired a weekend supervisor who is a RN who is allowed to work 10-12-hour days. She stated the purpose of eight hours RN courage was to ensure everything was being done correctly by staff, provide assistance when needed, and supervise the residents. She stated the potential risk to the residents was not getting the care they needed. She stated they did have concerns with RN staffing on weekends and they had since made corrections by hiring an RN dedicated to the weekends. The DON advised she was on salary and was scheduled Monday through Friday weekly with weekends off. During an interview on 02/20/25 at 1:30 PM with the Administrator who stated she would have been made aware of the lapse in RN coverage on the weekends by the DON. She further advised she was currently Interim Administrator, and the DON would be more equipped to answer this matter pertaining to RN coverage. She stated the risk of not having RN coverage on the weekend was that it was a requirement for the residents, and it would have a negative impact on the care provided to residents. When asked what does the facility do when there is not a licensed nurse available in a 24-hour period? She stated we get someone call them in, if we need to, we have our DON. They are our initial backup followed by our nurse consultant is the DON's back up. If they are not able to work out DON was expected to cover. When asked how does this impact residents in the facility? Administrator stated, it could have a negative impact if an RN specialty was needed, and they are not here. It could affect their care. Review of the facility's policy on RN Coverage, undated, revealed Facilities are responsible for ensuring they have an RN providing services at least 8 consecutive hours a day, 7 days a week.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41211 Based on observation, interview, and record review the facility failed to store, prepare, distributed, and serve food in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food and nutrition services. 1. The facility failed to ensure the ice machine in the tray-serving area was cleaned on 02/18/25. 2. The facility failed to ensure the opened packages of food in the dry goods pantry were sealed properly after opening on 02/18/25. 3. The facility failed to ensure the desert was covered until ready to serve on 02/19/25. 4. The facility failed to ensure the kitchen staff wore the appropriate hair covering while food was being prepared in the main kitchen on 02/19/25. These failures could place residents at risk for cross contamination and other air-borne illnesses. Findings include: Observations on 02/18/25 from 10:40 AM to 11:37 AM in the facility's main kitchen revealed: The ice machine had dried white drip stains on the door of the machine. There were brownish and white stains and build up above the door, where the front panel and the door connect. On the front right corner and along the seam of the left and right sides of the machine, clumps of the same build up was visible. When the door was lifted, there was brownish and white build up lining the bottom edge of the door. There was black build up at the edge of the ledge on which the door rests, when closed. There were also white stains on the ledge and along the side edges, where the door made contact. The under side of the door, on all edges, had white stains. The part of the door casing, which held the medal hinge, had brown stains all the way across from left to right. The white plastic fall guard, which the ice slides from and into the bin, had black and brown substances on the edge. An opened bag of powdered milk was folded down; however, not securely closed. An opened bag of elbow macaroni pasta was loosely twisted; however, not securely closed. An opened bag of corn meal was loosely folded down; however, not securely closed. An opened bag of long grain rice was folded down; however, not securely closed. An opened bag of breadcrumbs was twisted to close; however not securely closed and a dried brown substance was on the top edge of the bag. When touched, the substance crumbled onto the other packages of food, below it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An opened large bag of instant potatoes, on the bottom shelf, was loosely folded down; however, not securely closed. During an observation on 02/19/25 at 11:39 AM, an uncovered container of diced peaches was on a cart, which was adjacent to the preparation space in the plating area of the kitchen. The cart was next to the door which was being used for entering and exiting the kitchen. There were also 12 desert cups, which contained fruit salad on the preparation space of the plating area. The cups of fruit were also, uncovered. During an observation on 02/19/25 at 12:20 PM, the uncovered desert cups had been placed on trays which were awaiting meal plates and distribution. During observation on 12/19/25 at 12:23 PM, of meal-plating and serving, the [NAME] and Dietary Aide were wearing hair nets; however, the Cook's hair was uncovered in the back and the edges of hair around the forehead, temples, and sideburn areas of the Dietary Aide were not covered. In an interview with the [NAME] on 02/19/25 at 1:08 PM, she stated she thought all of her hair was covered. She stated all hair should be covered because hair could get into the food, which was not a good thing. In an interview with the Dietary Aide on 02/19.25 at 1:21 PM, she stated she was having to go outside and back in, so she was putting her warm cap on over the hair net. She stated taking the cap off, must have caused some of her hair to come out of the hairnet. She stated not having the hair fully covered by the hairnet, hair can fly everywhere and end up in the food. She stated she would make sure her hair was properly covered at all times. She also stated they cover all foods and drinks which go out to the halls, on the food carts. She stated they had not been covering the deserts which are going on trays to the dining room. She stated they send the meals to the locked unit before they start plating the meals for the main dining room. She stated during her preparing for the trays to the locked unit, she filled too many cups and the ones which were observed on the preparation area, were the overflow and were going to be used for the trays to the dining room. She stated the container of diced peaches, which were sitting next to the door, were sat there in case she ran out of the mixed fruit. She acknowledged that she should not have removed the lid until she actually needed the peaches. She stated the fruit in the desert cups and the container of peaches should have been covered because of the possibility of cross contamination of the food. In an interview with the Dietary Manager on 02/19/25 at 3:12 PM, she stated it was important for hair to be completely covered in the kitchen because hair could get in the food. She stated it was important for food to be securely closed to prevent attracting insects, to keep the food fresh, and to prevent cross contamination. She stated she had been the person who was cleaning the ice machine and stated after initial round of the kitchen, she cleaned the ice machine by using a disposable cleaning rag with hot water. She stated she would in-service the kitchen staff on how to properly store food once it had been opened. In an interview with the Administrator on 02/20/25 at 2:40 PM, stated food not being properly closed and stored, after opening could cause the food to go bad, attract insects and rodents, and cross contamination. She stated she expected kitchen staff to keep their hair properly covered to prevent hair from getting in the food. She stated leaving food uncovered, could cause food borne illnesses or cross contamination. She stated she expected staff to ensure foods are covered until ready to use. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy on Ice Machines and Ice Storage Chests (January 2012), revealed Ice machines and ice storage/distribution containers will be used and maintained to assure a safe and sanitary supply of ice .1. Ice-making machines, ice storage chests/containers, and ice can all become contaminated by: b. waterborne microorganisms naturally occurring in the water source, c. colonization by microorganisms . 2. To help prevent contamination of ice machines, ice storage chests/containers or ice, staff shall follow these precautions: f. Clean and sanitize the tray and ice scoop daily .j. Flush and clean the ice machine and dispenser after lengthy water disruptions (if not disconnected prior to disruption) .3. Our facility has established procedures for cleaning and disinfecting ice machines and ice storage chests which adhere to the manufacturer's instructions. The infection preventionist (or designee) maintains a copy of these procedures. Record review of the facility's policy on Sanitization (November 2022), revealed The food service area is maintained in a clean and sanitary manner .11. Ice chests and coolers used to store and transport ice are cleaned regularly, especially prior to use or when contaminated or visibly soiled. Record review of the facility's policy on Food Receiving and Storage (November 2022), revealed Foods shall be received and stored in a manner that complies with safe food handling practices .1. [Critical Control Point] means a specific point, procedure, or step in food preparation and serving process at which control can be exercised to reduce, eliminate, or prevent the possibility of a food safety hazard. Some operational steps that are critical to control in facilities to prevent or eliminate food safety hazards are .and employee hygienic practices . 3. Dry foods and goods are handled and stored in a manner that maintains the integrity of the packaging until they are ready to use.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50444 Based on observation, interview, and record review the facility failed to establish and maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two of eight residents (Resident #22 and Resident #38) reviewed for infection control. 1.The facility failed to ensure CNA B changed her gloves and performed hand hygiene while providing incontinent care to Resident #22 on 02/12/2025. 2.The facility failed to ensure LVN B changed her gloves and performed hand hygiene while providing wound care to Resident #38 on 02/20/2025. This failure could place residents at risk of cross-contamination and development of infections. The findings included: 1.Record review of Resident #22's Face Sheet, dated 02/12/2025, reflected the resident was an [AGE] year-old female who was admitted to the facility on 08/05/2020. Resident #22 had diagnoses which included dementia and contracture of muscle in multiple sites. Record review of Resident #22's Quarterly MDS Assessment, dated 12/11/2024, reflected the resident was unable to complete the assessment and had a BIMS score of 99. Section C reflected Resident #22 never/rarely made decisions regarding tasks of daily life. The MDS reflected the resident was always incontinent of bowel and bladder. Record review of Resident #22's Comprehensive Care Plan, dated 02/11/2025, reflected Resident #22 is at risk for pressure ulcer due to moisture. One intervention was to Check incontinence pads frequently (every 2-3 hours) and change as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview on 02/18/25 at 9:55 AM revealed CNA B was preparing to provide incontinence care for Resident #22. CNA B had wipes and a clean brief on the bedside table. CNA B was wearing gloves. The curtain was pulled around the bed for privacy and CNA B told Resident #22 she was going to change her brief. CNA B unfastened the tape of the brief on both sides and tucked the front part of the brief in between the resident's legs. CNA B got clean wipes, cleaned the front of the resident, and dropped the wipes into the wastebasket. CNA B turned Resident #22 to her right side, placed a clean brief under her, and removed the soiled brief. CNA B did not change gloves and use hand sanitizer before touching the clean brief. CNA B used a clean wipe to clean Resident # 22's bottom. Resident #22 rolled to her back and CNA B secured the tabs on the sides of the brief. CNA B removed her gloves and tied the bag of trash containing the soiled brief and wipes. CNA B did not used hand sanitizer or wash her hands before leaving the resident's room. CNA B took the bag of trash to the dirty linen room, next to Resident #22's room, and dropped the bag into a trash barrel. When questioned about hand hygiene, CNA B stated she usually had a bottle of hand sanitizer with her, but she had forgotten it. CNA B stated she was supposed to use hand sanitizer when she changed her gloves to prevent spreading germs and causing infection. She stated you never know what a resident has and we don't want to spread it. CNA B agreed she should have removed her gloves and used hand sanitizer before touching the clean brief and before leaving the room. She stated she was going to get a bottle of hand sanitizer to carry with her. During an interview on 02/18/25 at 1:55 PM, LVN C stated it was important for all staff to change gloves and wash their hands or use hand sanitizer when providing care to residents to prevent cross contamination. During an interview on 02/18 25 at 2:10 PM, the DON stated CNA B should have changed gloves and washed her hands or used hand sanitizer while providing incontinence care for Resident #22. The DON stated she expects staff to use correct hand hygiene to prevent the spread of infection to the staff member and other residents. She stated if staff does not wash their hands or use hand sanitizer and change gloves, they contaminate any surfaces they touch. On 02/20/25 at 9:00 AM, the ADON stated her expectation was for all staff to change gloves and wash their hands or use hand sanitizer while providing care to residents. The ADON stated staff must always follow these measures to prevent the risk of cross contamination and infection. She stated she was going to in-service staff. 2.Review of Resident #38's Face Sheet, dated 02/20/2025, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #38's diagnoses included Wernicke's encephalopathy (Vitamin B 1 deficiency due to malnutrition), cerebral infarction (affects blood flow to the brain), and polyneuropathy (nerve damage on both sides of the body). Review of Resident #38's Quarterly MDS Assessment, dated 01/07/2025, reflected the resident had severe cognitive impairment with a BIMS score of 4. Section M indicated pressure wounds and the application of dressings to the feet. Review of Resident #38's Comprehensive Care Plan, dated 01/07/2025, reflected the resident had pressure ulcers on both feet and one intervention was to administer treatments as ordered and monitor effectiveness. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #38's Physician's Orders, dated 01/03/25, reflected Cleanse wound to left lateral foot with WC/NS, pat dry. Apply santyl (apply betadine to periwound) and cover with island dressing once a day. Cleanse left heel with WC/NS, pat dry. Apply hydrogel & collagen and cover with island dressing once a day. Cleanse right heel with WC/NS, pat dry. Apply santyl (apply betadine to periwound) and cover with island dressing once a day. During an interview and observation on 02/20/25 at 10:45 AM, LVN A was preparing to provide wound care for Resident #38. There were wound care items on a pad on Resident #38's bedside table and LVN A was wearing gloves. LVN A told the resident she was going to change the dressings on his feet. LVN A removed the dressing on the left lateral (on the side) foot and dropped it into the wastebasket next to her. She sprayed normal saline on gauze and cleaned the wound with gauze. LVN A then used a betadine (antiseptic solution) pad to wipe around the wound. She then dipped her index gloved finger into a small medicine cup containing the Santyl (ointment that cleans wounds) and applied the ointment to the wound bed. She covered the wound with a dressing. LVN A changed her gloves but did not use hand sanitizer or wash her hands. LVN A removed the dressing from the left heel, sprayed gauze with normal saline and cleaned the wound with the gauze. LVN A picked up a dressing that had hydrogel and collagen (both promote wound healing) on it and placed the dressing on the left heel. LVN A then removed her gloves, took a pair of gloves from her shirt pocket, and put them on. She did not use sanitizer or wash her hands. LVN A removed the dressing from the right heel, cleaned the wound with normal saline and gauze. She applied the betadine around the wound bed and used her gloved index finger to remove Santyl from the medicine cup and apply it to the wound bed. LVN A applied a dressing to the right heel and then put the heel protectors back on the resident's feet. LVN A removed her gloves and washed her hands in the resident's restroom. LVN A brought the bottle of normal saline spray from Resident #38's room and placed it in a drawer on the medication cart with other wound care supplies. The DON was in the hall when the surveyor and LVN A exited the resident's room and was present during the interview with LVN A. LVN A stated she should not have brought the bottle of hand sanitizer into the resident's room because it was used in other rooms too. She agreed it also contaminated the spray bottle by using it with soiled gloves. The DON recommended to LVN A in the future to take a plastic 8 oz cup with clean dry gauze and a cup with normal saline and gauze in it. The DON stated the bottle of normal saline should not be taken in an out of residents' rooms because of the risk of contamination. LVN A and the DON agreed LVN A should have washed her hands or used hand sanitizer each time she changed gloves. The DON stated LVN A should not have used the fingertip of her soiled glove to apply Santyl to the wound bed. LVN A stated she had tongue depressors on the cart, and she could have used that to apply the ointment. The DON stated she would provide in-service to the staff. Review of the facility's policy Handwashing/Hand Hygiene, updated 01/2025, reflected Hand hygiene is indicated: a. immediately before touching a resident. b. before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device); c. after contact with blood, body fluids, or contaminated surfaces; d. after touching a resident; e. after touching the resident's environment; f. before moving from work on a soiled body site to a clean body site on the same resident; and g. immediately after glove removal. Review of the facility's policy Dressing: Dry/Clean, revised September 2013, reflected Wash and dry your hands thoroughly. Put on clean gloves. Loosen tape and remove soiled dressing. Pull glove over dressing and discard into plastic or biohazard bag. Wash and dry your hands thoroughly. Apply the ordered dressing . Remove disposable gloves and discard into designated container. Wash and dry your hands thoroughly.