STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676313	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laredo Nursing and Rehabilitation Center	1701 Tournament Trail Dr Laredo, TX 78041

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50969 Based on observation, interview, and record review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care for 3 of 4 Residents (Resident's #87, #61 and #26) reviewed for care plans. The facility failed to have quarterly care plan and Interdisciplinary Team Meetings to review Residents #87, #61 and #26's care plans. This failure could place residents at risk for not receiving the required care. The Findings for Resident #87 included: Record review of face sheet revealed Resident #87 as a [AGE] year-old male with an original admitted [DATE], and a current admitted [DATE]. Record review of Resident #87's Quarterly MDS dated [DATE] revealed a BIMS score of 08, which indicated moderately impaired cognition. Record review of Care Plan Conference dated 7/2/24 revealed this as being the most recent care plan meeting for Resident #87. In an interview with the MDS Nurse on 1/8/24 at 3:08 PM, she stated the last care plan meeting was in July, so the care plan had not actually been reviewed or adjusted since July, and Resident #87 should have had another meeting in October or November. In an interview with the Social Worker on 1/8/25 at 3:20 PM, she stated Resident #87 had a lot of back and forth to the hospital, and there was a lot of conversation with the responsible party, but the most recent care plan meeting she could find that was an actual care plan meeting was in July 2024. She stated she typically called the family or sent an email regarding the care plan meeting. Social worker stated that she would call the family right now, and notify the other staff that she was scheduling a care plan meeting for this Resident #87. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON, 1/8/25 at 3:50 PM, he stated the Inter Disciplinary Team included: the social worker, the activities director, different nursing staff, the director of nursing, and sometimes the administrator attends care plan meetings. He stated the social worker is the one who coordinates the meetings, and she typically notifies the responsible party by phone, then lets staff know when the meeting is. The MDS nurse typically updates the care plans. Meetings are held quarterly, or every three months, or with a change in condition. This resident's last care plan meeting was 7/2/24, and he should have had another one in October 2024. The Findings for Resident #61 included: Record review of Resident #61's face sheet revealed an [AGE] year-old-male with initial admission of 3/5/21, and a current admission of 1/1/25. Record review of Resident #61's nursing home discharge MDS dated [DATE] revealed no BIMS score listed for this resident. MDS revealed resident is coded to have a memory problem and cognitive skills for daily decision making is coded as severely impaired. Record review of Resident #61's care plan revealed that prior to 1/6/25, the most recent care plan conference for Resident #61 was in August of 2023. In an interview with the MDS Nurse on 1/9/25 at 9:10 AM, she stated she did not know or understand why the resident was showing the most recent care plan meeting to have been in August of 2023, but she would get with the SW and find out what was going on. She stated she cannot find any other care plan conferences or notices for a care plan meeting, but they did have a meeting with the responsible party yesterday regarding transfer to a rehab for cardio-pulmonary rehab. In an interview with the Human Resources Director, 1/9/25 at 10:15 AM, she stated she is the one who sends out the notices of resident discharges and transfers to the RPs, but regarding notifications about care plan conferences or meetings, those notices are sent by the social worker. The Findings for Resident #26 included: Record review of Resident #26's face sheet revealed a [AGE] year-old male with an original admitted [DATE], and a current admitted [DATE]. Record review of Resident #26's quarterly MDS dated [DATE] revealed resident has a BIMS of 11, which revealed moderately impaired cognition. Record review of Care Plan Conference date 7/19/2021 revealed this was the most recent care plan conference or care plan meeting for this resident. In an interview with the Social Worker, 1/8/25 at 3:20 PM, she stated she typically called the family or sent an email regarding the care plan meetings and is not sure why she cannot find a recent care plan conference or meeting for Resident #26. She stated the meetings should be done quarterly or with a change of condition. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON, 1/8/25 at 3:50 PM, he stated the Inter Disciplinary Team included: the social worker, the activities director, different nursing staff, the director of nursing, and sometimes the administrator attends care plan meetings. He stated the social worker coordinates the meetings, and she typically notifies the RP by phone, then lets staff know when meeting is. The MDS nurse typically updates the care plans. Meetings are held quarterly, or every three months, or with a change in condition. This resident's last care plan meeting was 7/2/24, and he should have had another one in October. In an interview with the MDS Nurse on 1/9/25 at 9:10 AM, she stated she did not know or understand why Resident #26 was showing the most recent care plan meeting to have been in 2021, but she would find out what is going on. She stated she could not find any other care plan conferences or notices for a care plan meeting for this resident since the 2021 meeting.

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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** 44748 Based on observations, interviews, and record review, the facility failed to ensure residents who needed respiratory care was provided such care, consistent with professional standards of practice, person centered care plans, and resident's goal and preferences for 2 of 2 residents (Resident #13 and #44) reviewed for respiratory care. 1. The facility failed to ensure Resident #44's oxygen was provided continuously. 2. The facility failed to ensure Resident #13's respiratory exercises were consistent with the physician's orders. These failures could place residents who receive respiratory care at risk of developing respiratory complications and a decreased quality of life. Findings included: 1. Record review of Resident #44's face sheet dated 07/18/24 indicated a [AGE] year-old female with an original admitted [DATE]. Diagnoses included heart failure, respiratory failure, mitral valve insufficiency (a weak valve in the heart), atrial fibrillation, a pacemaker, heart disease, high blood pressure, dementia, anxiety, and depression. Record review of Resident #44's quarterly MDS report dated 10/23/24 revealed a BIMS score of 6 indicating severe cognitive impairment. She required moderate assistance with toileting and showering, supervision with lower body dressing, footwear, and personal hygiene, and set-up with upper body dressing, oral hygiene, and eating. She utilized a wheelchair and could self-propel short distances. She was frequently incontinent of bladder and always incontinent of bowel. She required continuous oxygen therapy and was on hospice care. Record review of Resident #44's most recent care plan dated 01/06/25 revealed she was at risk for experiencing shortness of breath, she removed oxygen at times, turned off her oxygen concentrator, and needed reminders to put them back on. Created on 07/18/24 and revised 01/07/25. Interventions included o Alert my nurse for concentrator alarms and/or if my oxygen tank needs to be changed. Date Initiated: 07/18/2024. Provide oxygen as ordered/recommended by my physician. Created on 07/18/24. Record review of Resident #44's active physician orders dated 07/19/24 indicated Continuous Oxygen at 3 liters per nasal cannula every shift. During an interview and observation of Resident #44 on 01/07/25 at 1:49 pm, she said she wore oxygen and had to have it. Resident #44's oxygen concentrator was turned off. She said she did not know why it was off. There was a portable oxygen tank in Resident #44's room at the end of her bed with tubing on it. The oxygen tank registered empty. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN J on 01/07/25 at 1:55 pm, she said Resident #44's family had taken her on a stroll inside the facility. The portable oxygen tank had been left on and was empty. She said she needed to educate the CNAs and the family and monitor Resident #44 whenever she was out of her room. LVN J said she called Resident # 44's family member on 01/07/25 at 2:10 pm and she told her she came for lunch with Resident #44. She said the family member took her from her room without oxygen around noon and was gone for about 30 minutes then returned without reconnecting it. LVN J said Resident # 44 and her family member usually stayed in Resident #44's room to visit. She said she was glad Resident #44 did not suffer any injuries related to not having her oxygen on because she could have gone in to cardiopulmonary arrest. In an interview with the DON on 01/08/25 at 4:28 pm, he said the nurses were responsible for maintaining, providing, and administering oxygen and related therapies such as incentive spirometry and nebulizer treatments. He said Resident #44 was on continuous oxygen for a history of heart failure and chronic respiratory failure, and she will not get better. He said Resident #44's oxygen was sustaining-if she was without it for an hour or so, it could have a bad effect such as she could have an increase in shortness of breath (hypoxia) and ultimately have cardiopulmonary arrest. He said her code status was DNR and she was on hospice. He said it would be a big deal if someone forgot to turn oxygen on. He said the family should notify the nurse if they wanted to move Resident # 44 from her room with portable oxygen. He said the family should be telling the nurses upon her return so the nurse could reconnect her to the oxygen concentrator in her room because the family would not be familiar with the equipment. He said if the family did not tell the nurse, it was not ok. He said it was odd for the nasal cannula to be on the resident and the concentrator to be off. He said it was either nursing error or family error. He said the responsibility fell on the nurses to educate families and for him to educate the nurses. He said in the time he had been working at the facility, (Nov. 1, 2024), he was unaware of any training regarding educating nurses and families on oxygen and equipment for it. He said it was ultimately the responsibility of the bedside nurse. He said portable oxygen tanks were checked daily, but he had not seen a log for refilling or checking the stored oxygen tanks. In a phone interview with the family member on 01/09/25 at 7:10 pm, she said she brought Resident #44 a taco on 01/07/25 for lunch. She said when she arrived at the facility, Resident #44 was sitting in her wheelchair at the entrance of her room, facing the hallway. She said Resident #44 was not wearing oxygen. She said since Resident #44 was already at her doorway, they decided to go to the common area to eat, which they did. She said Resident #44 got tired after she ate and wanted to go back to her room. She said she helped Resident #44 back to bed and put her nasal canula from the concentrator on her but did not realize it was off. She said the nurses usually set up the portable oxygen tank whenever Resident #44 left her room, but this time, they left from the doorway, so she did not think about it. She said she would be more careful next time because she visited Resident #44 nearly daily and never had this issue that she knew of. 2. Record review of Resident #13's face sheet dated 10/16/24 indicated an [AGE] year-old female with an original admitted [DATE]. Diagnoses included pneumonia, Parkinson's (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), diabetes, kidney disease, Dementia, and high blood pressure. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #13's quarterly MDS report dated 10/24/24 revealed a BIMS score of 8 indicating moderate cognitive impairment. She had verbal behaviors/symptoms directed toward others. She required substantial assistance with lower body dressing, and footwear, moderate assistance with toileting, showering, upper body dressing, and personal hygiene, and supervision with oral hygiene and eating. She utilized a motorized wheelchair. She was always incontinent of bladder and bowel. Respiratory therapy was received daily. Record review of Resident #13's active physician orders dated 12/15/24 indicated change 02 and/or nebulizer tubing every week. Oxygen at 2 Liters per nasal cannula as needed for Shortness of breath . dated 05/04/24. Incentive Spirometer Treatment Order: Steps: Sit up straight as much as possible. Encourage and demonstrate inhaling & exhaling 2-3 times Place device in patient's mouth, instruct to close lips on mouthpiece. Instruct to slowly inhale raising indicator as high as possible as marked goal, then slowly exhale. Repeat respiratory exercises of incentive spirometer deep breathing exercises x 3-5 times reps 2 times daily dated 08/16/24 and 05/04/24. Record review of Resident #13's most recent care plan dated 12/25/24 revealed I am at risk for experiencing shortness of breath. Recent HX of RSV w\residual effects Date Initiated: 10/24/2024 Created on: 01/20/2024 o I will tolerate the use oxygen and treatment without any signs of distress or decline in condition through my next review date. Date Initiated: 10/24/2024 Created on: 01/20/2024 o Administer my respiratory treatments / nebulizers as ordered by my doctor Date Initiated: 01/20/2024 Created on: 01/20/2024 o Alert my nurse for concentrator alarms and/or if my oxygen tank needs to be changed. Date Initiated: 01/20/2024 Created on: 01/20/2024 Revision on: 10/24/2024 o Provide oxygen as ordered/recommended by my physician. Date Initiated: 01/20/2024 Created on: 01/20/2024 o Administer oxygen as recommend by physician. Follow community's protocols for changing tubing and filter cleaning as indicated. Date Initiated: 01/20/2024 Created on: 01/20/2024 o Refer to skilled therapy services for strengthening, mobility as well as oxygen conservation techniques as indicated. Date Initiated: 01/20/2024 Created on: 01/20/2024. Record review of Resident #13's MAR dated 01/01/25-01/08/25 revealed Incentive Spirometer Treatment Order: Steps: Sit up straight as much as possible. Encourage and demonstrate inhaling & exhaling 2-3 times Place device in patient's mouth, instruct to close lips on mouthpiece. Instruct to slowly inhale raising indicator as high as possible as marked goal, then slowly exhale. Repeat respiratory exercises of incentive spirometer deep breathing exercises x 3-5 times reps 2 times daily, two times a day for Therapy Respiratory Exercise -Start Date- 08/16/24. The document indicated the IS treatment was administered as ordered. The same order was repeated with the date of 05/04/24 and with all dates initialed as given. During an interview and observation of Resident #13 on 01/07/25 at 1:17 pm revealed she had no oxygen in her room or an incentive spirometer (a hand-held medical device used to improve the function of the lungs). She said she had not used oxygen or the IS since sometime in June 2024. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 01/08/25 at 4:28 pm, he said nursing checked the charts and the physician reviewed their orders monthly. He said the orders for oxygen and incentive spirometry for Resident #13 had been active since 01/01/24; 1 year ago. He had no answer as to why these orders were still in the chart as active. He said the ADONs should have updated the orders. The ADON had worked at the facility since 06/21/22. He said Resident #13's oxygen should have been on because she could have gone in to cardiopulmonary arrest. In an interview and observation with LVN H on 01/09/25 at 3:37 pm, he identified his initials on the MAR and said he administered IS to Resident # 13 this week as ordered. He said the IS was in Resident # 13's bedside cabinet. Observation of Resident # 13's bedside cabinet with LVN H at 3:41 pm revealed no IS in any of the drawers or in the room. He said he had no idea where the incentive spirometer was. He said providing respiratory care would not have been ordered if the resident did not need it to keep them from getting pneumonia. In an interview and observation with LVN I on 01/09/25 at 3:58 pm, she identified her initials on the MAR and said she administered IS this week to Resident #13 as ordered. Observation of Resident #13's room, bedside table, and chest of drawers revealed no IS. She said she did not know why it was not in the room. She said respiratory care for Resident #13 was necessary to keep her lungs working better and prevent pneumonia. Record review of the facility policy revised 01/2023, titled Oxygen Administration revealed under compliance guidelines: A resident receives oxygen therapy when there is an order by a physician.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50039 Based on observations, interviews, and record review the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 8% based on 2 errors out of 25 opportunities, which involved 1 of 4 residents (Resident #38) reviewed for medication errors. - RN B failed to administer medication as ordered to Resident #38 by preparing only one 25mg tablet of sertraline instead of three 25mg tablets as ordered. - RN B failed to administer medications as ordered to Resident #38 by not preparing a 20mg tablet of isosorbide dinitrate as ordered. These failures could place residents receiving medication at risk of inadequate therapeutic outcomes. The findings included: Record review of Resident #38's face sheet dated 01/08/25 revealed a [AGE] year-old female with an admitted [DATE]. Pertinent diagnoses included vascular dementia, heart failure, and major depressive disorder. Record review of Resident #38's Comprehensive MDS assessment section C, cognitive patterns, dated 12/27/24 revealed a BIMS score of 15 (cognition intact). Record review of Resident #38's care plan revealed the focus I have heart disease. I am at risk for associated cardiac complications such as chest pain, SOB, fatigue, dizziness, poor endurance/activity intolerance and edema initiated on 01/03/25. Interventions listed for the problem included Administer my medications as ordered by my physician initiated on 01/03/25. Further record review revealed the focus I require psychotropic medications and I am at potential risk for side effects r/t my medication regimen initiated on 01/03/25. Interventions listed for the problem included Administer medications as ordered and monitor for potential side effects and notify MD/NP as indicated & ensure that resident/family are educated r/t the potential side effects, and risks associated with psychotropic medications and obtain consent for medication use initiated on 01/03/25. Record review of Resident #38's order summary revealed an active order dated 12/18/24 for Zoloft Oral Tablet 25 MG (Sertraline HCL) Give 3 tablets by mouth one time a day for depression 3 tabs = 75mg. Further record review reflected an active order dated 12/18/24 for Isosorbide Dinitrate Oral Tablet 20 MG (Isosorbide Dinitrate) Give 1 tablet by mouth one time a day for heart failure. During an observation on 01/08/25 at 8:04 AM, RN B prepared medications for Resident #38 during medication pass. RN B only popped one 25mg tablet of sertraline out of the blister package for administration and did not pop any 20mg isosorbide dinitrate tablets out of the blister package. After RN B finished gathering all morning medications for Resident #38, this state surveyor asked RN B if he had all of Resident #70's medication in the cup, to which RN B stated yes. This state surveyor asked RN B to check the sertraline and isosorbide dinitrate orders again and RN B then caught his errors. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with RN B on 01/08/25 at 8:06 AM, RN B stated he had not yet clicked save on his MAR to signify he was completed. RN B stated he remembered answering yes to being asked if he had finished popping all the medication out of the blister packages. RN B stated if a resident did not receive their isosorbide dinitrate tablet they could get elevated blood pressure. RN B stated taking 25mg of sertraline instead of the prescribed 75mg may cause the resident to experience symptoms of depression. During an interview with the DON on 01/08/25 at 4:04 PM, the DON stated it was important for a resident to receive all their prescribed medications to stop the progression of disease, stabilize the disease process, and to prevent bad outcomes. The DON stated if a resident did not receive their full dose of sertraline they could have issues with cognition, mental regression, and mental distress. The DON stated if a resident missed their dose of isosorbide dinitrate they may experience symptoms of heart failure. During an interview with the ADON on 01/09/25 at 3:36 PM, the ADON stated residents should always receive the medications prescribed to them unless they refuse them. The ADON stated antidepressants were important to be taken at a certain time and dose because their serum levels could be thrown off if they did not. The ADON stated medications that lower blood pressure were important to help keep it controlled. The ADON stated if a resident's blood pressure became too elevated, they could have a stroke. Record review revealed the facility policy titled Medication Administration implemented March 2019 and revised January 2023 stated the following: Verify the medication label against the medication sheet for accuracy of drug frequency, duration, strength, and route. The nurse/medication aide shall be responsible to read and follow precautionary or instructions on prescription labels. Administer medications as ordered by the physician. Routine medications shall be administered according to the established medication administration schedule for the community.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50039 Based on interviews and record review, the facility failed to maintain clinical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident #70) of 10 residents reviewed for accuracy and completeness of clinical records. The facility failed to accurately document in the treatment administration record when Resident #70 received their dose of vancomycin (antibiotic) on 01/05/25. This failure could result in residents' records not accurately reflecting the administration of medications and could result in further error and a decline in heath. The findings included: Record review of Resident #70's face sheet dated 01/08/25 revealed a [AGE] year-old female with an initial admitted [DATE] and a current admitted [DATE]. Pertinent diagnosis included enterocolitis due to Clostridium Difficile not recurrent (Inflammation of the small and large intestine caused by the bacteria Clostridium Difficile). Record review of Resident #70's Discharge MDS assessment section C, cognitive patterns, dated 11/19/24 revealed a BIMS score of 7 (severe impairment). Record review of Resident #70's care plan revealed the focus At risk for infection or recurrent/chronic infection r/t compromised medical condition: Actual infection: C-Diff 1/3/24 [sic]-Vancomycin HCL Oral Capsule 125 MG (Vancomycin HCL). Give 1 capsule by mouth four times a day related to enterocolitis due to clostridium difficile, not specified as recurrent for 10 days initiated on 01/03/25. Interventions listed for the problem included: - Report changes in condition to MD as clinically indicated. - Administer medication and/or antibiotic as per MD orders. - Monitor vital signs as indicated. - Isolation Precautions as clinically indicated. - Coordinate and schedule appointments with physician as indicated. Record review of Resident #70's order summary revealed an active order dated 01/03/25 for Vancomycin HCL Oral Capsule 125 MG (Vancomycin HCL). Give 1 capsule by mouth four times a day related to enterocolitis due to clostridium difficile, not specified as recurrent for 10 days. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #70's MAR on 01/08/25 revealed the order for Vancomycin HCL Oral Capsule 125 MG (Vancomycin HCL) Give 1 capsule by mouth four times a day related to enterocolitis due to clostridium difficile, not specified as recurrent for 10 days was only administered 3 times on 01/05/25 with documentation absent for the 4th dose. An interview with Resident #70 was attempted on 01/07/25 at 4:37 PM, but Resident #70 refused the interview. In an interview with the DON on 01/08/25 at 4:04 PM, the DON stated because the MAR was blank, there could be multiple things that happened including the resident refused the medication, the patient was asleep, or the nurse could have administered the medication but not recorded it. The DON stated if the medication was refused by the resident then it should be documented in the MAR. The DON stated missing a dose of vancomycin during a C. Diff infection could cause the infection to become worse or help create a super bug. The DON stated it was important to document medications in case they needed to reach out to the doctor to change the antibiotic. The DON stated the nurse that administered the medication should sign the MAR. In an interview with the ADON on 01/09/25 at 3:36 PM, the ADON stated it looked like Resident #70 did not receive her 4th dose of vancomycin on 01/05/25 because one of the boxes for that day was blank. The ADON stated if the resident refused the medication, it should be documented. The ADON stated it was important to document medication and treatments so they could know that it was given. The ADON stated the doctor would need to be notified if a dose of medication was missed. The ADON stated the person that administered the medication should sign the MAR. Record review revealed the facility policy titled Medication Administration implemented March 2019 and revised January 2023 stated the following: Record the results of medications administered as necessary. Initial the electronic administration record after the medication is administered to the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676313	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laredo Nursing and Rehabilitation Center	1701 Tournament Trail Dr Laredo, TX 78041

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 50969 Based on observations, interviews and record reviews the facility failed to maintain an infection control and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections for 3 of 5 residents (Residents #53, #44, and #79) observed for infection control practices. CNA D, E, B, and A failed to properly change gloves, as well as wash or sanitize hands when moving from a dirty area to a clean area when incontinent care was observed for Residents #53, #44, and #79. These failures and deficient practices could place residents at risk for cross contamination and infection. Findings included: During observation of incontinent and peri care on three separate occasions on 1/8/25, on three separate residents (Residents #53, #44, and #79) revealed all CNAs performing the same improper techniques on all three different observations of incontinent and peri care. The CNAs would use a single wipe multiple times, folding over and over until bowel movement could be seen all the way around the inside and the outside of the wipes, to include against the CNAs gloves where the wipes were being held. The dirty gloves that held the dirty wipes were used to reenter the package of wipes to continue to grab clean wipes. The dirty gloves were used to grab the container of barrier cream ointments that were being used for the residents. The dirty gloves were also used to touch the resident's clothing, resident's blankest, as well as open the privacy curtain in the resident's rooms. In an interview with CNA D on 01/08/25 at 9:12 AM, she stated she has worked here 10 -11 months, and this was typical of how she performed incontinent care. She stated she had some training here in the beginning, as well as at a previous employment. According to CNA - D, the process for incontinent care was to do rounds every 2 hours, wash hands, put on gloves, ask resident if it was okay to change them, start wiping the area, and have them roll or turn and clean the other area. Then, once areas were wiped and clean, place a clean brief on. She stated she did not change the gloves if she did not see them dirty, but she did change gloves between patients. In regard to the wipes, they may not have enough in the supply room sometimes, so they tried to conserve the wipes during care. She stated no one ever told them to do this, they just tried to conserve the wipes until it is fully stocked again. CNA - D stated we do have enough wipes to do the job, but sometimes they get low, and we have to wait for someone to get here during the day with the key to restock the supplies. Housekeeping has the key, and she has seen her restock the supplies. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with CNA - E on 01/08/25 at 9:22 AM, CNA - E stated she has worked here a year, and the process she used for incontinent care included to knock on the door, wash her hands, don gloves, get supplies and start peri-care. She stated she uses a pair of gloves for peri care and changed gloves for backside or incontinent care for bowel movements, as well as if they got soiled. If she wiped, and the wipe was soiled, she would throw it away, but only if she could visibly see that it was soiled. She stated it was not okay to keep folding the wipe with it covered in feces. CNA - E also stated it could contaminate the package to stick the soiled glove back into the package to get clean wipes out, as well as transfer feces from resident to resident and room to room when touching packages and other items with dirty gloves. She stated she was not trained to do peri or incontinent care the way it was performed this morning. She was trained by another CNA that was no longer here. CNA - E stated that sometimes they run short on supplies in supply closets, but they have access via housekeeping to get to outside building with extra supplies if needed. Housekeeper and administrator have the key to the shed out back with extra supplies. She has never had to ask them to go get supplies for her because they have never been that low before the closets get restocked. CNA - E stated the lead housekeeper is responsible for keeping the supplies in the supply closets in the building stocked. In an interview with the DON on 01/08/25 at 9:26 AM, the DON stated they have been monitoring and trending if the stock was running low or where it was dispersed. The Director of Education has done in-services on incontinent care. He monitors the in-services, as well as makes recommendations on in-services. In an interview with CNA - B on 01/08/25 at 9:54 AM, CNA - B stated she has worked here since September of this year and the technique she followed was to knock on the door, greet the resident, introduce herself, wash her hands, explain the procedure to the resident, grab supplies, and perform incontinent care. First, she cleaned the front, then after that, she changed gloves and cleaned the backside. She would check to see if she needed to clean any further. She did not change gloves after they get soiled. She stated she did not remember the last in-service or training on incontinent care. She stated she understood why hands should be clean and dirty gloves changed, so that she was not causing a cross contamination between residents. In an interview with CNA - A on 01/08/25 at 2:41 PM, CNA - A stated she had worked here for 2 weeks, but she had been a CNA since May 2024. Her first three days on the job she followed, watched and learned from other CNAs. She did not recall any in-services or trainings on incontinent care. She stated the incontinent care procedure or technique she used was to go in the room, check for gloves and diapers, gathered supplies, and told resident that she was going to change them. She pre-pulled the wipes based on how many she thought she would need, took the brief off and cleansed the front with maybe 3 different wipes, tucked it into the diaper, took off the old diaper and put on new diaper, then wiped the backside. She did not change gloves or clean hands when going from dirty to clean area or brief. She stated she understood that if she did not change out her gloves she could contaminate others and cause infection or sickness. In an interview with the DON on 1/8/2024 at 4:25 PM, he stated improper peri or incontinent care could lead to urinary tract infections, other infections, cross contamination, and, given their age and co-morbidities, could put these residents at a higher risk. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with HK - F on 1/9/24 at 12:25 PM, she stated she had a key to the storage building out back and the supply closets inside. The storage building had incontinent supplies to include gloves, wipes, briefs and pull ups. Housekeeping are the ones who stocked supply closets, and CNAs distributed to other areas. She stated they stocked supply closets every three days by counting what is in the closet and taking an inventory. Maintenance, the Administrator, and housekeeping all have a key to the building or shed with the extra supplies in it. It was rare that it ever got low because she always checked the closets to make sure they were stocked. She stated the CNAs complained about not having supplies, but they also hoard supplies in cabinets and rooms. In an interview with the Administrator on 1/9/24 at 12:30 PM, he stated the CNAs called him at night or on the weekends in the past if their supplies ran low, and he gave them access to his office via the key code where the keys for the building out back are located. He stated they always had access to the storage building if needed, and they knew they could always call if needed. Record review of the facility's Infection Control Policy, Revised 2024, page 1, under Surveillance, revealed the infection preventionist is responsible for gathering and interpreting surveillance data, and the infection preventionist will conduct ongoing surveillance for healthcare associated infections and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections, and detecting unusual pathogens with infection control implications. Prevention of infection include identifying possible infections or potential complication of existing infections, instituting measures to avoid complications or dissemination, educating staff and ensuring they adhere to proper techniques and procedures. Page 4, under Prevention of Infection, educating staff and ensuring that they adhere to proper infection prevention and control practices when performing resident care activities as it pertains to his/her role responsibilities and situation. Page 6, under Glove and Handwashing section, revealed in addition to wearing gloves as outlined under standard precautions, wear gloves during the course of caring for a resident, change gloves after having contact with infective material that may contain high concentration of microorganisms (fecal material and wound drainage). Record review of infection surveillance monitoring for October 2024, November 2024 and December 2024 revealed 45 urinary tract infections. Record review of in-services dated 10/4/24 and 11/21/24 revealed staff were in-serviced over proper showering and peri-care due to residents were found improperly showered, bathed, and peri-care not properly performed. It was also in-serviced that rounding and changing was done every 2 hours, even if residents were continent or have foleys. Peri-care must be done every shift for everyone.