

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 05/28/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676316	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER High Hope Care Center of Brenham		STREET ADDRESS, CITY, STATE, ZIP CODE 401 East Blue Bell Road Brenham, TX 77833	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on observation, interviews, and record reviews, the facility failed to treat residents with respect and dignity and care for them in a manner and in an environment that promoted maintenance or enhancement of their quality of life for three (Resident # 33, Resident # 49 and, Resident #162) of seven residents reviewed for resident rights. 1. The facility failed to ensure Resident #33 and Resident #49 were served their lunch tray at the same time as other residents that were seated at the same table. 2. The facility failed to treat Resident #162 with respect and dignity when the staff was standing while feeding Resident #162. This failure placed residents at risk of a diminished quality of life and embarrassment. Findings included: 1. Review of Resident #33 face sheet revealed a [AGE] year-old female admitted on [DATE] with diagnoses of unspecified dementia (clinical syndrome that describes a group of symptoms that impact memory, thinking, and social abilities), muscle weakness, and unspecified lack of coordination (a condition where a person has difficulty coordinating their movements). Review of Resident #33's undated care plan revealed interventions that Resident required total assistance with meals and was unable to feed self. Review of Resident #49 face sheet revealed an [AGE] year-old man admitted on [DATE] with diagnoses of unspecified dementia, anxiety, and senile degeneration of brain. Review of Resident #49 undated care plan revealed Resident #49's ADL self-performance varies. Resident interventions included total assist with eating. Observation on 01/07/2025 at 12:42 PM revealed CNA H served Resident #41 her meal tray. Observation on 01/07/2025 at 12:43 PM revealed CNA H served Resident #48 her meal tray. (continued on next page)		

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

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

FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 676316	If continuation sheet Page 1 of 36
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 01/07/2025 at 12:49 PM revealed Resident #49 and Resident #33 did not have their meal tray. Resident #49 and Resident #33 were seated at the same dining table as Resident #41 and Resident #48. Observation on 01/07/2025 at 12:48 PM revealed Resident #7 was served her tray and was seated at a different table . Observation on 01/07/2025 at 12:51 PM revealed Resident #17 was served her tray. Observation on 01/07/2025 at 12:52 PM revealed CNA H asked Resident #17 if she was ready to eat as she sat down to assist the resident with eating. Further observation revealed Resident #49 responded yes from the other dining table. Observation on 01/07/2025 at 12:54 PM revealed hospitality aide J sat to feed Resident #49. Observation on 01/07/2025 at 12:55 PM revealed Resident #33 sat without her tray while all other residents at her table had been served. Observation on 01/07/2025 at 1:05 PM revealed Resident #33 still had not been served her tray. Observation on 01/07/2025 at 1:10 PM revealed Resident #33 still had not been served her tray. Resident's tray sat on the dining cart with her name on the meal slip. During an interview on 01/09/2025 at 11:01 AM, hospitality aide J stated that she usually served residents who ate in their rooms first. She stated when trays were served in the dining room, residents who were able to feed themselves were served first and then residents who needed assistance with feeding. She sated it was not okay for residents to sit there when everyone else at their table is eating. She stated she was aware Resident #33 sat without being fed. She stated that it was usual for a resident who needed assistance with feeding being left to wait to eat. During an interview on 01/09/2025 at 11:15 AM, CNA E stated that Resident #33 and Resident #49 required assistance with feeding. She stated that residents who could feed themselves get their trays first and then the residents who need assistance are given their trays. She stated that residents who need assistance sit at different tables. She stated residents were supposed to get their trays at the same time if they are sitting at the same table. During an interview on 01/10/2025 at 9:20 AM the DON stated all residents sitting at the same table were expected to be served first before serving residents at another table. She stated if a resident or residents waited 15 minutes or longer after their table mates received their meal tray, this was too long for the other residents to wait before they received their meal. She stated this was against resident rights and the resident's dignity. She stated if a resident watched another resident eat at least 15 minutes this could affect the resident self-esteem due to feeling they was not going to get any food. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #162's face sheet dated, 01/08/2024, reflected a [AGE] year-old male admitted on [DATE] with diagnosis of unspecified dementia, moderate, with other behavioral disturbance (a person with illnesses that affect a person's thinking, memory, reasoning, mood and/or behavior), unspecified glaucoma (damage of the eyes which can lead to vision loss or blindness), and senile degeneration of the brain (cause a gradual decline of cognitive abilities such as the person's inability to recall information and to properly judge a situation). Record review of Resident #162's MDS Admission Assessment was in progress. Record review of Resident #162's Baseline Care Plan, dated 12/27/2024, reflected Resident #162 required substantial/maximal assistance (helper does more than half the assistance) with eating, upper body assistance, and transfers. Resident #162 had poor cognition. He had dietary risks such as: risk for swallowing and chewing problems. Observation on 01/07/2024 at 12:15 PM, LVN C delivered Resident #162's tray to his table. She set up Resident #162's tray and stood partially behind him and at his side. LVN C was not facing Resident #162 or was not completely standing on the right side of him. LVN C began feeding the resident at an angle from the back to side of him. Resident #162 was turning his head and was not able to locate the utensil when LVN C asked Resident #162 to open his mouth for his lunch. He became agitated when LVN C would attempt to feed him. LVN C stood approximately 10 minutes when feeding Resident #162. LVN C stated to Resident #162 she would get a chair and sit and feed him. LVN C sat in chair and faced Resident #162 and he was able to open his mouth when she was feeding him without being cued. Resident #162 decreased his agitation during feeding after LVN C sat in the chair and faced him. In an interview on 01/07/2024 at 12:50 PM LVN C stated she had been in serviced to always sit when feeding a resident. She stated she made a mistake when she stood and fed Resident #162 for several minutes before she obtained a chair and sat where he could see her. LVN C stated Resident #162 was not able to see her or the utensil where she was standing. She stated she was not standing completely at his right side. LVN C stated part of her body was behind him. She stated she did not introduce herself or explain what was on his plate. LVN C stated this was a dignity issue for someone to stand and feed a resident. She stated he was agitated when she was standing and feeding him. LVN C stated his agitation decreased when she sat in a chair, faced him, and fed him. In an interview on 01/07/2024 at 1:10 PM the Corporate Nurse stated all staff were expected to sit and face the resident when feeding any of the residents. She stated it was a dignity issue if staff stood over a resident when feeding and there was a potential the resident may have difficulty with swallowing the food if they had dysphagia (difficulty with swallowing). In an interview on 01/10/2024 at 9:20 AM, the DON stated she required all staff to sit when feeding a resident. She stated this could affect a resident ability to see the utensil if a staff was feeding at an angle. The DON stated it was a dignity issue for the resident if someone was standing during feeding. She stated staff had been in-service to sit in a chair and face the resident when a resident required assistance with eating. In an interview on 01/10/2024 at 9:45 AM CNA I stated she had been in serviced on feeding residents. She stated all staff was expected to sit in a chair and face the resident during feeding. CNA I stated it was a resident right issue when staff stood and fed a resident. She stated it was a possibility a resident may become embarrassed for someone to stand over them when feeding their meal. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Facility's Policy on Quality of Life- Dignity, revised in August 2009, reflected Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Residents shall be treated with dignity and respect at all times. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. 42600		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on observation, interview, and record review, the facility failed to ensure the resident's right to a safe, clean, comfortable, and homelike environment for 4 of 9 residents reviewed for environment (Residents #7, #22, #26 and #46). A) The facility failed to ensure Resident #7's wheelchair was clean. B) The failed to ensure Resident #22 and Resident #26's wheelchairs were maintained. C) The facility failed to ensure Resident #46's room was at a comfortable temperature on 01/07/2025 and 01/08/2025 and failed to ensure a broken window in his room was repaired. These failures placed residents at risk of discomfort and diminished quality of life. Findings included: A) Review of Resident #7's face sheet revealed a [AGE] year-old female admitted on [DATE] with diagnoses of Alzheimer's disease (a brain disorder that gradually destroys memory and thinking skills, and eventually the ability to perform daily tasks), mood disorder (a mental health condition that causes a person's mood to be persistently disturbed, leading to changes in their emotional state), dementia (a general term for a group of brain conditions that cause a decline in mental abilities) and other schizoaffective disorders (a rare mental illness that combines symptoms of schizophrenia and a mood disorder). Review of Resident #7's quarterly MDS dated [DATE] revealed the BIMS were not completed due to resident being rarely understood. Further reviewed revealed Resident #7 normally used her wheelchair. Review of Resident #7's undated care plan revealed Resident #7 had long and short-term memory deficits that impaired decision-making abilities and required her to need cues and supervision, goal included to have needs anticipated. B) 2. Review of Resident #22's face sheet revealed a [AGE] year-old-male admitted on [DATE] with diagnoses of unspecified dementia (a diagnosis given when a person has dementia but it can't be classified as a specific type), mild cognitive impairment (a condition that causes people to have more memory or thinking problems than others their age), and type 2 diabetes (a common disease that occurs when the body doesn't use insulin properly, resulting in high blood sugar levels). Review of Resident #22's annual MDS dated [DATE] revealed resident normally used his wheelchair. Further review revealed Resident #22 had a BIMS score of 09 which indicates moderate cognitive impairment. Review of Resident #22's undated care plan revealed Resident #22 was at risk for skin breakdown due to impaired mobility with a goal that resident will be free from avoidable skin breakdown. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #26's face sheet revealed a [AGE] year-old male admitted on [DATE] with diagnoses of other symbolic dysfunctions (disorder that affect a person's ability to perceive or perform certain activities), vascular dementia (a type of dementia that occurs when blood flow to the brain is disrupted, damaging brain tissue and impairing memory, thinking, and behavior), and aphasia (a language disorder that affects a person's ability to understand and express language, as well as read and write). Review of Resident #26's quarterly MDS dated [DATE] revealed Resident normally used wheelchair. Further reviewed revealed Resident had a BIMS score of 10 which indicated moderate cognitive impairment. Review of Resident #26's undated care plan revealed Resident #26 was at risk for skin breakdown due to wheelchair mobility, goal included Resident will have minimal complications with skin breakdown through the next review date. During an interview on 01/08/2025 at 9:03 AM, Resident #26 stated that his seat bothered him when he was sitting in it and it had scratched him in the past. Observation and interview on 01/08/2025 9:43 AM revealed Resident #22's arm rest on right wheelchair was cracked. Review #22 denied any issues with the arm rest scratching him. Observation on 01/09/2025 at 12:10 PM revealed Resident #22's right arm rest was still cracked. Observation and interview on 01/08/2025 at 9:03 AM revealed seat of Resident #22's wheelchair was worn and cracked on the edge with filling exposed. Resident stated that the chair does bother him when sitting in it and has scratched him in the past. Observation on 01/09/2025 at 12:12 PM revealed Resident #26's back seat of wheelchair was separating from the frame. During an interview on 01/09/2025 at 11:55 AM, the maintenance supervisor stated that if a wheelchair was broken he would try to fix it or provide the resident with a new wheelchair. He stated that he has to speak with therapy first to ensure what type of wheelchair would work. He stated if the seat or arm rest was torn he would be able to replace it. He stated that today (01/09/2025) they were going to replace Resident #26's wheelchair. He stated that he was notified about Resident #26's wheelchair few days ago and he ordered a new one as soon as he was told. The Maintenance supervisor stated that he usually wrote things in the maintenance book but it does not always dawn on him to write things he has addressed in the book. He stated that at night DON has CNAs washing wheelchair but it was overall a team effort. He stated if a wheelchair was very dirty any staff could wash it. The Maintenance supervisor stated he was not aware of Resident #22's arm rest being cracked. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/09/2025 at 1:19 PM, CNA F stated that if she saw a wheelchair torn or worn, she would let her nurse and maintenance know. She stated that sometimes she writes things in the maintenance log but usually she will just go and tell the maintenance supervisor. CNA F stated she did not notice anything wrong with Resident #22 or Resident #26's wheelchairs. She stated that the aides that worked evening and night shift were responsible for cleaning wheelchairs. CNA F stated that if she saw a wheelchair that was dirty she would wipe it down. She stated she was unsure how often wheelchairs were cleaned. She stated if it was very dirty she would take it to the shower room and spray it down. During an interview on 01/09/2025 at 2:15 PM, hospitality aide J stated she does not know when wheelchairs were cleaned. She stated it has changed a few times as to who and when they would be cleaned. Hospitality aide J stated that if she noticed a cracked seat or arm rest she would usually tell therapy or maintenance. During an interview on 01/09/2025 at 2:16 PM, CNA G stated she was unsure who was responsible for cleaning wheelchairs. During an interview on 01/09/2025 at 5:15 PM, the DON stated that CNAs were responsible for cleaning wheelchairs. She stated she had two programs in which aides were assigned different wheelchairs but the book disappeared. She stated that day shift had two wheelchairs, evening had two wheelchairs and night shift had four wheelchairs they were responsible for cleaning. She stated that wheelchairs were supposed to be cleaned once a week, but she had a hard time getting them washed. She stated all staff were responsible for monitoring the condition of wheelchairs. She stated if staff found a wheelchair that was tearing or loose they were supposed to report to DON or the maintenance supervisor. She stated if the maintenance supervisor cannot fix or repair the wheelchair it can be sent out for repair. The DON stated the potential harm from residents using torn or worn wheelchairs was that the resident could fall, it could rip and it could damage their skin. During an interview on 01/09/2025 at 5:39 PM, the administrator stated everyone was responsible for cleaning wheelchairs and they should be cleaned as necessary. She stated that they have used a power washer to clean wheelchairs in the past and they were sat out to dry. The Administrator stated the maintenance supervisor and all staff monitor condition of wheelchairs. She stated that if seats were torn or worn, staff were expected to tell the maintenance supervisor to get arm rests swapped out. She stated seats were different but the facility could get new wheelchairs if needed. She stated worn or torn wheelchairs could cause skin impairments. Review of the facility policy titled Maintenance Service dated December 2009 revealed maintenance service shall be provided to all areas of the building, grounds, and equipment. Maintenance department is responsible for maintain the buildings, ground, and equipment in a safe and operable manner at all times. Maintenance personnel shall follow established safety regulations to ensure the safety and well-being of all concerned. Review of the maintenance log for last 6 months (August 2024- January 2025) reflected no issues noted with resident wheelchairs. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Cleaning and Disinfection of Resident-Care Items and Equipment dated September 2022 revealed resident-care equipment, including reusable and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard. Non-critical environment surfaces included bed rails, bedside tables etc. DME is cleaned and disinfection before reuse by another resident. C) Review of Resident #46's face sheet reflected a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses fracture lower end of right femur (a break in the thigh bone near the knee joint.), diabetes mellitus type II (A condition results from insufficient production of insulin, causing high blood sugar.), and atherosclerotic heart disease (A condition where the arteries become narrowed and hardened due to buildup of plaque (fats) in the artery wall). Review of Resident #46's quarterly dated 12/22/2024 reflected Resident #46 was assessed to have a BIMS score of 13 indicating he was cognitively intact. Resident #46 was assessed to require moderate assist with ADLs. Resident #46 was further assessed be at risk for pressure ulcers and was assessed to have one stage four unhealed pressure ulcer. Review of Resident #46's comprehensive care plan not dated reflected Resident #46 ADL self-performance varies, may need more assist at times than other times due to functional limitations related to fracture of lower end of right femur. Interventions included bed mobility extensive to total assist with 1-2 staff and to check every 2 hours and as needed and to provide assist as needed. Observation and interview on 01/07/2025 at 3:05 PM revealed Resident #46 in room in bed with multiple covers on. Resident #46 stated it was cold in his room. He stated his window was broken and it had been taped like that for 2 months. Observation of Resident #46's window which his bed was pushed up against revealed it was a double pane window with one of the panes open 1/3 of the way and the other pane was broken. Blue tape was observed loosely applied to a piece of plexiglass that was taped to the window. Air could be felt blowing through the window on the left side where the tape was completely loose. Observation on 01/07/2025 at 4:00 PM revealed Resident #46's room temperature to be 67 to 69 degrees using [NAME] Tools thermometer that measures ambient temperature. Observation on 01/08/2025 at 8:36 AM revealed Resident #46's room temperature to be 67 to 69 degrees using [NAME] Tools thermometer that measures ambient temperature. In an interview on 01/09/2025 at 12:25 PM the MS regarding window in Resident 46's room stated he was aware the window was broken. The MS stated an aide bumped into it while providing care and broke the glass. The MS stated he put a piece of plexiglass over the window. He stated he usually fixes these things himself. He stated he did feel the air flow through the window and has re-taped it. He stated he was not sure how long the window had been broken. He stated Resident #46 did complain about it being cold in the room and he went to check on it. He stated the vent to the room was also closed and he did not realize that. He stated the room temperatures should be between 74 and 76 degrees. He stated the room temp should not be 67. He stated he contacted a glass company, and the window will be replaced on 01/15/2025. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/09/2025 at 12:25 PM the MS regarding window in Resident 46's room stated he was aware the window was broken. The MS stated an aide bumped into it while providing care and broke the glass. The MS stated he put a piece of plexiglass over the window. He stated he usually fixes these things himself. He stated he did feel the air flow through the window and has re-taped it. He stated he was not sure how long the window had been broken. He stated Resident #46 did complain about it being cold in the room and he went to check on it. He stated the vent to the room was also closed and he did not realize that. He stated the room temperatures should be between 74 and 76 degrees. He stated the room temp should not be 67. He stated he contacted a glass company, and the window will be replaced on 01/15/2025. In an interview on 01/09/2025 at 12:45 PM the Administrator stated she did not know about the broken window in Resident #46's room and she expected the MS to maintain the facility. She stated she expected the MS to tell her when things needed to be fixed and keep her updated on his progress of current projects. She stated the resident rooms temperature should be maintained at a comfortable level for the resident. Review of the facility policy Quality of life- Homelike environment dated 05/2017 reflected Residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible . The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include . Clean, sanitary, and orderly environment; .Comfortable and safe temperatures (71 F - 81 F).		

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NAME OF PROVIDER OR SUPPLIER High Hope Care Center of Brenham		STREET ADDRESS, CITY, STATE, ZIP CODE 401 East Blue Bell Road Brenham, TX 77833	
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on observation, interviews, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming and personal and oral hygiene for two of six residents (Resident #43 and Resident #59) reviewed for quality of life. The facility failed to ensure Resident #43 and Resident #59 nails were cleaned, trimmed, and did not have any rough edges on 01/07/2025. These failures could place residents at risk for not receiving adequate care and services to prevent infection, injury, and diminished quality of life. Findings included: 1. Record review of Resident #43's face sheet, dated, 01/08/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #43 had diagnoses which included type 2 diabetes mellitus with circulatory complications (chronic condition where the body does not use insulin effectively, causing blood sugar levels to become too high because the cells cannot absorb glucose properly, leading to a buildup of sugar in the blood stream. Circulatory- diabetes associated with circulatory complications a person has increased risk of heart disease), peripheral vascular disease, unspecified (a chronic circulatory condition that occurs when blood vessels outside the brain and heart narrow, spasm or become blocked), and unspecified age-related cataract (clouding of the eye's lens that can lead to vision loss). Record review of Resident #43's Quarterly MDS Assessment, dated, 12/30/2024, reflected the resident had a BIMS score of 11, which indicated her cognition was moderately impaired. Resident #43 required substantial/maximal assistance (helper does more than half the effort) with personal hygiene, oral hygiene, and upper body dressing. Resident #43 was total dependent on staff with toileting, showers, and lower body dressing. Record review of Resident #43's Comprehensive Care Plan, not dated, reflected Resident #43 had impaired vision. Resident #43's ADL self-performance varies, may need more assistance sometimes due to general weakness and fatigue. Intervention: Resident #43 required total assistance with showers. Resident #43 needed one staff extensive to total assistance with personal hygiene. Resident #43 had cognitive deficit related to vascular dementia. Intervention: Notify physician of any cognitive changes. Resident #43 was at risk for dehydration related to diabetes. Intervention: Diet as ordered. Observe/ document signs and symptoms of dehydration every shift. Record review of Resident #43's Nurses Notes, dated 01/01/2025 thru 01/07/2025 reflected Resident #43 did not refuse nail care. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 01/07/25 10:02 AM revealed Resident #43 were in her room lying in bed. Her nails on her right hand were not smooth around the edges and had a blackish/brownish substance underneath her middle, ring, and fore fingernails on her right hand. Resident #43 also had a blackish/brownish substance on the tip of her middle and ring finger on her right hand. Resident #43 stated she asked someone few days ago to cut and clean her fingernails and the person stated they would sometime during the week. She did not recall the name of the staff, the date or time she made the request. Resident #43 stated she did not want to discuss her nails anymore. 2. Record review of Resident #59's face sheet, dated 01/08/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #59 had diagnoses which included muscle weakness (a reduction in the strength of muscle or muscles), unspecified glaucoma (an eye disease that occurs when fluid builds up in the eye which can lead to vision loss or blindness), and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a person with mild cognitive impairment has not yet been diagnosed). Record review of Resident #59's Admission MDS Assessment, dated 12/27/2024, reflected Resident #59 had a BIMS score of 7, which indicated her cognition was severely impaired. Resident #59 required partial/moderate assistance (helper does less than half the effort) with personal hygiene and, oral hygiene. Resident #59 was dependent on staff for showers and, toileting. Record review of Resident #59's Comprehensive Care Plan, dated 01/06/2025, reflected Resident #59 ADL self-performance varies, she sometimes may need more assistance related to impaired cognition. Intervention: Resident #59 required assist of one staff for personal hygiene and oral hygiene. Record review of Resident #59's Nurses Notes, dated 01/01/2025 thru 01/07/2025, reflected Resident #59 did not refuse nail care. Observation and interview on 01/07/25 at 11:03 AM revealed Resident #59 were in her room lying in bed, on her right hand underneath her middle and ring fingernails was blackish/brownish substance. Resident #59 had rough edges around her fingernails on her right hand and around her middle and fore fingernails on her left hand. Resident #59 stated she did not like her nails to be dirty. She stated she did not remember if she asked someone to help her with her nails. Resident #59 stated she was tired and wanted to go to sleep. In an interview on 01/10/2024 at 8:56 AM, LVN B stated the nurses was responsible for filing and trimming all residents' nails and the CNAs was responsible to clean all residents' nails except the residents with diagnosis of diabetes. She stated nail care on residents was completed weekly by the nurse. She stated this usually occurred on Sundays. LVN B stated CNAs were to clean underneath residents' nails as needed . She stated it depended on what type of bacteria was underneath the residents' nails if a resident became ill such as stomach issues. LVN B stated she was not a physician and was unable to answer what type of illness a resident may receive if the resident swallowed some type of bacteria. LVN B stated she had trimmed and cut residents nails. She stated she was not aware of Resident #43 or Resident #59 refusing nail care. She stated the nurses documented in nurse's notes anytime a Resident refused any type of care including nail care. LVN B stated if a resident's nail was not trimmed properly and was jagged, there was a possibility the resident may scratch themselves, staff or other residents and cause a skin tear. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/10/2025 at 9:10 AM the Director of Nurses stated she expected the nurse on duty to do all nail care on a resident. She stated the nurse or CNA can clean resident's nails. The Director of Nurses stated if a resident nails was not smooth around the edges of the nails, there was a potential the resident may scratch themselves or another resident and cause a skin tear. She stated also the resident may scratch their eye and may cause issues such as a tear on the eyeball. She stated the CNAs were expected to check resident's nails on shower days and report to the nurse supervisor if a resident nails needed to be trimmed, filed or any issues the CNA observed with the Residents fingernails. She stated if a resident had a blackish/brownish substance on tip of their finger or underneath their nails it was a possibility a resident may ingest the blackish/brownish substance and become ill such as vomiting and/or diarrhea. She stated if a resident refused nail care or any type of care the nurse was to document the refusal in the nurses' notes. In an interview on 01/10/2024 at 9:25 A, CNA I stated the CNAs were responsible for cleaning the resident's nails and the nurses was responsible for cutting and filing all residents' nails. CNA I stated residents' nails were usually cleaned on their shower days or when needed. She stated if a resident's nails were dirty, nail care was expected to be completed immediately. CNA I stated if any staff observed resident's nails needed to be cut or filed, the staff was to report the observation to the nurse supervisor. CNA I stated if a resident had nails not trimmed or was rough on top of the nail, there was a possibility a resident may scratch themselves and develop a skin tear. CNA I stated if there was a blackish substance on the residents' fingertips or underneath their nails and the resident swallowed the blackish substance there was a possibility a resident may become ill with stomach issues such as vomiting and being nauseated. CNA I stated he had been in-service on cleaning, filing and trimming residents' nails. CNA I stated she did not remember the date of the in-service. CNA I stated she was not aware of Resident #43 or Resident #59 refuse nail care. CNA I stated she worked at least 1-2 times a week on the halls where Resident #43 and Resident #59 lived. In an interview on 01/10/2024 at 11:05 AM CNA M stated the nurses completed all nail care on residents except cleaning resident's nails. She stated the Nurses were responsible to complete nail care such as trimming, filing, and cleaning once a week or as needed. CNA M stated if staff observed a resident's nails needed to be trimmed or filed, the staff was to report it to the nurse supervisor. She stated the nurse or CNA can clean resident's nails but ultimately it was the CNAs responsibility during showers and/or as needed. CNA M stated if a resident had blackish substance underneath their nails there was a possibility a resident may become ill such as nausea or diarrhea depending on the type of bacteria. CNA M stated if a resident had rough edges around their nails, it was a possibility the resident may scratch themselves and develop an infection or a skin tear. She stated she was not aware of Resident #43 or Resident #59 refusing nail care. CNA M stated Resident #59 may refuse to change clothes sometimes, but she was not aware of Resident #59 refusing nail care. Record review of the Facility's Activity of Daily Living Policy, revised in March 2018, reflected Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care).		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on observations, interviews, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one of (Resident #33) of five residents reviewed for quality of care. The facility failed to ensure Resident #33's geri sleeves were applied daily as ordered. This failure could place residents at risk of not receiving necessary preventative measures, and result in medical care, harm, and hospitalization . Findings include: Review of Resident #33 face sheet revealed a [AGE] year-old female admitted on [DATE] with diagnoses of unspecified dementia (clinical syndrome that describes a group of symptoms that impact memory, thinking, and social abilities), muscle weakness, and unspecified lack of coordination (a condition where a person has difficulty coordinating their movements). Review of Resident #33 quarterly MDS dated [DATE] revealed resident had application of nonsurgical dressing as a skin treatment. Review of Resident #33's physician's order dated 01/12/2024 revealed to apply geri sleeves to bilateral arms to help prevent bruise and skin tears and to check every shift that resident has them on. Further revealed reviewed additional order dated 01/12/2024 revealed to apply geri sleeves bilateral lower legs to help prevent bruises and skin tears. Review of Resident #33's undated care plan revealed Resident #33 was at risk for alteration of skin. Goal included Resident will have minimal complications with skin breakdown through next review date. Review also revealed Resident #33 had potential for skin impairment due to fragile skin. Interventions included to apply geri sleeves to bilateral upper and lower extremities and remove each shift to observe for changes in skin condition and then replace. Review of Resident #33's nursing progress note dated 01/03/2025 revealed sleeves were not present. Review of Resident #33's nursing progress note dated 01/04/2025 revealed geri sleeves were missing. Review of Resident #33's nursing progress note dated 01/04/2025 revealed no leg sleeves were available. Observation on 01/07/2025 at 10:26 AM revealed Resident #33 was sitting in the common area of the secured unit. The resident's geri sleeves were not observed on her legs or arms. Skin on resident's ankle appeared to have discoloration of healed scar. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/08/2025 at 3:39 PM revealed Resident #33 sitting in a wheelchair in the common area with no geri sleeves on legs or arms. Observation on 01/09/2025 at 9:50 AM revealed Resident #33 sitting in the common are with no geri sleeves on her legs. During an interview on 01/09/2025 at 11:13 AM hospitality aide J said Resident #33 usually had geri sleeves on her arms, but she has never seen them on her legs. She stated that Resident #33 sometimes hits her ankles on her footrests and slides her feet off her wheelchair footrests. She stated she has not seen Resident #33 injure or scape her ankles. During an interview on 01/09/2025 at 11:15 AM, CNA E stated that she has never been told Resident #33 needed to have geri sleeves on her legs, only her arms. She stated Resident #33 was supposed to wear them every day. She stated the aides or nurses can put them on and Resident #33 wore the geri sleeves to protect her skin. During an interview on 01/09/2025 at 11:25 AM, LVN D stated that he was the nurse working for the secured unit. LVN D stated that he was familiar with Resident #33 and he did not know if she was supposed to wear geri sleeves but he could look it up in her chart. LVN D stated he did not know if Resident #33 had geri sleeves on. LVN D stated that Resident #33 was just supposed to have geri sleeves on her legs. He stated that geri sleeves were to protect the skin. During an interview on 01/09/2025 at 1:19 PM, CNA F stated she was familiar with Resident #33 and she worked with her regularly. She stated that normally the nurse puts geri sleeves on. She stated she worked with Resident #33 yesterday and she did not think she had them on. She stated she did not usually see geri sleeves on Resident #33's legs only her arms. During an interview on 01/09/2025 at 1:30 PM, LVN B stated that geri sleeves were used so a resident does scratch themselves or get skin tears. She stated it would be important for geri sleeves to be put on if the resident had an order to wear them everyday. LVN B stated that if a resident does not have their geri sleeves on and were supposed to they could get a skin tear or if they had an IV in place, pull out their IV. She stated the nurse was responsible for putting geri sleeves on residents. During an interview on 01/09/2025 at 2:17 PM, CNA G stated that Resident #33 wore geri sleeves on her arms and not her legs. She stated that she usually saw Resident #33 with geri sleeves on and she wore them every day. During an interview on 01/09/2025 at 5:21 PM, the DON stated she expected staff to apply geri sleeves daily if a resident had an order for it. She stated Resident #33 wore upper geri sleeves and compression hose or geri sleeves on her legs. The DON stated that geri sleeves disappear in the laundry. She stated Resident #33 wore geri sleeves because she had very fragile skin and gets skin tears easily. The DON stated the purpose of geri sleeves was to protect the skin and keep the skin from direct contact with anything. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/09/2025 at 5:32 PM the Administrator stated she expected nursing staff to follow physician's orders. She stated that she would expect a resident to have their geri sleeves applied if they have an order for it. She stated that the potential harm of not follow physician orders for geri sleeves was the resident could get a skin tear. Record review of the facility policy related to geri sleeves was requested from ADM on 01/09/2025 at 2:25 PM. The facility did not provide policy related to geri sleeves.		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32452 Based on observation, interview, and record review the facility failed to ensure residents receive care consistent with professional standards of practice, to prevent pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and once developed, failed to ensure necessary treatment and services to promote healing for one (Resident #46) of three residents reviewed for pressure ulcers. The facility failed to ensure Resident #46 who was admitted to the facility on [DATE] without a pressure ulcer to his right lateral calf did not develop a pressure ulcer. The facility failed to ensure interventions were in place to perform skin checks under his right leg brace and Resident #46 developed an unstageable DTI (deep tissue injury, a pressure-related injury to subcutaneous tissues under intact skin.) to his right lateral calf on 09/27/2024 . The facility further failed to ensure once a pressure ulcer developed it was assessed routinely and failed to perform a wound assessment from 12/18/2024 until 01/08/2025. These failures resulted in an Immediate Jeopardy (IJ) situation on 01/08/2025. The IJ template was provided to the facility on [DATE] at 5:00 PM. While the IJ was removed on 01/10/2025, the facility remained out of compliance at a severity level of no actual harm at a scope of isolated due to staff needing more time to monitor the plan of removal for effectiveness. These failures placed the residents at risk for developing worsening pressure ulcers, Cellulitis (skin infection), Osteomyelitis (infection of the bone), Sepsis (infection of the blood), severe pain or death. Finding Include: Review of Resident #46's face sheet dated 01/08/2025 reflected a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses, fracture lower end of right femur (a break in the thigh bone near the knee joint.), diabetes mellitus type II (A condition results from insufficient production of insulin, causing high blood sugar.), and atherosclerotic heart disease (A condition where the arteries become narrowed and hardened due to buildup of plaque (fats) in the artery wall). Review of Resident #46's quarterly MDS dated [DATE] reflected Resident #46 was assessed to have a BIMS score of 13 indicating he was cognitively intact. Resident #46 was assessed to require moderate assist with ADLs. Resident #46 was further assessed be at risk for pressure ulcers and was assessed to have one stage four unhealed pressure ulcer. Review of Resident #46's comprehensive care plan not dated reflected a focus area not dated Resident has potential for alteration in skin due to decline in mobility related to fracture of right femur and wearing a splint to right leg. Open area to the right calf. Interventions included Apply treatment as ordered per MD or Wound MD; Apply Wound VAC as ordered, notifying MD & RP of any changes; Encourage good nutrition and hydration in order to promote healthier skin; Identify potential causative factors and eliminate when possible; Keep skin clean and dry, use lotion on dry scaly skin. The care plan did not address a current pressure ulcer or detailed interventions for splint management. (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #46's hospital discharge instructions dated 09/13/2024 reflected Distal femur fracture treated with immobilization .if you have a removable splint: wear the splint as told by your health are provider. Remove it only as told by your health care provider. Check the skin around the splint every day. Tell your health care provider about any concerns. Loosen the splint if your toes [NAME], become numb . Further review of Resident #46's hospital discharge packet reflected medication orders, post op wound care and therapy orders. Review of Resident #46's admission assessment under the skin integrity section dated 09/14/2024 reflected no open areas to his right lateral calf. Further review of Resident #46's admission assessment reflected the DON signed the skin integrity section as completed by her. Review of Resident #46's nursing progress note dated 09/27/2024 reflected Resident has an open blister on right calf under leg stabilizer. New order to apply Calcium Alginate, gauze and cover with Border Island dressing every day. Signed by RN A. Review of Resident #46's consolidated physician orders dated September 2024 reflected an order dated 09/28/2024 to cleanse right calf open area with wound cleanser or normal saline, pat dry, apply Calcium alginate and cover with gauze dressing every day. Further review reflected an order dated 09/27/2024 Remove splint every shift every and examine skin every shift to monitor skin under the knee immobilizer. Further review of Resident #46 consolidated physician orders dated September 2024 reflected no order to remove the splint and examine Resident #46 skin under the splint prior to 09/27/2024. Review of Resident #46's TAR dated September 2024 reflected an entry dated 09/28/2024 Cleans right calf open area with wound or normal saline, pat dry , apply calcium alginate and cover with gauze and border island dressing every day. With signatures beginning on 09/28/2024. Further review reflected an entry dated 09/27/2024 Remove splint every shift and examine skin every shift to monitor skin under the knee immobilizer. With signatures beginning on 09/27/2024. Review of Resident #46's post-op follow up visit to the orthopedic physician dated 09/30/2024 reflected Resident #46's knee immobilizer was removed .Patient was advised to follow-up with wound care and utilize dressing changes outside the leg for the next 2 weeks .Notified patient we will place him on a hinge knee-brace next visit but allow for this wound to heal at this time . Review of Resident #46's wound care physician notes dated 10/02/2024 reflected etiology-pressure, classified as an unstageable DTI within and around wound measuring 4 cm x 4 cm x 0.1 cm deep. Review of Resident #46's EMR reflected his last wound care MD visit was 12/18/2024 which reflected a Stage 4 pressure ulcer extend below the subcutaneous fat into your deep tissues, including muscle, tendons, and ligaments.) of the right, lateral calf full thickness 2.6 cm x 1.2cm x 0.5 cm depth with 30% slough (slough in a wound indicates a healing process that is stalled in the inflammatory phase.) Review of Resident #46's EMR reflected his 12/18/2024 wound assessment was the last wound assessment conducted until 01/08/2025. (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 01/08/2025 at 1:45 pm revealed the Treatment Nurse in Resident #46's room to do wound care. She removed the dressing to his right lateral calf to reveal a Stage IV pressure ulcer 0.4 x .03 approximately .5 deep with moderate drainage no odor 100% granulation tissue no slough. In an interview on 01/08/2025 at 1:55 PM Resident #46 stated he was not admitted with the pressure ulcer to his right leg. He stated he got the pressure ulcer at the facility when his brace was digging into his leg. Resident #46 stated he told the facility the brace was rubbing his leg, but they did not look at it right away. He stated it was only when he continued to complain about the brace rubbing and pushing into his leg that they took it off. He stated they told him he had a sore on the outside of his calf from the brace. Resident #46 stated he did not remember them taking the brace off his right leg to look at his skin before he went to his post op appointment about two weeks after he was admitted to the facility. In an interview on 01/08/2025 at 2:10 PM the DON stated the pervious wound care nurse was in charge of wound assessments and she was supposed to assess Resident #46 on admission and develop a plan of care. She stated she realized she had not done that and that orders for removing the splint were missed only after Resident #46 developed his pressure ulcer. In an interview on 01/08/2025 at 3:58 PM the Wound Care MD stated the first time he saw Resident #46 was 10/02/2024. He stated at that time he had an unstageable DTI to his right lateral calf. The Wound Care MD stated the last time he saw Resident #46 was 12/18/2024. He stated he was out of town after that. The Wound Care MD stated the pressure ulcer on Resident #46 right lateral calf was definitely avoidable if the splint had been removed regular. In an interview on 01/08/2025 at 4:09 PM the DON stated after reviewing Resident #46's EMR that there had not been a wound assessment done for Resident #46 since 12/18/2024. The DON stated she did not know a wound assessment had to be done weekly. She stated the wound care nurse just started on 01/06/2025 to replace the last wound care nurse whose last day was 11/15/2024. She stated she had not conducted recent wound assessment for Resident #46 and did not see one in his medical record. The DON stated the wound care MD was at the facility and a wound assessment would be performed. In an interview on 01/09/2025 at 10:34 AM RN A stated her last day at the facility was 11/15/2024. She stated she did not know it was her responsibility for the wound care plans. She stated the facility had the wound care MD seeing Resident #46 for wound care and she thought he was doing the splint care. RN A stated the splint was in place for Resident #46 when he was admitted but they never had instructions to remove it. RN A stated the DON or MDS coordinator were in charge of doing care plans. RN A stated she did the assessments of the current wounds not the new wounds. She stated Resident #46's surgeon put the brace on Resident #46, and she did not remove it because she did not have orders to remove it. RN A stated she was not aware of any discharge instructions for splint care. She stated she did not do care plans. RN A stated she was not the only one taking care of Resident #46 and she only did his wounds periodically. RN A stated there were other nurses, the charge nurses doing his wounds as well. She stated she was in charge of following up on skin assessments the charge nurse did. She stated she would follow up after an assessment if they found any new skin areas and she would do the weekly skin reports. She did not remember the DON asking her about Resident #46's splint and stated she believed the DON did that. RN A stated the charge nurses would tell her if they found something, and she would check it out. RN A stated it would have been the charge nurses who did the weekly skin checks and who should have checked the splint for Resident #46 but since they did not have instructions to remove the splint and perform skin checks they would not have. (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 01/09/2025 at 10:40 AM the DON stated she was ultimately responsible for ensuring that once a residents was admitted that the baseline care plan was done, a full skin assessment was complete and the plan for wound care or splints was completed. She stated RN A was her wound care nurse and she asked her to look at all of Resident #46 wounds and to make sure orders were in place for care and pressure ulcer prevention interventions. She stated she asked RN A to check Resident #46's splint for pressure points. The DON stated she did not follow up with RN A. The DON stated she was not aware of the issue with Resident #46 until the pressure ulcer had already developed. She stated a full assessment and order review just did not get done and she should have followed up. She stated, I relied on her (RN A) to take care of it. In an interview on 01/09/2025 at 12:40 PM the Administrator stated the facility had a wound care nurse that monitored the wounds but she left in November, she stated she expected the DON to follow up on new wound orders and new admits to make sure the residents had everything they needed for care and to prevent pressure ulcers. In an interview on 01/10/2025 at 11:13 AM the Nurse Consultant stated it was facility policy that an RN complete weekly wound assessment. The Nurse Consultant stated it was also the facility policy that residents who admitted with splints were to have orders to remove and monitor the skin under any splints or removable casts. Review of the facility's policy Skin assessment dated (no month) 2024 reflected It is our policy to perform a full body skin assessment as part of our systematic approach to pressure injury prevention and management .A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury .Begin head to toe, thoroughly examining the resident's skin for conditions. Pay close attention to pressure points, bony prominences, and underneath medical devices. Review of the facility's policy Stabilization and Securement devise dated 02/2022 reflected .The device is removed regularly, and the resident assessed for the following: a. Circulation; b. Skin integrity ;c. Catheter functionality; and d. Range of motion . Review of the facility's policy Prevention of pressure ulcers/injuries dated 07/2017 reflected The purpose of this procedure is to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors .Assess the resident on admission (within eight hours) for existing pressure ulcer/injury risk factors. Repeat the risk assessment weekly and upon any changes in condition. Conduct a comprehensive skin assessment upon admission, including: a. Skin integrity - any evidence of existing or developing pressure ulcers or injuries. b. Tissue tolerance - the ability of the skin (and supporting structures) to endure the effects of pressure; and c. Areas of impaired circulation due to pressure from positioning or medical devices . The Administrator was notified on 01/08/2025 at 5:47 PM, that an Immediate Jeopardy had been identified due to the above failures and an IJ template was provided. The following POR was accepted on 01/09/2025 at 4:55 PM. (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/08/2025 an abbreviated survey was initiated at[name of facility]. On 01/08/2025 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to resident health and safety. The notification of Immediate Jeopardy states as follows: 1. Identification of Residents Affected or Likely to be Affected: The facility took the following actions to address the citation and prevent any additional residents from suffering an adverse outcome. (Completion Date: ____ 1/8/2025 ____) All residents with a pressure ulcer were assessed and measured by the wound care MD on 1/8/25. Resident #46 was assessed by the wound MD on 1/8/25. No other individuals were found to be affected by this practice. The wound care doctor assessed all other residents with wounds. The medical director was notified of the IJ on 1/8/25. 2. Actions to Prevent Occurrence/Recurrence: The facility took the following actions to prevent an adverse outcome from reoccurring. (Completion Date: 1/9/25 and ongoing for PRN staff before returning to the floor). All facility policies and procedures related to skin care, wound care, and pressure injury prevention were reviewed 1/8/25. Corporate Nurse/Consultant Nurse provided education to the Administrator, DON and facility nurses on facility policies and procedures related to skin/wound care, as well as appropriate wound treatment measures, including weekly assessment and measuring by a RN. A self-test will be completed by all nurses. The treatment nurse will be responsible for daily wound care. A self-test will be monitored by DON or designee. A direct in-service was done with the facility DON/RN that wound measurements must be done by a RN weekly in the weekly wound assessment UDA (User Defined Assessment,. following physician orders, splints/brace care and plans of care for any resident. We will do a self with Physician orders, braces, and splints. DON/Corporate Nurse/Consultant Nurse Monitoring will continue to monitor/audit the following: Weekly skin assessments/wound assessments. Corporate nurse will complete system validation checklist weekly for compliance. (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 01/10/2025 at 12:06 PM the MDS Coordinator stated she was in-serviced on skin assessments on weekly basis and as needed. She stated the DON was going to assess the skin once a week. If anyone comes in with splint, brace or wrap it needs to be removed and checked on a daily basis. They were to check the physician order and follow the physician orders. If they remove the splint and see a new wound she will do assessment, document my information, call the doctor, family and get an order for the treatment if the doctors' orders a treatment will document it in physician orders. She stated she would notify the DON, the administrator, and the Treatment nurse. She stated they had a quiz on skin assessments and splints. She stated she was in-serviced on care planning for splint and skin care. She said an order needs to be written about the splint and brace such as what type of care the resident needs for the splint brace and all orders need to be reviewed on admission. In an interview on 01/10/2025 at 12:17 PM the Treatment Nurse stated they had a quiz. She stated she learned the splint/ brace and skin care needed to be care planned and documented on physician order. She further stated she learned that the physician orders needed to be reviewed on new admits check residents' skin under and around splint this is supposed to be checked daily. Check splints, boot, wrapping, Geri-sleeves we are to check the resident's skin daily. The residents wearing any device such as splint check daily - Q Shift. She stated if you see a new wound or red area on residents' skin she would call the doctor and see if the doctor has a referral for wound care. She further stated she would contact the wound care doctor if needed and would report to the DON and report to the family. She stated If the resident received a new order from the doctor for any type of skin treatment she would input the order in the medical record PCC and would follow the order. She further stated she was in-serviced on skin assessments- they were to be completed weekly on every resident in the facility. In an interview on 01/10/2025 at 12:48 PM LVN O stated she was in-serviced on skin assessments, and they were to be completed weekly, but they do not do skin assessments on night shift, and she worked night shift. She stated if she worked during the day if it was time for a resident to have a skin assessment she would make sure it was completed. She stated the staff was to take off any type of medical device on resident skin including splint every shift and check skin for any redness of new wounds or decline in an existing wound. She stated if she observed any new skin concerns she would call the physician and follow his orders, call the DON, call the treatment nurse, and call the family. She stated if there was a new treatment she would enter it in PCC and do a skin assessment and a nurses note. She stated she would document everything she did and who she called. She stated she took a quiz about skin issues and splints. She stated she learned all orders needs to be reviewed and any device a resident has needed to be on the care plan and physician order and that skin needs to be check under the splints. In an interview on 01/10/2025 at 1:21 PM LVN N stated she completed a wound care in-service this morning. She learned that mobilizing and checking the skin was necessary to avoid wounds and if she notices a wound they instructed her on when to report it and to whom. She would report it to the DON and notify the physician. If she had a resident with a splint she would remove it if the orders allowed, check the area, and determine if there were any skin concerns. If she does find a skin concern she will ask for a second set of eyes. She will notify the DON and the physician of any concerns. She will provide wound care according to physician orders received. (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 01/10/2025 12:39 PM LVN M stated she completed two in-services today, one on Splints and the other on Skin Assessments. She said she learned that RNs have to do skin assessments on residents. She said all residents with any skin concerns should be reported immediately to the DON. She said anything new or different observed on a resident was an immediate report and it was important to keep the integrity of the resident's skin. It is important to inspect the area of the splint and ensure can wiggle fingers or toes, review physician orders, and follow any treatment directions. In an interview on 01/10/2025 02:15 PM LVN D stated he completed an online training yesterday and was tested on skin assessments. He said he learned when to assess and to check the pulse and the area. He said if he found any concerns with a skin assessment he would report to his supervisor and wound care staff. He said if he had a resident with a splint he would ensure he check the area thoroughly and report any new or changes to an area. Any concerns identified he would report directly to his supervisor to move forward with notifying the physician. Review of the weekly wound tracking worksheet completed on 01/10/2025 reflected all current pressures ulcers were documented. Review of Resident #46's wound MD assessment reflected it was completed on 01/8/2025. Review of in-service training reflected in-service dated 01/10/2025 attended by all nine nurses including DON reflected the training topic was Wounds must be evaluated by an RN weekly. If a resident has a device the device must be removed frequently to check skin integrity, wounds must be evaluated by a RN to include measurements. Review of Knowledge check for nursing regarding splint care reflected training taken by all nurses and covered the following areas: 1) All orders should be reviewed on new admission 2) Use of a splint should be included in the resident's care plan. 3) The resident's skin under and around the splint should be checked and results documented at least daily. 4) An order should be written for skin assessment under a splint/brace. Review of the weekly wound tracking worksheet completed on 01/10/2025 reflected all current pressures ulcers were documented. The Administrator was informed the IJ was removed on 01/10/2024 at 3:30 PM, the facility remained out of compliance at a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of its corrective systems.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on interviews and record reviews, the facility failed to ensure residents who are trauma survivors received culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization for one (Resident #35) of two residents reviewed for quality of care. The facility failed to ensure that Resident #33's potential triggers were care planned. This failure could place residents at increased risk for psychological distress due to re-traumatization. Findings included: Record review of Resident # 35's face sheet, dated 01/08/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #35 had a diagnosis of post-traumatic stress disorder, unspecified (a mental health condition develop after experiencing or witnessing a traumatic event), emotional liability (a condition where a person experiences rapid and intense mood swings, often characterized by sudden outbursts of emotions like laughing or crying may be inappropriate for that situation), and major depressive disorder, recurrent, mild (a type of depression characterized by repeated episodes of mild depressing - feelings of sadness, hopelessness, and emptiness). Record review of Resident 35's Annual MDS Assessment, dated 10/25/2024, reflected the resident had a BIMS score of 11, which indicated his cognition was moderately impaired. Resident #35 was diagnosed with depression, PTSD (post-traumatic stress disorder- (a mental health condition develops after experiencing or witnessing a traumatic event)), and emotional liability. (a condition where a person experiences rapid and intense mood swings, often characterized by sudden outbursts of emotions like laughing or crying may be inappropriate for that situation) Record review of Resident #35's Comprehensive Care Plan, completed date of 10/28/2025, reflected Resident #35 was at risk for altered status due to a traumatic life experience (PTSD). Interventions: Approach from the front and speak in a calm, unhurried manner. Observe for changes in mental status and document noted changes. Identify causes/triggers for behavior and reduce factors that may provoke resident. Refer to a psychological counseling/mental health specialize as ordered. (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/09/2025 at 10:45 AM, Resident #35 was sitting in his wheelchair in his room. He stated he did not have anxiety and there were times when he did have triggers of his PTSD. He stated he had several triggers especially when someone comes in her room and he does not know they are in the room and they don't knock on the door . He stated he did become depressed when he was having difficulty with his PTSD and sometimes became very nervous. Resident #35 stated if the staff bumped his bed and he was lying in bed or sitting on his bed this was a trigger for him. Resident #35 stated it startled him and brought back bad memories. Resident #35 stated it would help his anxiety and PTSD if the staff did know his triggers. He stated sometimes after the staff left his room he becomes more anxious and it affects his PTSD. Resident #35 did not specify how it affected her PTSD. He stated he did receive psychiatry services. Resident #35 stated no one at the facility had asked him what triggered his PTSD or his depression. In an interview on 01/10/2024 at 8:56 AM LVN B stated if a resident had triggers from diagnosis of PTSD, the residents' triggers needed to be care planned. LVN B stated if a resident was having major behaviors such as throwing things, the staff may prevent these behaviors of the residents if they knew the residents' triggers . LVN B stated the staff will sometimes ask the residents about their triggers. In an interview on 01/10/2025 at 9:10 AM, The Director of Nurses stated if a resident had PTSD (post-traumatic stress disorder) the residents' triggers were expected to be documented on their comprehensive care plan. She stated if the staff was not aware of the triggers for the resident there was a possibility it could affect their quality of life. She did not respond to any further questions about PTSD triggers such as how it would affect their quality of life. The Director of Nurses stated the MDS Coordinator was responsible to care plan triggers of any resident with PTSD. In an interview on 01/10/2024 at 9:25 AM CNA I stated she did not know Resident #35 had PTSD. She stated she knew he had depression. CNA I stated now she understands now why his mood and behaviors sometimes changes. She stated it would help the staff to know Resident #35 triggers of his PTSD. CNA I stated it was a possibility the staff could avoid doing anything that caused Resident #35's PTSD to trigger. She stated it was according to what his triggers were and she thought his triggers of PTSD needed to be on his care plan. In an interview on 01/10/2024 at 11:20 AM, MDS Coordinator stated that a resident with a diagnosis of PTSD the resident's triggers needed to be identified on the resident's care plan. The MDS Coordinator stated failure to properly care plan a resident for PTSD and triggers could result in a resident being re-traumatized. She stated she was responsible for including PTSD triggers in the resident's care plan . MDS Coordinator stated she would need to check with her supervisor to determine if there was a forms she could use to identify residents' triggers. In an interview on 01/10/2025 at 9:10 AM, The Director of Nurses stated if a resident had PTSD (post-traumatic stress disorder) the residents' triggers were expected to be documented on their comprehensive care plan. She stated if the staff was not aware of the triggers for the resident there was a possibility it could affect their quality of life. She did not respond to any further questions about PTSD triggers such as how it would affect their quality of life. The Director of Nurses stated the MDS Coordinator was responsible to care plan triggers of any resident with PTSD. (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy on Care Plans, Comprehensive Person-Centered, revised on December 2016, reflected A comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan will : 1. Describe services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychological well-being. 2. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 32452 42600 Based on observations, interviews, and record review, the facility failed to serve foods that were palatable and attractive and prepare food by methods that conserve nutritive value, flavor, and appearance for 1 of 1 kitchen observed. 1. The test tray of the lunch meal included foods that were bland, unappealing, and inedible. 2. The facility failed to follow the recipe of the cabbage and did not include spices or prepare the dish as the recipe was written. These failures could place residents at risk of decreased food intake, hungry, unwanted weight loss, and diminished quality of life. Findings included: Observation on 01/08/2025 at 10:21 AM reveled [NAME] L chopped heads of cabbage and boiled the chopped cabbage on the stove. [NAME] L was not observed adding additional spices or vegetables to the cabbage. During an interview on 01/08/2025 at 11:01 AM, [NAME] L stated that she did not add anything to the cabbage. [NAME] L stated she boiled the cabbage, and no spices were added. Food test tray was received at 1:10 PM on 01/08/2025 and the cabbage lacked flavor. Surveyor tested the tray and the corn casserole was inedible and had chunks of dough with no flavor. The corn bread had a powdery texture and lacked flavor. Review of 2024 Fall Winter Menu revealed meal for January 08, 2025 revealed southern fried chicken, corn casserole, southern style cabbage, cornbread, mock pecan pie and beverage/water on the menu. Review of recipe titled Southern Style Cabbage revealed bacon, cooked and crumbed, vegetable oil, fresh onion, light brown sugar, Worcestershire sauce, black pepper and salt were included in the recipe. During an interview on 01/09/25 at 01:34 PM, Dietary Manager stated that a cook knew to look into the recipe books to know how to cook the food and what to put in it. The Dietary Manager stated it was important to follow the recipe to ensure to not make anyone sick. She stated it was also important to follow the recipe, so it had the appropriate flavor. The Dietary Manager stated she did not know why the spices and other foods were not added to the cabbage. She stated maybe onion was added but she was not sure. The Dietary Manager stated she had not tried the corn casserole. She stated that the recipe for southern style cabbage should've been followed. (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 01/09/2025 at 1:50 PM, [NAME] L stated she knew what to add to food or how to cook based on the menus in the binder. [NAME] L stated that she did not add anything to cabbage, she did not have any onion available and thought it was just supposed to be boiled cabbage and did not know she was supposed to add anything. She stated she tried the cabbage and thought it tasted fine. She stated she would describe the flavor as cabbage and could not further elaborate. [NAME] L stated she did not try the corn casserole because she does not care for corn. During an interview on 01/09/2025 at 5:21 PM, the DON stated she has tried food from the kitchen and stated she has tried the fried chicken, fried fish, some breakfast foods. The DON stated she did get complaints that the food isn't seasoned enough and it was usually that it does not have enough salt. The DON stated she did not have any concerns with the food. During an interview on 01/09/2025 at 5:32 PM, the Administrator stated she tried food all the time from the kitchen and has not received complaints about the food. The Administrator stated the resident council minutes reflected there were compliments about the food. The Administrator stated she expected staff to follow recipes as written, unless the residents do not care for the recipe. She stated if the residents do not like the food then they would talk to the dietician and get a substitute. The Administrator stated as long as the substitute was nutritionally adequate and follows guidelines. She stated on these particular set of menus, there may have only been one menu that the residents may not be found of. The administrator stated that they did not voice complaints but there was leftover on their trays. Review of facility policy dated August 2024, titled Puree Food Preparation revealed it is the policy of this facility to provide food that has been prepared in a manner to conserve nutritive value, palatable flavor and attractive appearance. The policy defined food palatability as the taste and flavor of the food.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on observation, interview and record review, the facility failed to prepare, distribute, and serve food in accordance with professional standards for food service safety in one of one kitchen observed for food storage, preparation, and distribution. 1. The facility failed to ensure the low-temperature dishwasher reached manufacture temperature settings for each cycle. 2. [NAME] L and Dietary Manger failed to perform hand hygiene when preparing food and performing tasks in kitchen. These failures could place residents at risk for health complications, foodborne illnesses and decreased a quality of life. Findings include: Observation on 01/07/2025 at 11:25 AM revealed [NAME] L removed gloves and threw them away. [NAME] L put on new gloves without performing hand hygiene. Observation on 1/7/2025 at 11:46 PM of revealed [NAME] L transferred pureed pork loin from blender to serving container. Pureed meat spilled onto food prep area. [NAME] L turned on faucet and proceeded to wipe spilled meat into sink with gloves. Observation revealed water splashed in pureed meat serving container. Further observation revealed serving contained on food preparation area while [NAME] L grabbed wash rag from red bucket and proceeded to food preparation surface next to open serving container of pureed pork loin. [NAME] L placed rag back into bucket and then placed pork loin on serving station and did not change gloves. Observation on 01/08/2025 at 10:00 AM revealed dishwasher cycle run at 118 degrees. Observation on 01/08/2025 at 10:17 revealed dietary manager grab rag from sanitation bucket, wipe down hydration cart and place rag back into sanitation bucket. Further observation revealed dietary manager grab ice scoop without performing hand hygiene. Observation on 01/08/2025 at 10:21 AM revealed [NAME] L left food preparation area with gloves on, grabbed door handle of cooler and cabbage. [NAME] L proceeded to place unwashed cabbage on cutting board and washed head of cabbage with gloves on. Further observation revealed [NAME] L sliced cabbage. Observation on 01/08/2025 at 10:24 PM revealed [NAME] L left food preparation table and turned knobs on stove with gloves and returned to cut cabbage. Observation on 01/08/2025 at 10:50 PM revealed [NAME] L wash hands and replaced gloves. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 1/08/2025 at 10:53 AM revealed [NAME] L rinse used food preparation bowl in sink with gloves on. Further observation revealed [NAME] L kept opened package of brown gravy and stirred cabbage with same gloves on. Observation on 01/08/2025 at 10:57 AM revealed [NAME] L coughing into arm and proceeded to stir brown gravy without performing hand hygiene. Observation on 1/08/2025 at 10:59 AM revealed [NAME] L grabbed a rag from the sanitation bucket under food prep area and cleaned the area. Further observation revealed [NAME] L removed gloves and put new gloves on without hand hygiene. During an interview on 1/08/2025 at 11:01 AM [NAME] L stated that red buckets included sanitizer water. Observation on 1/08/2025 at 11:06 AM revealed [NAME] L removed gloves, lifted trash can lid with arm and grabbed clean cooking containers. Observation on 01/08/2025 at 11:17 AM revealed dishwasher operating requirements from manufacturer as water temperature to reach 125 degrees Fahrenheit minimum. Observation on 1/08/2025 at 11:18 AM revealed the dishwasher reached 95 degrees Fahrenheit in the rinse cycle. Observation on 1/08/2025 at 11:26 AM revealed the dishwasher reached 99 degrees Fahrenheit during wash and reached 116 degrees Fahrenheit during rinse cycle. During an interview on 01/08/2025 at 11:31 AM [NAME] K stated the temperature during the dishwasher wash cycle was 110 Fahrenheit degrees and 116 degrees Fahrenheit during the rinse cycle. [NAME] K stated it was supposed to be between 125- and 130-degrees Fahrenheit. Observation of dishwasher wash and rinse cycle on 01/08/2025 at 3:55 PM revealed temperature reached 110 degrees Fahrenheit during cycle. Observation and interview on 01/08/2025 at 3:56 PM revealed [NAME] L ran dishwasher and stated the temperature was at 118 degrees Fahrenheit. [NAME] K stated they were currently washing dishes. During an observation and interview on 1/8/2025 at 3:58 PM, [NAME] L stated the temperature during the wash should be at 122 degrees Fahrenheit. Observation revealed [NAME] L view the dishwasher log. [NAME] L stated it was supposed to be between 125- and 130-degrees Fahrenheit. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview 01/09/25 at 11:55 AM, the maintenance supervisor stated the dishwasher had to be ran three or four times to warm up. He stated he ran the dish washer a few times and the gauge read it 131 degrees Fahrenheit. He stated the dishwasher stated it needed to be at least reached 125 degrees Fahrenheit in order to sanitize the dishes. He stated on the log in the kitchen it stated that it needs to be at least 125 degrees. He stated he did not have the manual for the dishwasher. He stated if the dishwasher did not reach the temperature, it was not cleaning the dishes. He stated that once you warm it up you should not have to run it several more times. He stated that the staff in the kitchen were aware they needed to warm up the dishwasher. He stated usually if they had problems they would let him know and he could address it right away. During an interview on 01/09/2025 at 1:34 PM, the dietary manger stated that hand hygiene should be performed as soon as staff enter the door to the kitchen. She stated that if staff was prepping food and they touched a handle they should wash their hands. The Dietary manager stated that staff should wash their hands when they take their gloves off. The Dietary manager stated the dishwasher was supposed to reach 125 degrees Fahrenheit. She stated that when staff first started to run the dishwasher it needed to warm up. She stated once it warmed up it could be used to wash dishes. She stated that if the dishwasher sat it would need to be ran at least three times to warm up. Dietary manager stated if the correct temperature was not reached during the wash the dishes should not be washed as they may not be cleaned. The Dietary manager stated that the red buckets have sanitizer water. She stated staff should sanitize when they are done prepping food. She stated if you used the rag in the sanitizer buckets while [NAME] food it could splash into the food. During an interview on 01/09/2025 at 1:50 PM, [NAME] L stated that staff were supposed to perform hand hygiene before cooking and before working with food. [NAME] L stated that if you take your gloves off you should wash your hands. [NAME] L stated if you leave the food preparation area you were supposed to wash your hands. [NAME] L stated that the food preparation was anything on the same side as the food preparation table and this included the stove and cooler. [NAME] L stated she was supposed to sanitize the food preparation station before you prepared food and after. She stated you change the sanitation water every two hours, when you see particles, or it was cloudy. She stated there is sanitizer water in the red buckets in the kitchen. She stated you should not wipe near the food but stated she was done with the cabbage and was holding the container of food away from where she was wiping the puree clean. She stated you should not wipe or clean near food as it could cause cross contamination. During an interview on 01/09/2025 at 5:21 PM, the DON stated that hand hygiene in-services were done with the entire building, and this included kitchen staff. She stated she expected hand hygiene to be done all the time in the kitchen since they were handling food. During an interview on 01/09/2025 at 05:32 PM, the administrator stated she has not been made aware of any issues with the dishwasher in kitchen before we came in. She stated staff should warm it up before using it and get it to the correct temperature. The Administrator stated if staff were not warming up the dishwasher or if it did not get to the correct temperature the dishes may not come out clean and sanitized. The Administrator stated she expected staff to perform hand hygiene as needed in kitchen. She stated between dirty task to clean task hand hygiene was expected. Review of maintenance log for the last 6 months reflected no issues noted with the dishwasher. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of facility policy dated October 2008 titled Sanitation revealed the food service area shall be maintained in a clean and sanitary manner. Further review revealed low-temperature dishwasher (chemical sanitation) wash temperature should reach 120 degrees Fahrenheit. Review of facility policy dated October 2023 titled Handwashing/Hand Hygiene, revealed all personnel are expected to adhere to hand hygiene policies and practice to help prevent the spread of infection to other personnel, residents and visitors. Further review revealed staff should perform hand hygiene before applying non-sterile gloves. Review of facility policy dated April 2019 titled Food Preparation and Service revealed food and nutrition services employees prepare and serve food in a manner that complies with safe food handling practices. Review revealed, areas for cleaning dishes and utensils are located in a separate area from the food service line to assure a sanitary environment. Gloves are worn when handling food directly and changed between tasks.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 32452 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections, for one of one medication aides (MA P) observed for infection control practices during medication pass. MA P failed to sanitize the blood pressure cuff during medication pass after using it on Resident #40. This failure could place residents who require assistance with medication administration at risk for healthcare associated cross-contamination and infections. Findings include: Observation on 01/08/2025 at 9:58 AM revealed MA P removing a blood pressure cuff from her cart and entered Resident #40's room to perform a blood pressure check. After the blood pressure check she placed the blood pressure cuff back in her cart. MA P did not clean the blood pressure cuff before or after use. In an interview on 01/08/2025 at 10:29 AM MA P stated she did not clean the blood pressure cuff after she used it on Resident #40 or before putting it back in her cart. She stated by not cleaning it, it could lead to cross contamination and potential spread of infection. In an interview on 01/09/2025 at 11:50 AM the DON stated she expected MA P to sanitize resident care equipment between residents to prevent cross contamination and the spread of infection. Review of the facility's policy cleaning and disinfection of resident-care items and equipment dated 09/2022 reflected Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard .non-critical items are those that come in contact with intact skin but not mucous membranes. (1) Non-critical resident-care items include bedpans, blood pressure cuffs, crutches, and computers .non-critical items require cleaning followed by either low- or intermediate-level disinfection following manufacturers' instructions. Disinfection is performed with an EPA-registered disinfectant labeled for use in healthcare settings. All applicable label instructions on EPA registered disinfectant products are followed (e.g., use-dilution, shelf life, storage, material compatibility, safe use and disposal) . 42600		

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32452 Based on observation, interview, and record review the facility failed to ensure each room was designed or equipped to assure full visual privacy for 6 (Rooms 35, 36, 38, 39, 40, 41) of 6 dual occupancy rooms and 4 of (Rooms 92, 93, 94 and 95) of 4 single occupancy rooms reviewed for privacy in the facility. The facility failed to ensure that dual occupancy rooms and single occupancy rooms were provided with ceiling suspended curtains, which extended around the bed, to provide total visual privacy. This failure could lead to a lack of privacy for residents, allow residents' private medical treatment to be observed by roommates or others, and lead to a decline in psychosocial well-being. Findings included: Observation on 01/08/2025 at 10:44 AM of Rooms 35, 36, 38 and 41 revealed that each room had dual occupancy with an A and B bed in each. The rooms had a single ceiling to floor curtain that divided the center of the room but stopped approximately four feet from the opposite wall. The rooms did not have a second connecting curtain or partition that would allow for bed A or B to have total visual privacy. Observation on 01/08/2025 at 10:50AM of rooms [ROOM NUMBERS] revealed that each room had dual occupancy with an A and B bed in each. The rooms had a single ceiling to floor curtain that divided the center of the room but stopped approximately four feet from the opposite wall. The rooms did have a rail for a curtain for A bed, but no curtain was hung. Observation on 01/08/2025 at 10:50 AM of Rooms 92, 93, 94 and 95 revealed the rooms had no curtain and no rail to hang a privacy curtain in the room. In an observation and interview on 01/09/2025 at 12:40 PM the MS stated he thought he got all the rooms curtains fixed. Observation on rounds MS he stated that no, rooms 35-41 did not have curtain for A bed and the rooms that had the rail for a curtain did not have a curtain hanging. The MS stated that maybe they got dirty, and they took them down. The MS stated the single rooms 92-94 did not have a curtain or a rail at all which could expose the residents if the doors were open during care. He stated he did not know every room needed a privacy curtain; he thought if they were in the room alone they did not need one. Interview on 01/09/25 at 01:30 PM CNA F stated most of the rooms do not have the curtain for the A-bed. She stated when the door was opened if someone comes in it can expose the resident. Interview on 01/09/25 at 01:35 PM LVN B stated regarding rooms without privacy curtains that without the curtain the resident can be exposed. She stated you would have to make sure the resident was covered when anyone come in or out of the room. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/09/2025 at 12:45 PM the Administrator stated she thought the MS had installed all the privacy curtains since they had been cited for them last year. She stated all rooms should have privacy curtains to ensure resident privacy. She stated she expected the MS to maintain the facility. The Administrator stated they started putting up the curtains in double occupancy rooms and worked from there, but she had not done audit to make sure the work was being done. She stated she expected the MS to tell her when things needed to be fixed and keep her updated on his progress of current projects. Review of the facility's Quality of Life - Dignity policy dated August reflected, Each Resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Policy Interpretation and Implementation indicated: 6. Residents' private space and property shall be respected at all times. 10. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. Review of the facility's policy Bedrooms dated May 2017 reflected .Each room is designed to provide full visual privacy for each resident (in the form of ceiling-suspended curtains that extend around the bed) and equipped for adequate nursing care .		