STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676303	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mirador	5857 Timbergate Dr Corpus Christi, TX 78414

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47371 Based on observation, interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan, for one (Resident #1) of three residents reviewed for injuries. The facility failed when CNA A did not ensure Resident #1 was medically assessed before picking up Resident #1 off the floor after she fell off the bed and CNA A left her unattended and misaligned in bed on 09/07/2024. Resident #1 sustained a femur fracture and her feeding tube was dislodged as a result of the fall. An Immediate Jeopardy (IJ) was identified as past non-compliance on 04/25/25. The non-compliance began on 09/07/24 and ended on 09/07/24. The facility had corrected the non-compliance before the investigation began on 04/11/25. This failure could place residents with any acquired injury at risk for complications. Findings included: Record review of Resident #1's admission record dated 04/12/2025 revealed Resident #1 was an [AGE] year-old female who was initially admitted on [DATE] and readmitted on [DATE]. Resident #1 was admitted with diagnoses of cerebrovascular disease (stroke), and hemiplegia (paralysis) of right dominant side. Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed Resident #1 had a BIMS score of 12 which meant moderate cognitive impairment and was dependent on staff for ADLs. Record review of Resident #1's care plan initiated 01/04/2021 and revised on: 06/20/2023 revealed Resident #1 has an ADL self-care performance deficit. Goal: Resident #1 will maintain current level of function in (ADLs) through the review date. Bed mobility: Elder requires substantial max assist by staff to turn and reposition in bed (every 2 hours) and as necessary. Elder requires total dependence on staff with dressing. Personal hygiene: Elder requires substantial max assistance with personal hygiene. Elder requires dependent by staff for toileting. Transfer: Elder is dependent with transfers with staff assistance for transfers. (continued on next page)

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of local hospital emergency room records dated 10-Sep-2024 revealed Right distal femur nondisplaced fracture. Nonsurgical management of nondisplaced femoral fracture. Orthopedic surgery evaluated your fracture and recommended non-operative management. You will need to keep your brace on at all times. Frequently check the skin under your brace for skin breakdown. You will need a Hoyer lift to get into your wheelchair, which should have an elevated rest for your right leg. Primary Impression: Right femoral fracture Secondary Impressions: Fall, Malfunction of percutaneous endoscopic gastrostomy (PEG) tube. Disposition. Reason For Visit: Right Femoral Fracture Problems: Malfunction of gastrostomy tube. Onset: 7-Sep-2024. Impression By: Procedures PEG Tube Replacement. Observation of the in-room surveillance video dated 09/07/24 revealed the clock on the wall, located directly in front of Resident #1, showed a time of approximately 8:22, when CNA A was observed to be providing Resident #1 perineal/incontinent care while on her left side. Resident #1 was awake, was seen to move her arms and independently held the grab bars of the bed. Resident #1 had a sleeveless shirt on, but no pants or brief were on. CNA A instructed Resident #1 to roll this way indicating to her right side. Resident #1 was seen to initiate the task slowly and independently, and as Resident #1 was in a face up position, CNA A assisted in turning her to her right side. After providing personal hygiene, CNA A asked Resident #1 to turn (to her left side) and again Resident #1 initiated the task and held on to the left side of bed grab bar with both hands. Resident #1's pelvic area was observed to be at the center of the bed however, her legs were slightly bent forward, not in alignment with her pelvis. While on her left side, Resident #1's thighs were on top of each other while her right foot was behind her left foot. The video showed Resident #1 slowly repositioned her right foot over and in front of her left foot, closer to the edge of the bed. After CNA A removed the fitted bed sheet from the right upper corner of the bed, Resident #1's right leg/foot was seen slipping forward. When CNA A loosened the rest of the right side fitted bed sheet and removed the fitted sheet off the right foot of the bed, Resident #1's right leg was no longer seen on the bed. While Resident #1's right leg dangled off the bed, CNA A was seen rolling and tucking Resident #1's right side sheets toward and behind Resident #1's body. A couple of seconds later, CNA A turned around with his back to Resident #1 and then moved out of video footage, at the same time, Resident #1's right leg dangled off the bed and her left leg was seen slipping off the bed. Once Resident #1's both legs dangled down off the bed, her entire body fell off the bed. Resident #1 was seen to hit her head on the left grab bar of the bed and the left side table. CNA A immediately walked toward Resident #1, carried her off the floor and sat her on the edge of the bed then reached his right hand into his right pocket and pulled out his phone while he held on to Resident #1 with his left hand. Attempted phone interview with CNA A on 04/12/2025 at 4:22 PM, 04/13/2025 at 9:41AM, and 1:07PM. CNA A did not return call prior to exit conference. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During a phone interview on 04/12/2025 at 6:39 PM, LVN A stated CNA A notified him that Resident #1 had fallen out of bed and was found on the floor. LVN A stated when he arrived in Resident #1's room, she was not on the floor, but on her bed. LVN A stated he asked CNA A why Resident #1 was on the bed, given that CNA A had just notified him that Resident #1 was found on the floor. LVN A stated CNA A stated, I couldn't just leave her like that. LVN A stated he notified CNA A that Resident #1 should not have been moved prior to LVN A's physical head-to-toe evaluation, as an attempt to ensure that if Resident #1 had sustained an injury, the injury would not be exacerbated by additional movement. LVN A stated CNA A should have engaged the emergency light system that was connected to the call light system and should have waited for LVN A to arrive to conduct a physical assessment on Resident #1. LVN A stated CNA A could have compromised Resident #1's wellbeing by picking her up prior to LVN A's head-to-toe evaluation. LVN A stated he was not given access to the video regarding Resident #1's incident. LVN A stated he did not observe any skin irregularities but given that Resident #1 sustained an unwitnessed fall he sent her for evaluation and treatment to an emergency room . LVN A stated CNA A no longer was employed with the facility. During an interview on 04/12/2025 at 5:02 PM, the DON stated she was made aware of the incident by not only LVN A, but the previous administrator. The DON stated the previous administrator allowed her to watch the evidentiary video regarding Resident #1 from his phone that was not facility owned footage. The DON stated she observed CNA A enter Resident #1's room, followed by CNA A lifting Resident #1 to her bed from the floor. The DON stated the expectation was for all clinical staff to follow facility protocols regarding fall management. The DON stated CNA A should have left Resident #1 on the floor, notified LVN A of the situation, waited for LVN A to arrive to conduct a head-to-toe evaluation, then follow LVN A's directive. The DON did not give a definitive answer as to what potentially could have occurred given that CNA A did not follow fall management protocol. The DON stated in her professional opinion, the reason residents are not moved prior to physical evaluation by the nurses, is to minimize any exacerbation of initial injury. The DON stated LVN A conducted the physical head-to-toe assessment on Resident #1 and did not note any skin irregularities, but due to her unwitnessed fall, she was sent to the emergency room for evaluation and possible treatment. The DON stated CNA A was no longer employed by the facility . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In a subsequent interview with the DON on 04/23/2025 at 1:33 pm, who said she viewed footage from Resident #1's in-room camera the previous ADM showed her. She said the footage she saw cut off just before Resident #1 fell off the bed. She said Resident #1 was in her bed and CNA A was repositioning and performing peri care and he stepped away to grab supplies and it was at that time Resident #1 fell off the bed and suffered a fracture. She said Resident #1 was sent to the hospital and did not return to the facility. She said Resident #1 passed away about a month later. She said one of Resident #1's family members told them about her passing. She said CNA A had at least competency training once a year. She said CNA A was qualified for the job of repositioning and performing peri care. She said the previous ADM had a 5-point questionnaire that he asked, and it was in the investigation file. She said the facility conducted various in-services and computer-based training throughout the year in addition to yearly competencies. She said she and the ICP nurse spot checked hand washing, donning and doffing PPE, and dressing changes, but not repositioning. She said there was no specific policy or guideline for 1 or 2 person assists. She said staff utilized a census sheet with specifics for each resident and said if someone was a 1 or 2 person assist, it would be on the census sheet. She said the census sheets were saved on the nurse's computers as live documents and could be accessed by any staff member to modify or add to it. She said there was no way to retrieve past census sheets because the information in them was deleted with every discharge. She said the census sheet was not generated by the electronic charting system, it was an internal document that populated from resident's care plans. She said CNA A was not referred to the NAR (Nurse Aide Registry) that she knew of. In an interview with the ADM on 04/23/25 at 3:05 pm, she said the nursing team led all staff in-services and training, including monitoring after the incident. She said CNA A was fired. In a phone interview with MD on 04/24/2025 at 9:02 am, he said he remembered Resident #1 had a fall and he was notified. He said he did not know Resident #1's outcome because she did not return to the facility. He said Resident #1 was a lovely lady. He said since she hit her head, and broke her femur, an embolism from the long bone fracture could have caused the code at the local post-acute hospital. He said this incident may have exacerbated or caused the outcome or influenced Resident #1's death. He said Resident #1 was quite frail. He said when older people break their femur and cannot get it fixed, they generally do not do well. In a subsequent interview with LVN A on 04/24/2025 at 2:52 pm, he said he was the charge nurse on 09/07/2024 and was in the hall. He said CNA A called his phone to tell him that the Resident #1 had fallen off or rolled off the bed and assumed he meant she was on the floor. He said when he entered Resident #1's room, she was in the bed, not on the floor. He asked CNA A why he moved Resident #1. He said CNA A told him he did not want to leave her on the floor. LVN A said he did not know what CNA A was thinking. LVN A said he assumed CNA A was trained on not moving residents who had fallen or were on the floor because they could have a cervical (neck) injury, or some other injury. He said Resident #1 was normally pretty with it and alert. He said Resident #1 was groggy on his 1st encounter of seeing her on the bedside and could not tell him what happened. He said he noticed CNA A should not have picked Resident #1 up. He said CNA A was reluctant to follow directions. He said CNA A would [NAME] about being a CNA A for 20-[AGE] years. Record review of the facility's 09/07/2024 in-service regarding topics Abuse and Neglect, Reporting injuries of unknown origin, and fall prevention was facilitated ensue of the 09/07/2024 event and revealed CNA A was in attendance. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The following staff from the morning and evening shifts were interviewed on the below policies and procedures and in-services: 3 RN's, 4 CNA's, 2 CMA's, 3 HSK, and 2 LVN's . All staff were able to verbalize the identification of abuse, neglect, and exploitation as well as the policies and procedures as per the trainings listed below. Record review of facility documents revealed the following in-services: 06/23/24, 08/13/24, 08/23/24, 09/07/24 Abuse & Neglect; Identifying abuse as defined as willful, Types of abuse included physical, mental/verbal, Sexual/unwanted touching. 07/19/24, 09/07/24, 03/04/25, 04/21/25 Infection Control and Handwashing; To keep staff and resident's safe, not spread germs or infect someone who is not able to fight it off, Different types of isolation-contact isolation for c-diff is important because it can live outside the body for a very long time-that's why you have to use soap and water to clean your hands not just sanitizer. 07/31/24 Never Turn a Hip fracture to the affected side without specific orders; use the log roll method and make sure the resident is in a neutral position (aligned straight) on their back. Have sufficient pillows-minimum of two: between the thighs/knees to avoid misalignment which could cause pain, spasms, or dislocation. 08/13/24, 09/07/24 Injuries of Unknown Origin; reporting bruises, new pain, skin tears, redness, scratches, etc. right away to the nurse and/or administrator. Document. 09/07/24 Dignity; Respect at all times, permission to enter rooms and knocking first, not talking about residents to each other in the hall or elsewhere, keeping computers private, privacy especially when providing personal care-bathing, changing clothes or briefs or wound care, privacy bags on catheter bags. 12/20/24 Transfer Training; Proper use of mechanical lift-2 person at all times, sling straps must be double checked, how to maneuver the lift, resident safety is high priority-all instructions and education must be followed by each staff member. 12/26/24, 01/13/25, 03/05/25 Identifying and Reporting Types of Abuse; Identifying abuse as defined as willful, Types of abuse included physical, mental/verbal, Sexual/unwanted touching. 09/07/24, 01/29/25, 03/04/25 Hand Hygiene; Done before providing care. The number one thing to help prevent spreading germs, everyone has to do it-no exceptions, you can use hand sanitizer unless you know your hands are dirty or if it's c-diff, then you have to use soap and water. Sanitize before and after going in and coming out of the room, if you touch anything in the room and are going to touch the resident or their belongings. You have to lather for at least 20 seconds and use the towel you dry your hands with to turn off the faucet. 02/27/25 Gait Belts; Labeled with each room number for the resident in that room only. They will be sanitized as needed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	09/07/24, 03/04/25 PPE; gowns, gloves, eye protection and face mask. Use it when you do peri care, catheter care, if there's a feeding tube, an IV line, any dressing changes, and isolation. First, you wash your hands, then put on the gown, then the mask, then the eye protection then the gloves last. To take it off, reverse the order. 03/31/25 Foley Catheter care; Clean the catheter and surrounding area skin each shift to prevent bacteria build-up. Drainage bag must always be below the level of the bladder to avoid back flow and always have a privacy bag on the reservoir. Bags should never be touching the floor or placed on the bed. Check for kinks in the tubing. Clean the catheter with every incontinent episode or after toileting. Notify the charge nurse if there are any concerns. 09/07/24 Peri Care; PPE, wash your hands before you start, have all your supplies ready so you don't have to step away from the bedside, keep the resident covered so they don't get cold or if someone walks in, change gloves before you go from clean to dirty, on ladies, wipe from top to bottom and inside to outside, document and let the charge nurse know if you find anything new. 09/07/24 C-Diff; highly contagious. Can cause nausea, vomiting, diarrhea and/or fever. Hand washing with soap and water is essential. 09/07/24, 04/12/25 Falls and Falls with Injury; Fall risk factors such as wet floors, not having non-slip shoes or socks, when they need to go to the bathroom, UTI's (urinary tract infections), some medications, weakness, thinking they can when they can't get up on their own, using 2-person assistance when indicated 04/22/25 Norovirus; highly contagious. Can cause nausea, vomiting, diarrhea and/or fever. Hand washing with soap and water is essential. CNA A's signature was noted on all in-services dated from 06/23/24 to 09/07/24 . Record review of CNA A's yearly competency skills dated 02/24/24 revealed he met competency for Fall Prevention, Peri Care. Record review of CNA A's personnel file revealed a document titled, Understanding Job Expectations dated 09/02/24 revealed CNA A had been reported not using correct hand hygiene when providing resident care. Also noted at times not wearing proper PPE while providing resident care. CNA A was to ensure to wear gloves while providing resident care and ensure to use proper hand hygiene. The document was signed and dated by CNA A on 09/02/24. There were no other disciplinary actions documented in CNA A's personnel file. There was no documentation of CNA A's termination date. An email received from the present ADM stated, CNA A's termination was a progressive process. Our Administrator at the time spoke with him one on one following the incident. After this, we increased supervision of the care provided by providing spot checks. Then, we began to notice gaps in CNA A's performance, so we followed our companies progressive process and moved to term with his last day worked being 12/30/2024. Record review of the facility's Assessing Falls and Their Causes revision dated March 2018 documented, Steps in the Procedure (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	After a Fall: 1. If a resident has just fallen or is found on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities. 2. Obtain and record vital signs as soon as it is safe to do so. 3. If there is evidence of injury, provide appropriate first aid and/or obtain medical treatment immediately. 4. If an assessment rules out significant injury, help the resident to a comfortable sitting, lying or standing position, and then document relevant details. An Immediate Jeopardy (IJ) was identified as past non-compliance on 04/25/25. The non-compliance began on 09/07/24 and ended on 09/07/24. The facility had corrected the non-compliance before the investigation began on 04/11/25.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748 Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one (Resident #1) of four residents reviewed for accident hazards and supervision on 09/07/24. The facility failed to identify and eliminate a foreseeable fall. CNA A left Resident #1 unattended and did not ensure her body was positioned in a safe manner when providing incontinent care resulting in Resident #1 falling off her bed, sustaining a femur fracture, and her feeding tube to be dislodged. An Immediate Jeopardy (IJ) was identified as past non-compliance on 04/25/25. The non-compliance began on 09/07/24 and ended on 09/07/24. The facility had corrected the non-compliance before the investigation began on 04/11/25. This failure could affect residents by placing them at risk for falls, injury, major injury, or death. Findings included: Record review of Resident #1's face sheet revealed an [AGE] year-old female originally admitted on [DATE] and readmitted on [DATE]. Diagnoses included cerebrovascular disease, metabolic encephalopathy (a brain disorder caused by problems with the body's chemistry or metabolism such as liver or kidney disease, nutritional deficiencies .), gastrostomy status (feeding tube), dominant right sided weakness, dysphagia (difficulty swallowing), esophageal stricture (narrowing), malnutrition, abnormal posture, rheumatoid arthritis, seizures, and history of traumatic brain injury. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1 had a BIMS Score of 12 indicating moderate cognitive impairment and required substantial assistance with oral and personal hygiene, rolling left or right, sitting up or down, lying to sitting on side of bed, and was dependent or required extensive assistance with toileting, showering, upper and lower body dressing, footwear, and all transfers. She was always incontinent of bladder and bowel. Record review of Resident #1's care plan dated 08/29/24 revealed Resident #1 was dependent on staff assistance for transfers and all ADL's (Activities of Daily Living). o Resident #1 has become more active with activities Date Initiated: 07/15/2021 Revision on: 08/24/2022. o Resident #1 needs assistance/escort to activity functions. Date Initiated: 07/15/2021. Resident #1 has an ADL self-care performance deficit Date Initiated: 01/04/2021 Revision on: 06/20/2023. Resident #1 will maintain current level of function in (ADLs) through the review date. Date Initiated: 01/04/2021. Resident #1 has impaired cognitive function or impaired thought processes r/t short term memory loss Date Initiated: 02/21/2024. Resident #1 has an alteration in musculoskeletal status related to weakness. Date Initiated: 07/10/2024. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of PIR (Provider Investigation Report) interview questions dated 09/07/24 asked to CNA A by the previous ADM revealed: Did you witness the fall? answer: Yes, I did. She just shifted her weight and fell forward; she has never done that before. Did you leave the room completely and return to find her on the floor? answer: No, I was in the room, just went to the closet. Why did you pick her up? answer: I didn't know what to do. My first thought was to just help her right away. Why didn't you cover her up? answer: I was just grabbing the sheets from the closet, so I didn't plan on leaving her in that position, I was going to change her sheets right at that moment and continue care. Record review of local hospital emergency room records dated 10-Sep-2024 revealed Right distal femur nondisplaced fracture. Nonsurgical management of nondisplaced femoral fracture.Orthopedic surgery evaluated your fracture and recommended non-operative management. You will need to keep your brace on at all times. Frequently check the skin under your brace for skin breakdown. You will need a Hoyer lift to get into your wheelchair, which should have an elevated rest for your right leg. Primary Impression: Right femoral fracture Secondary Impressions: Fall, Malfunction of percutaneous endoscopic gastrostomy (PEG) tube. Disposition. Reason For Visit: RT FEMORAL FX Problems: Malfunction of gastrostomy tube. Onset: 7-Sep-2024. Impression By: Procedures PEG Tube Replacement. Observation of the personal in-room surveillance video dated 09/07/24 revealed the clock on the wall, located directly in front of Resident #1, showed a time of approximately 8:22 (am or pm not identified), when CNA A was observed to be providing Resident #1 perineal/incontinent care while on her left side. Resident #1 was awake, was seen to move her arms and independently held the grab bars of the bed. Resident #1 had a sleeveless shirt on, but no pants or brief were on. CNA A instructed Resident #1 to roll this way indicating to her right side. Resident #1 was seen to initiate the task slowly and independently, and as Resident #1 was in a face up position, CNA A assisted in turning her to her right side. After providing personal hygiene, CNA A asked Resident #1 to turn (to her left side) and again Resident #1 initiated the task and held on to the left side of bed grab bar with both hands. Resident #1's pelvic area was observed to be at the center of the bed however, her legs were slightly bent forward, not in alignment with her pelvis. While on her left side, Resident #1's thighs were on top of each other while her right foot was behind her left foot. The video showed Resident #1 slowly repositioned her right foot over and in front of her left foot, closer to the edge of the bed. After CNA A removed the fitted bed sheet from the right upper corner of the bed, Resident #1's right leg/foot was seen slipping forward. When CNA A loosened the rest of the right side fitted bed sheet and removed the fitted sheet off the right foot of the bed, Resident #1's right leg was no longer seen on the bed. While Resident #1's right leg dangled off the bed, CNA A was seen rolling and tucking Resident #1's right side sheets toward and behind Resident #1's body. A couple of seconds later, CNA A turned around with his back to Resident #1 and then moved out of video footage, at the same time, Resident #1's right leg dangled off the bed and her left leg was seen slipping off the bed. Once Resident #1's both legs dangled down off the bed, her entire body fell off the bed. Resident #1 was seen to hit her head on the left grab bar of the bed and the left side table. CNA A immediately walked toward Resident #1, carried her off the floor and sat her on the edge of the bed then reached his right hand into his right pocket and pulled out his phone while he held on to Resident #1 with his left hand. (continued on next page)

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	676303	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mirador	5857 Timbergate Dr Corpus Christi, TX 78414

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview with the ADM on 04/22/2025 at 1:15 pm, she said the FRI (Facility Reported Incident) was cited for falls because CNA A picked Resident #1 up off the floor. Incidentally, he was immediately suspended then terminated because of this incident and for not following policies for peri care/positioning. The ADM said she was not here at the time of the incident on 09/07/24-she started on 12/30/24. She said there was an active lawsuit against the facility at this time. She said they have not yet gone to litigation. She believed they were going to mitigation this summer. In an interview with the ICP/ADON on 04/22/2025 at 1:45 pm, said she had worked here for more than [AGE] years and almost 4 years as ICP. She said annual competencies included infection control, fall prevention, hand washing, peri care, transfers, etc. She said she had corrected, documented, and educated CNA A 1:1 on several occasions regarding infection control and peri care, but this incident was the last straw. She said he would pass his annual competencies without any problems, but when no one was there to watch him, implying he would not properly use PPE. In an interview with the DON on 04/23/2025 at 1:33 pm, she said she had worked at the facility for 6 years. She said she viewed footage from Resident #1's personal in-room camera the previous ADM showed her. She said the footage she saw cut off just before Resident #1 fell off the bed. She said Resident #1 was in her bed and CNA A was repositioning and performing peri care and he stepped away to grab supplies and it was at that time Resident #1 fell off the bed and suffered a fracture. She said Resident #1 was sent to the hospital and did not return to the facility. She said Resident #1 passed away about a month later. She said one of Resident #1's family members told them about her passing. She said CNA A had at least competency training once a year. She said CNA A was qualified for the job of repositioning and performing peri care. She said the previous ADM had a questionnaire that he asked, and it was in the investigation file. She said the facility conducted various in-services and computer-based training throughout the year in addition to yearly competencies. She said she and the ADON nurse spot checked hand washing, donning and doffing PPE, and dressing changes, but not repositioning. She said there was no specific policy or guideline for 1 or 2 person assists. She said staff utilized a census sheet with specifics for each resident and said if someone was a 1 or 2 person assist, it would be on the census sheet. She said the census sheets were saved on the nurse's computers as live documents and could be accessed by any staff member to modify or add to it. She said there was no way to retrieve past census sheets because the information in them was deleted with every discharge. She said the census sheet was not generated by the electronic charting system, it was an internal document that populated from resident's care plans. She said CNA A was not referred to the NAR (Nurse Aide Registry) that she knew of. In an interview with the ADM on 04/23/25 at 3:05 pm, she said the nursing team led all staff in-services and training, including monitoring after the incident. She said CNA A was fired. In a phone interview with MD on 04/24/2025 at 9:02 am, he said he remembered Resident #1 had a fall and he was notified. He said he did not know Resident #1's outcome because she did not return to the facility. He said Resident #1 was a lovely lady. He said since she hit her head, and broke her femur, an embolism from the long bone fracture could have caused the code at the local post-acute hospital. He said this incident may have exacerbated or caused the outcome or influenced Resident #1's death. He said Resident #1 was quite frail. He said when older people break their femur and cannot get it fixed, they generally do not do well. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview with LVN A on 04/24/2025 at 2:52 pm, he said he recalled seeing CNA A in Resident #1's room without PPE. He said he was the charge nurse that day and he was in the hall. He said CNA A called his phone to tell him that the Resident #1 had fallen off or rolled off the bed and assumed he meant she was on the floor. He said when he entered Resident #1's room, she was in the bed, not on the floor. He asked CNA A why he moved Resident #1. He said CNA A told him he did not want to leave her on the floor. LVN A said he did not know what CNA A was thinking. LVN A said he assumed CNA A was trained on not moving residents who had fallen or were on the floor because they could have a cervical (neck) injury, or some other injury. He said his findings during his assessment of Resident #1 were no peg tube (feeding tube), and pain to her right upper leg, and she was groggy. He said Resident #1 was normally pretty with it and alert. He said Resident #1 was groggy on his 1st encounter of seeing her on the bedside and could not tell him what happened. He said he noticed CNA A should not have picked Resident #1 up. He said Resident #1 was on contact isolation at the time for c-diff. He said signage & PPE was outside the door of her room. He said CNA A did not have PPE on. He said we (staff) got trained on infection control and PPE-we just had one (in-service/training) within the last few weeks and last month. He said CNA A had gloves on. He said he knew about the in-room camera. He said he would not be surprised that CNA A did not change his gloves if he forgot the PPE for a contact isolation room for C-Diff and was performing incontinent care. He said CNA A was reluctant to follow directions. He said CNA A would [NAME] about being a CNA A for 20-[AGE] years. LVN A said if he saw staff not wearing proper PPE, he re-educated them on the spot and informed the ICP. The following staff from the morning and evening shifts were interviewed throughout the investigation from 04/22/25-04/25/25 on the below policies and procedures and in-services: 3 RN's, 4 CNA's, 2 MA's, 3 HSK, and 2 LVN's . All staff were able to verbalize the identification of abuse, neglect, and exploitation as well as the policies and procedures as per the trainings listed below. Record review of facility documents revealed the following in-services: 06/23/24, 08/13/24, 08/23/24, 09/07/24 Abuse & Neglect; Identifying abuse as defined as willful, Types of abuse included physical, mental/verbal, Sexual/unwanted touching. 07/19/24, 09/07/24, 03/04/25, 04/21/25 Infection Control and Handwashing; To keep staff and resident's safe, not spread germs or infect someone who is not able to fight it off, Different types of isolation-contact isolation for c-diff is impoortant because it can live outside the body for a very long time-that's why you have to use soap and water to clean your hands not just sanitizer. 08/13/24, 09/07/24 Injuries of Unknown Origin; reporting bruises, new pain, skin tears, redness, scratches, etc. right away to the nurse and/or administrator. Document. 09/07/24 Dignity; Respect at all times, permission to enter rooms and knocking first, not talking about residents to each other in the hall or elsewhere, keeping computers private, privacy especially when providing personal care-bathing, changing clothes or briefs or wound care, privacy bags on catheter bags. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	09/07/24, 01/29/25, 03/04/25 Hand Hygiene; Done before providing care. The number one thing to help prevent spreading germs, everyone has to do it-no exeptions, you can use hand sanitizer unless you know your hands are dirty or if it's c-diff, then you have to use soap and water. Sanitize before and after going in and coming out of the room, if you touch anything in the room and are going to touch the resident or their belonging's. You have to lather for at least 20 seconds and use the towel you dry your hands with to turn off the faucet. 09/07/24, 03/04/25 PPE; gowns, gloves, eye protection and face mask. Use it when you do pericare, catheter care, if there's a feeding tube, an IV line, any dressing changes, and isolation. First, you wash your hands, then put on the gown, then the mask, then the eye protection then the gloves last. To take it off, reverse the order. 09/07/24 Peri Care; PPE, wash your hands before you start, have all your supplies ready so you don't have to step away from the bedside, keep the resident covered so they don't get cold or if somone walks in, change gloves before you go from clean to dirty, on ladies, wipe from top to bottom and inside to outside, document and let the charge nurse know if you find anything new. 09/07/24 C-Diff; highly contagious. Can cause nausea, vomiting, diarrhea and/or fever. Hand washing with soap and water is essential. 09/07/24, 04/12/25 Falls and Falls with Injury; Fall risk factors such as wet floors, not having non-slip shoes or socks, when they need to go to the bathroom, UTI's (urinary tract infections), some medications, weakness, thinking they can when they can't get up on their own, using 2 person assistance when indicated CNA A's signature was noted on all in-services dated from 06/23/24 to 09/07/24 . Record review of CNA A's yearly competency skills dated 02/24/24 revealed he was competent to perform Infection Control/PPE, Fall Prevention, Handwashing, Peri Care, Foley Catheter care, Diet Textures, Transfers and Gait Belt, and N95 Fit testing. Record review of CNA A's personnel file revealed a document titled, Understanding Job Expectations dated 09/02/24 revealed CNA A had been reported not using correct hand hygiene when providing resident care. Also noted at times not wearing proper PPE while providing resident care. CNA A was to ensure to wear gloves while providing resident care and ensure to use proper hand hygiene. The document was signed and dated by CNA A on 09/02/24. There was no other disciplinary actions documented in CNA A's personnel file. There was no documentation of CNA A's termination date. An email received from the present ADM stated, CNA A's termination was a progressive process. Our Administrator at the time spoke with him one on one following the incident. After this, we increased supervision of the care provided by providing spot checks. Then, we began to notice gaps in CNA A's performance so we followed our companies progressive process and moved to term with his last day worked being 12/30/2024. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of nurse's note evaluations dated 08/15/24 at 12:01 am revealed Resident #1 had no decrease in food intake or weight loss in the last 3 months. Resident #1 was bed or chair bound, had not suffered psychological stress or acute disease in the past 3 months. Resident #1 had severe dementia or depression. Resident #1 was cooperative with transfers but not cooperative with repositioning. Resident #1did not have upper extremity strength, was not able or partially able to assist with transfers from bed to bed. Resident #1 was partially able to assist with repositioning in bed, but not able to assist with repositioning in chair. Resident #1 had parts of her body that lacked sensation. Record review of lab results dated 08/30/24 revealed Resident #1 was positive for c-diff. Record review of nurse's notes dated 09/07/24 at 8:30 am revealed Resident #1 had a witnessed fall at 8:20 am. CNA A called nurse that resident was on the floor. Nurse gowned and entered room with resident. CNA A in front of resident with resident sitting on the side of the bed. PEG tube (feeding tube) was not in place. Resident noted in a daze and was not responding while being conscious. Resident #1 was then repositioned by CNA A. Resident #1 states she rolled out of bed. Did not hit head, complained of pain to right leg. Nurse upon entering room Resident #1 noted in bed after fall. Assessed vital signs, Checked Range of motion, Assessed pain to upper extremities and lower extremities. Pain noted to right hip. 8/10. Blood Pressure:154/64 Pulse:73 Oxygen saturation: 93% Respiratory rate; 18. Peg tube site noted blood. PEG tube was removed during fall. Resident #1 did speak to notify of pain to leg. Notified MD at 8:38 am, Daughter at 8:40 am to 8:43 am till answered. Notified DON, ADON. Called 911 and sent to local ER per family request. Resident #1 picked up 9:03 am. Report called to at 9:06 am. Record review of the facility policy revised August 2021, titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program . 5. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive, or emotional problems. Record review of the facility policy revised March 2018, titled, Falls and Fall Risk, Managing under Fall risk Factors 2. Resident conditions that may contribute to the risk of falls include b. infection, c. delirium and other cognitive impairment, e. lower extremity weakness, k. incontinence. 3. Medical factors that contribute to the risk of falls included d. neurological disorders e. balance and gait disorders. An Immediate Jeopardy (IJ) was identified as past non-compliance on 04/25/25. The non-compliance began on 09/07/24 and ended on 09/07/24. The facility had corrected the non-compliance before the investigation began on 04/11/25.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program, including hand hygiene, designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for one (Resident #1) of 4 residents reviewed for infection control practices. The facility failed to ensure CNA A wore a gown before entering a contact isolation room to perform incontinent care on 09/07/24. The facility failed to ensure CNA A wore his face mask properly while in a contact isolation room for a communicable disease on 09/07/24. The facility failed to ensure CNA A performed hand hygiene before putting on gloves to perform incontinent care on 09/07/24. The facility failed to ensure CNA A changed his gloves or sanitized his hands during incontinent care, applying a clean brief, touching everything, and helping Resident #1 remove her shirt, assisting with turning her, and changing her linen on 09/07/24. A Past Non-Compliance (PNC) at a second level was identified on 04/25/25. The non-compliance began on 09/07/24 and ended on 09/07/24. The facility had corrected the non-compliance before the investigation began on 04/11/25. These failures could place residents at risk of exposure to communicable diseases, cross-contamination, and infections. Findings included: Record review of Resident #1's face sheet revealed an [AGE] year-old female originally admitted on [DATE] and readmitted on [DATE]. Diagnoses included cerebrovascular disease, gastrostomy status (feeding tube), dysphagia (difficulty swallowing), right dominate paralysis, esophageal stricture (narrowing), malnutrition, rheumatoid arthritis, seizures, and history of traumatic brain injury. Record review of Resident #1's quarterly MDS dated [DATE] revealed Resident #1 had a BIMS Score of 12 indicating moderate cognitive impairment and required substantial assistance with oral and personal hygiene, rolling left or right, sitting up or down, lying to sitting on side of bed, and was dependent or required extensive assistance with toileting, showering, upper and lower body dressing, footwear, and all transfers. She was always incontinent of bladder and bowel. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #1's care plan dated 08/29/24 revealed Resident #1 was totally dependent on staff to provide (bath/shower)(3x/week) and as necessary. Date Initiated: 01/04/2021 Revision on: 06/20/2023. o Resident #1 requires substantial max assist by staff to turn and reposition in bed (every 2 hours) and as necessary. Date Initiated: 01/04/2021 Revision on: 06/05/2024. Resident #1 requires total dependence on staff with dressing. Date Initiated: 01/04/2021 Revision on: 06/19/2024. Resident #1 required substantial max assistance with personal hygiene. Date Initiated: 01/04/2021 Revision on: 06/19/2024 Resident #1 was dependent on staff for toileting. Date Initiated: 01/04/2021 Revision on: 06/19/2024. Resident #1 was dependent on staff assistance for transfers and all ADL's. Resident #1 has become more active with activities Date Initiated: 07/15/2021 Revision on: 08/24/2022. Resident #1 needs assistance/escort to activity functions. Date Initiated: 07/15/2021. Resident #1 has an ADL self-care performance deficit Date Initiated: 01/04/2021 Revision on: 06/20/2023. Resident #1 will maintain current level of function in (ADLs) through the review date. Date Initiated: 01/04/2021. Resident #1 has impaired cognitive function or impaired thought processes r/t short term memory loss Date Initiated: 02/21/2024. Resident #1 had an alteration in musculoskeletal status related to weakness. Date Initiated: 07/10/2024. Resident #1 is on antibiotic therapy, Vancomycin for diagnosis: C diff. (a bacterial infection that can cause diarrhea and produce toxins that can damage the colon lining. It is often transmitted through contaminated surfaces or hands that have been in contact with feces from an infected person. The germ can live outside the body for months or years on surfaces and in the soil.) Resident is on contact isolation. Date Initiated: 06/17/2024 Revision on: 06/19/24. Record review of nurse's notes dated 08/31/24 at 1:39 am revealed: Received results of Stool sample and was positive for Clostridium Difficile. Sent MD copy of lab and he gave new orders: Flagyl 500mg per tube 4x/day for 14 days, Questran 1pkg BID (twice a day) x 7 days and Acidophilus 3x/day for 14 days. Did put sign on door, wrote orders for contact isolation and set up isolation outside room. Notified Administration. Observation of the personsl in-room surveillance video dated 09/07/24 revealed the clock on the wall, located directly in front of Resident #1, showed a time of approximately 8:15 (am or pm was not identified) when CNA A approached the bedside of Resident #1 to perform incontinent care, brief, clothing, and linen changes. He was wearing gloves but did not change them when moving from dirty to clean; after wiping, then touching the resident to assist turning, and while removing her clothing. He removed clean wipes from their container with the same gloves on. He was not wearing a gown and his face mask was under his chin. Resident #1 was on contact isolation (for C-Diff - a bacterial infection that can cause diarrhea and produce toxins that can damage the colon lining. It is often transmitted through contaminated surfaces or hands that have been in contact with feces from an infected person. The germ can live outside the body for months or years on surfaces and in the soil.) CNA A was seen rolling and tucking Resident #1's sheets toward and behind Resident #1's body. In an interview with the ADM on 04/22/2025 at 1:15 pm, she said CNA A was immediately suspended then terminated because of this incident and for not following policies for peri care/positioning and infection control. The ADM said she was not here at the time of the incident on 09/07/24-she started on 12/30/24. She said there was an active lawsuit against the facility at this time. She said they have not yet gone to litigation. She believed they were going to mitigation this summer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	In an interview with the ICP/ADON on 04/22/2025 at 1:45 pm, she said she had worked at the facility for more than [AGE] years and almost 4 years as ICP. She said annual competencies included infection control, fall prevention, hand washing, peri care, transfers, etc. She said she had corrected & educated CNA A 1:1 on several occasions regarding infection control and peri care, but this incident was the last straw. She said he would pass his annual competencies without any problems, but when no one was there to watch him, implying he may not use PPE properly. In an interview with the DON on 04/23/2025 at 1:33 pm, she said she had worked at the facility for 6 years. She said she was shown a video from Resident #1's in-room camera by the previous ADM. She said CNA A was not wearing PPE and at that time, Resident #1 was positive for C-Diff. She said there was signage and PPE equipment outside of the room. She said cross contamination was also part of their yearly competencies. She said the previous ADM had asked CNA A, and it was in the investigation file. She said she did not know if CNA [NAME] been counseled for not wearing PPE, she would have to look at his file. She said the facility conducted various in-services and computer-based training throughout the year that included infection control, PPE, and handwashing. She said she and the ICP nurse spot checked staff for hand washing, PPE, and dressing changes. She said the ICP had the documentation in a folder. She said the CNA was not referred to the NAR that she knew of. She said CNA A had at least competency training once a year. She said the CNA was qualified for the job of repositioning and incontinent care including proper PPE. In an interview with the ADM on 04/23/2025 at 3:05 pm, she said the nursing team led all staff in-services and training, including monitoring. She said CNA A was immediately suspended to protect other residents and staff, then terminated. In an interview with LVN A on 04/24/2025 at 2:52 pm, he said he recalled seeing CNA A in Resident #1's room without PPE. He said he was the charge nurse that day and he was in the hall. He said CNA A called his phone for assistance with Resident #1. LVN A said he assumed CNA A was trained on infection control and PPE. He said Resident #1 was on contact isolation on 09/07/24 for C-Diff. He said signage & PPE was outside the door of Resident #1's room. He said CNA A did not have PPE on throughout the encounter. He said we (staff) got trained on infection control and PPE-we just had one (in-service/training) within the last few weeks and last month. He said CNA A had gloves on. He said he knew about the in-room camera. He said he would not be surprised that CNA A did not change his gloves if he forgot the PPE for a contact isolation room for C-Diff and was performing incontinent care. He said CNA A was reluctant to follow directions. He said CNA A would [NAME] about being a CNA A for 20-[AGE] years. LVN A said if he saw staff not wearing proper PPE, he verbally re-educated them on the spot and informed the ICP. The following staff from the morning and evening shifts were interviewed throughout the investigation from 04/22/25-04/25/25 on the below policies and procedures and in-services: 3 RN's, 4 CNA's, 2 MA's, 3 HSK, and 2 LVN's . All staff were able to verbalize the identification of abuse, neglect, and exploitation as well as the policies and procedures as per the trainings listed below. Record review of facility documents revealed the following in-services: 07/19/24, 09/07/24, 03/04/25, 04/21/25 Infection Control and Handwashing; To keep staff and resident's safe, not spread germs or infect someone who is not able to fight it off, Different types of isolation-contact isolation for c-diff is important because it can live outside the body for a very long time-that's why you have to use soap and water to clean your hands not just sanitizer. (continued on next page)

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	676303	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mirador	5857 Timbergate Dr Corpus Christi, TX 78414

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	09/07/24 Dignity; Respect at all times, permission to enter rooms and knocking first, not talking about residents to each other in the hall or elsewhere, keeping computers private, privacy especially when providing personal care-bathing, changing clothes or briefs or wound care, privacy bags on catheter bags. 12/20/24 Transfer Training; Proper use of mechanical lift-2 person at all times, sling straps must be double checked, how to maneuver the lift, resident safety is high priority-all instructions and education must be followed by each staff member. 09/07/24, 01/29/25, 03/04/25 Hand Hygiene; Done before providing care. The number one thing to help prevent spreading germs, everyone has to do it-no exceptions, you can use hand sanitizer unless you know your hands are dirty or if it's c-diff, then you have to use soap and water. Sanitize before and after going in and coming out of the room, if you touch anything in the room and are going to touch the resident or their belongings. You have to lather for at least 20 seconds and use the towel you dry your hands with to turn off the faucet. 02/27/25 Gait Belts; Labeled with each room number for the resident in that room only. They will be sanitized as needed. 09/07/24, 03/04/25 PPE; gowns, gloves, eye protection and face mask. Use it when you do peri care, catheter care, if there's a feeding tube, an IV line, any dressing changes, and isolation. First, you wash your hands, then put on the gown, then the mask, then the eye protection then the gloves last. To take it off, reverse the order. 03/31/25 Foley Catheter care; Clean the catheter and surrounding area skin each shift to prevent bacteria build-up. Drainage bag must always be below the level of the bladder to avoid back flow and always have a privacy bag on the reservoir. Bags should never be touching the floor or placed on the bed. Check for kinks in the tubing. Clean the catheter with every incontinent episode or after toileting. Notify the charge nurse if there are any concerns. 09/07/24 Peri Care; PPE, wash your hands before you start, have all your supplies ready so you don't have to step away from the bedside, keep the resident covered so they don't get cold or if someone walks in, change gloves before you go from clean to dirty, on ladies, wipe from top to bottom and inside to outside, document and let the charge nurse know if you find anything new. 09/07/24 C-Diff; highly contagious. Can cause nausea, vomiting, diarrhea and/or fever. Hand washing with soap and water is essential. 09/07/24, 04/12/25 Falls and Falls with Injury; Fall risk factors such as wet floors, not having non-slip shoes or socks, when they need to go to the bathroom, UTI's (urinary tract infections), some medications, weakness, thinking they can when they can't get up on their own, using 2-person assistance when indicated 04/22/25 Norovirus; highly contagious. Can cause nausea, vomiting, diarrhea and/or fever. Hand washing with soap and water is essential. CNA A's signature was noted on all in-services dated from 06/23/24 to 09/07/24 . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of CNA A's yearly competency skills dated 02/24/24 revealed he was competent to perform Infection Control/PPE, Fall Prevention, Handwashing, Peri Care, Foley Catheter care, Diet Textures, Transfers and Gait Belt, and N95 Fit testing. Record review of the facility counseling document dated 06/02/22, titled Understanding Job Expectations under Infection Control revealed CNA A was reported for not wearing PPE correctly or adequately during incontinent care with a resident. CNA A was reminded of Infection Control policies and handwashing procedures. Employee recently completed skills check off for handwashing and equipment sanitizing. CNA A will ensure to wear gloves and PPE properly with good handwashing skills when providing resident care. Random check offs will be completed to ensure this is being done correctly. Record review of the facility counseling documentation form dated 12/20/23, written warning for performance revealed CNA A on 12/19/23 and 12/20/23 left two different residents with foley catheters up in their chairs and left the premises at the end of his shift without emptying the 2 residents' foley catheters, even though he was told to do so. It was documented one of the resident's foley bag had 1,000 ml the first day and 800 ml the next day and she was crying with pain. CNA A was advised to do a final round on patients. Leaving patients up can cause breakdown and pain. Not emptying patient's foley bag is dangerous, can cause pain and also infection. Record review of the facility counseling document dated 08/14/24, titled Understanding Job Expectations revealed CNA A was reported for leaving his assignment without having resident's ready for breakfast, changed, etc. He was advised to follow care plans and CNA duties to better assist residents with care, skin integrity, and dignity while in their facility. Record review of the facility counseling document dated 09/02/24, titled Understanding Job Expectations revealed CNA A was reported for not using correct hand hygiene when providing resident care. Also noted at times not wearing proper PPE while providing resident care. A family member voiced concerns twice about a resident being left in his wheelchair and not laid down to bed or toileted after lunch. The resident was found on the 2 occasions with puddles of urine on the floor before 3 pm. CNA A was instructed to ensure to wear gloves while providing resident care and to ensure to use proper hand hygiene. CNA A was advised that gloves and hand hygiene were an important part of Infection Control because they protected both patients and healthcare workers from exposure to potentially infectious material. Gloves should be worn even if a patient seemed healthy and had no signs of germs. ICP nurse would be spot checking him to ensure he was performing tasks accordingly. He was told if he continued to have difficulty with not using proper hand hygiene or using PPE, it may lead up to disciplin1ry action and/or termination of employment. There were no other disciplinary actions documented in CNA A's personnel file. There was no documentation of CNA A's termination date. An email received from the present ADM stated, CNA A's termination was a progressive process. Our Administrator at the time spoke with him one on one following the incident. After this, we increased supervision of the care provided by providing spot checks. Then, we began to notice gaps in CNA A's performance, so we followed our companies progressive process and moved to term with his last day worked being 12/30/2024. Record review of nurse's notes dated 09/04/24 at 12:04 am revealed Antibiotic follow up: Resident #1 on Flagyl day 5 of 14 due to C. difficile in the stool. No adverse reactions noted, remains under isolation, continuing to monitor stools. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of nurse's notes dated 09/06/20 at 2:57 am: Resident #1 remains on contact isolation for C-diff and did have an explosive bout of loose/liquidy stool this shift it came out of brief and onto lines and clothing. Resident #1 had to have gown changed as well. Bowel sounds very active and an odor. Day 7 of 14 of Cipro. Afebrile (no fever) at 97.4 F. Record review of the PIR (Provider Investigation Report) dated 09/07/24 questions asked to CNA A by the previous ADM revealed: Why weren't you wearing required PPE (resident positive for C-Diff) answer: I just didn't think of it, she was very impatient and wanted to be changed right away. Why didn't you cover her up? answer: I was just grabbing the sheets from the closet, so I didn't plan on leaving her in that position, I was going to change her sheets right at that moment and continue care. Record review of the facility policy revised October 2018, titled, Policies and Practices-Infection Control. Policy statement: This facility's infection con1rol policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. Policy Interpretation 1. This facility's infection control policies and practices apply equally to all personnel .2. The objectives of our infection control policies and practices are to: a. Prevent, detect, investigate, and control infections in the facility. b. Maintain a safe, sanitary, and comfortable environment .c. Establish guidelines for implementing Isolation Precautions, including standard and transmission-based precautions. E. Maintain records of incidents and corrective actions related to infections. Record review of the facility policy revised February 2018, titled, Perineal Care Equipment and Supplies The following equipment and supplies will be necessary when performing this procedure: 5. Personal protective equipment (e.g., gowns, gloves, mask, etc.) Steps in the Procedure 2. Wash and dry your hands thoroughly. 5. Fold the sheet down to the lower part of the body. Cover the upper torso with a sheet. 6.Avoid unnecessary exposure of the resident's body. 7. Put on gloves. 9. Discard disposable items .10. Remove gloves and discard .11. Wash and dry hands thoroughly. 12. Reposition the bed covers .16. Wash and dry your hands thoroughly. Record review of the facility policy revised October 2023, titled, Handwashing/Hand Hygiene. Policy statement: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. 1. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. Indications for Hand Hygiene a. immediately before touching a resident; 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. 3. Wash hands with soap and water: a. when hands are visibly soiled; and b. after contact with a resident with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella and C. difficile. 5. The use of gloves does not replace hand washing/hand hygiene. Applying and Removing Gloves 1. Perform hand hygiene before applying non-sterile gloves. Record review of the facility policy revised October 2018, titled, Personal Protective Equipment. 4. A supply of protective clothing and equipment is maintained at each nurse's station. PPE required for transmission-based precautions is maintained outside and inside the resident's room. as needed. 6. Employees who fail to use personal protective equipment when indicated may be disciplined in accordance with personnel policies. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A Past Non-Complainace (PNC) at a second level was identified on 04/25/25. The non-compliance began on 09/07/24 and ended on 09/07/24. The facility had corrected the non-compliance before the investigation began on 04/11/25.