STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676326	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Rehabilitation and Care Center	1101 Windbell Dr Mesquite, TX 75149

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on interviews and record review, the facility failed to ensure assessments accurately reflected the resident's status for 3 (Residents #17, #37, and #60) of 8 residents reviewed for accurate MDS assessments. Resident #17's Admission MDS assessment (Section L) by MDS Coordinator dated 08/31/23 was coded not having any dental problems. Resident #37's Admission MDS assessment (Section L) by MDS Coordinator dated 02/26/24 was coded not having any dental problems. Resident #60's Admission assessment (Section L) by MDS Coordinator dated 10/09/23 and Quarterly assessment (Section L) dated 01/19/24 were coded not having any dental problems. These failures placed residents at risk of not receiving care and services to meet their needs which could cause decay and loss of teeth, pain, chewing and swallowing problems which could result in decline in health and well-being. Findings included: 1) Review of Resident #17's Admission MDS Assessment signed by RN Assessment Coordinator RN G dated 08/31/23 who admitted on [DATE] revealed a [AGE] year-old male with a BIMS score of 11 (moderate cognitive impairment). He ate independently with setup assistance only, extensive assistance with one-person physical assistance, and no dental. Supervision with touch assistance for Oral hygiene and medically complex diagnosis. And section L (signed by MDS Coordinator): Dental None of the above were present for oral/dental status. Review of Resident #17's Progress Note by Former SW F dated 09/01/23 revealed, SW completed resident's Admission MDS Assessment for 8/31. Resident has clear speech and no teeth; He has top/bottom dentures that he left at home because he doesn't like to wear them . (continued on next page)

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

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and Interview on 04/10/24 at 11:32 am Resident #17 stated he would like to see the dentist and had told the staff he needed a dental checkup. He stated not having any dental pain because he had no teeth. He stated he had dentures but could not get used to them because they were not comfortable to wear. He stated he had to use his gums to eat his food and as long as his food was soft, he could manage. He stated he had spoken to the nurses about needing to see the dentist and they said they would let the SW know. He opened his mouth, and he did not have any teeth. 2) Review of Resident #37's Admission MDS Assessment by RN Assessment Coordinator DON dated 02/26/24 revealed a [AGE] year-old male who admitted [DATE] with severely impaired vision and BIMS score of 13 (intact cognition). He needed supervision or touching assistance with eating and oral hygiene and partial/minimum assistance with personal hygiene one person assistance. And for Section L (Signed by MDS Coordinator): Dental None of the above were present. Observation and interview on 04/12/24 at 9:50 am, Resident #37 was sitting up in bed and stated he would like to be seen by the dentist and did not know this facility had a dentist. He stated having only 8 upper teeth, 7 lower teeth, and 2 root canals and said he had not seen a dentist since being here 2 months. He stated he had no pain or problems chewing, but one of his upper molar teeth he took out himself last year. He stated the last time he went to a dentist was a couple of years ago. He stated he would like to get all of his top teeth taken out then opened his mouth which revealed six brownish broken upper teeth, two broken front teeth, and the lower teeth looked brown, and several teeth were missing. 3) Review of Resident #60's Admission MDS Assessment signed by RN Assessment Coordinator RN G dated 10/09/23 revealed an [AGE] year-old female who admitted [DATE] with a BIMS score of 05 (severe cognitive impairment) and needed supervision with touch assistance with eating, and substantial/maximal assistance with personal hygiene. She had other neurological conditions and for section L (signed by MDS Coordinator): Dental None of the above were present. Review of Resident #60s Quarterly MDS Assessment signed by RN Assessment Coordinator DON dated 01/19/24 revealed an [AGE] year-old female who admitted [DATE] with a current BIMS score of 06 (severe cognitive impairment). She needed set-up assistance with eating, supervision with touching for oral hygiene, and substantial assistance for personal hygiene. She had neurological conditions section L (signed by MDS Coordinator): Dental had no checkmarks in the dental section. Review of Resident #60's Nurses Notes by MDS assessment dated [DATE] at 1:33 pm revealed, Interviews and evaluations completed for MDS: 02/29/24 quarterly .Dental Natural teeth missing several in poor condition. Interview and observation on 04/12/24 at 9:41 am, Resident #60 stated she had been at this facility for a while and needed to see the dentist. She was missing two upper front teeth, other teeth were brownish and broken, and the upper left tooth was brownish, very crooked, and angled very differently from the other teeth. And the bottom teeth were brownish, and several teeth were missing and broken off. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/12/24 at 1:22 pm, LVN D stated Resident #17 had no issues with his teeth and was not sure if he had missing or no teeth at all. She stated he had no issues with tolerating his meals, but he tended to eat slowly at times. She stated Resident #37 had teeth but was not sure if he had any missing teeth and Resident #60 ate very good and she had not noticed her having any missing or broken teeth. She stated anytime she noticed a resident needing dental work or complained of pain she called the resident's Doctor and notified the SW. She stated they were without a SW for one or two months. She stated normally when residents first admitted they assessed the residents and if they had missing or broken or no teeth, they notified the Doctor and SW for a dental consult. In an interview on 04/12/24 at 3:15 pm, the MDS Coordinator (LVN) stated the nurses did the dental assessments upon the resident's admissions and after that the dental assessments were done as a part of the MDS assessments. She stated after reviewing Residents #17, #37, and #60 Admission Nurses assessments, the nurses did not document any issues with their teeth. She stated after the charge nurses did their initial dental evaluations, she reviewed it and the SW notes to fill out her section of the dental assessments. She stated she did Resident #17's MDS Assessment on 03/02/24 and coded he had no actual teeth but had upper and lower dentures with poor fit. She stated not being sure why his 08/31/23 MDS showed he had no dental issues that was done by the former SW F. She stated after review of former SW F notes revealed Resident #17 had dentures he chose not to wear and said she was not sure why. She stated former SW F should have put he had upper and lower dentures not fitting on his 08/31/23 Admission MDS Assessment and was not sure why she did not do that. She stated she did Resident #37's Admission MDS assessment dated [DATE] including the Dental section L and tried to do his dental assessment, but he refused to open his mouth. She stated she did not try to make another attempt to assess his teeth and was not sure why. She stated she checked None of the above on his Admission MDS despite the resident saying he had natural teeth and thought she saw he had teeth but was not able to tell the condition of them. She stated she believed he had natural teeth that was why she coded None of the above because he was not complaining of pain and in hindsight should have coded, he had natural teeth that were broken. She stated Resident #60's Quarterly MDS assessment dated [DATE] was coded None in poor condition. She stated she did not assess Resident 60's teeth when she first admitted . She stated since having this conversation with the HHSC State Surveyor she was going to start going behind the nurses and SW and do her own dental assessments, not rely on what they said, and would do her own documentation. She stated if residents were not getting appropriate dental assessments upon admission and quarterly assessments, the resident's teeth could deteriorate and get infected, and they could start having cardiac issues and poor appetite that could lead to a lot of other things. In an interview on 04/12/24 at 4:32 pm, the DON stated she was not aware of any issues with the Dental section of the MDS Assessments being inaccurate. She stated it was the responsibility of the person coding that section for it to be right. She stated when the residents admitted to this facility, the nurses were to do their admission assessments including the condition of their teeth and stated there were no issues with the nurse's admission assessments. She stated the nurse's dental assessments depended on a lot of factors because the residents may not always open their mouths. She stated based on the observation seen they needed to document it accurately. She stated she was not sure who did the dental section of the MDS Assessments and could not really say but thought the MDS Coordinator was responsible for ensuring the MDS Assessments were accurate. She stated after everyone completed their parts, she signed the MDS Assessment as the RN, but said she was not responsible for ensuring the MDS Assessments were accurate. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/12/24 at 4:50 pm, the Administrator stated not being aware of any errors with the MDS assessments for Residents #17, #37, and #60. He stated the MDS Coordinator, and the DON were responsible for ensuring the MDS Assessments were accurate. He added his expectations for the MDS Assessments were for them to always be accurate and to know how their residents were and the resident's plan of care. He stated, I know what can happen to the residents if they were not getting accurate assessments, but I don't want to say because it will be quoted in the tag. He stated his plan to prevent inaccurate MDS assessments was to ensure the MDS assessments were done accurately. He stated he planned to solicit the assistance of corporate to develop a plan of correction and monitoring tool. Review of the facility's MDS Nursing Policies and Procedures email revision dated 09/28/23 revealed, Subject: Minimum Data Set (MDS) .Policy: A licensed nurse will conduct or coordinate each assessment with the interdisciplinary team. An MDS, which is comprehensive, accurate .will be completed for each resident . The facility is responsible for addressing all the needs and strengths of each resident .Each staff member will note their liability for the accuracy of data recorded by signing (electronically) their name and identifying the MDS Sections and questions to which they provided responses. A registered nurse (RN) must sign and certify that the assessment is completed .3. Interview, observe, and physically assess to obtain validation of items identified on the medical record and to collect information for items where no documentation exists. Documentation of participation must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070 Based on observations, interviews, and record review the facility failed to review and revise the person-centered comprehensive care plan to reflect the resident's current status, for 2 of 6 residents (Resident #33 and Resident #58) reviewed for care plans. The facility did not update Resident #33's care plan to reflect goals and interventions for the current fall. The facility did not update Resident #58's care plan to reflect goals and interventions for the current falls. This failure could place residents at risk for not receiving appropriate care and intervention to meet their current needs. The findings were: Review of Resident #33's MDS quarterly assessment dated [DATE], reflected he was a [AGE] year-old male admitted on [DATE]. His diagnoses included Huntington Chorea (neuro-muscular disease), dementia (confusion), anxiety disorder, and muscle weakness. He had a BIMs score of 6 which reflected his cognitive status was severely impaired. He required moderate to maximum assist of one staff member for activities of daily living. Section J of the MDS was marked for falls. Record review of Resident #33's Care Plan initiated on 08/02/23 reflected, it had been edited on 04/11/24, there was no updated problem listed for the fall or a revision to the care plan goals specific for the latest fall with injury on 03/14/24. Record review of the incident/accident logs dated 01/2024 through 04/2024 reflected on 03/14/2024 Resident #33 attempted to transfer himself from his low bed to his wheelchair, falling and lacerating the back of his head, that required a trip to the emergency room , where Resident #33 received staples to the back of his head. Review of Resident #58's MDS quarterly assessment dated [DATE], reflected he was an [AGE] year-old male admitted on [DATE]. His diagnoses included: Traumatic subdural hemorrhage (brain bleed), malignant neoplasm of the prostate (cancer of the prostate), and dementia (confused). His BIMs score of 9 reflected his cognitive status was moderately impaired. He required moderate to maximum assist of one staff member for activities of daily living. Record review of Resident #58's Care Plan initiated on 01/05/24 reflected, the care plan had been edited on 04/15/24 there was no updated problem listed for the fall or a revision to the care plan goals specific for the latest fall on 02/24/24. Record review of the incident/accident logs dated 01/2024 through 04/2024 reflected on 02/24/24 Resident #58 had a non-injury related fall, when he was observed sitting next to his bed on his stability mat, when he tried to transfer himself without any assistance. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/12/24 at 11:30 a.m. with the DON and the ADON revealed, the MDS/care plan nurse should be aware of any changes with the residents. She stated we go over all the falls and changes of resident's condition in the morning meetings. She would be able to update all care plans then. Both the DON and the ADON stated that the MDS/care plan nurse answered directly to the Administrator. The DON stated that she does sign off on the MDS's as being completed and she does attend care plan meetings. The ADON stated she attended care plan meetings also. She stated we do not always attend the meetings together we take each other's place for nursing. Both the DON and the ADON were aware that Resident #33 and Resident #58 had falls. They were both aware the last fall resulted in an injury for Resident #33. The DON and the ADON stated they were unaware if the care plans had been updated. The DON stated she did not follow-up on the plan of care that was through regional oversight, she presumed, she had never been asked to oversee the plans of care. The DON stated if the care plans were not follow-up on appropriately then the staff would not know what the goals are. The DON stated Resident #58 fell with an injury, this should be on his plan of care, to guide in assisting in preventing further falls. The DON stated the MDS/care plan nurse conducts and schedules the meetings and the department heads all attend. In an interview on 04/12/24 at 3:00 p.m. with the Administrator revealed the MDS/care plan nurse was not working today. The Administrator stated he was aware there was a problem with the care plans. He stated the corporation had conducted a Mock survey and that was one of the deficiencies they had been working on. The Administrator stated it was a work in progress. He was unclear who was following up on the care plans . Attempts were made to contact the MDS/care plan nurse on 04/12/24 at 1:00 p.m., 2:15 p.m., and 4:00 p.m. Review of the facility's policy titled Care plan Process and Person-Centered Care dated May 1,252023, reflected the following: 6.The Interdisciplinary Team (IDT) will review for effectiveness and revise the person-centered care plan after each assessment. This includes both the comprehensive and quarterly assessments. For the comprehensive assessment the review will be completed with seven (7) days of and no more than 21 days after admission. 9.Thru ongoing assessment, the facility will initiate person-centered care plans when the resident's clinical status or change of condition dictates the need such as but not limited to falls and pressure ulcer development. 11.The person-centered care plan includes: A. Date B. Problem C. Resident goals for admission and desired outcomes D. Time frames for achievement E. Interventions, discipline specific services, and frequency (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F. Refusal of services and/or treatments 1) Evaluation of resident's decision-making capacity 2) Educational attempts 3) Attempts to find alternative means to address the identified risk/need G. Discharge plans 1) Resident's preference and potential for future discharge 2) Resident's desire to return to the community and any referrals to local contact agencies and/or other appropriate entities, for this purpose H. Resolution/Goal Analysis

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on observations, interviews, and record review, it was determined the facility failed to provide de or obtain from an outside resource, in accordance with routine dental services to meet the needs of each resident or two (Residents #17 and #60) of 8 residents reviewed for social services. The facility failed to ensure Resident #17 was referred to the dentist after he admitted [DATE]. The facility failed to ensure Resident #60 was referred to the dentist after she admitted [DATE]. These failures could affect the residents by placing them at risk of deteriorating teeth causing pain and swallowing issues resulting in a decrease in their health and psycho-social well- being. Findings included: 1) Review of Resident #17's Admission MDS Assessment signed by RN Assessment Coordinator RN G dated 08/31/23 revealed a [AGE] year-old male admitted on [DATE] with a BIMS score of 11 (moderate cognitive impairment). He ate independently with setup assistance only, extensive assistance with one-person physical assistance, and no dental. Supervision with touch assistance for oral hygiene and medically complex diagnosis. And section L (signed by MDS Coordinator): Dental None of the above were present for oral/dental status . Review of Resident #17's Quarterly MDS Assessment signed by RN Assessment Coordinator DON dated 03/02/24 revealed a [AGE] year-old male who admitted [DATE] with a BIMS score of 09 (moderate cognitive impairment). For Supervision or touch assistance with feeding and oral hygiene and substantial/maximum assistance with personal hygiene. And for section L (Signed by MDS Coordinator): Dental Broken and loosely fitting denture or partial ., Review of Resident #17's Progress Note by Former SW F dated 09/01/23 revealed, SW completed resident's Admission MDS Assessment for 8/31. Resident has clear speech and no teeth; He has top/bottom dentures that he left at home because he doesn't like to wear them . Observation and Interview on 04/10/24 at 11:32 am Resident #17 stated he would like to see the dentist and had told the staff he needed a dental checkup. He stated not having any dental pain because he did not have any teeth. He stated he had dentures but could not get used to them because they were not comfortable to wear. He stated he had to use his gums to eat his food and as long as his food was soft, he could manage. He stated he had spoken to the nurses about needing to see the dentist and they said they would let the SW know. He opened his mouth, and he did not have any teeth. Review of Resident #17's Physician's Order dated 08/29/23 revealed, Consults: .Dental as needed. 2) Review of Resident #60's Admission MDS Assessment signed by RN Assessment Coordinator RN G dated 10/09/23 revealed an [AGE] year-old female who admitted [DATE] with a BIMS score of 05 (severe cognitive impairment) and needed supervision with touch assistance with eating, substantial/maximal assistance with personal hygiene. She had other neurological conditions and for section L (signed by MDS Coordinator): Dental None of the above were present. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) Review of Resident #60s Quarterly MDS Assessment signed by RN Assessment Coordinator DON dated 01/19/24 revealed an [AGE] year-old female who admitted [DATE] with a current BIMS score of 06 (severe cognitive impairment). She needed set-up assistance with eating, supervision with touching for oral hygiene and substantial assistance for personal hygiene. She had neurological conditions section L (signed by MDS Coordinator): Dental had no checkmarks in the dental section. Review of Resident #60's Nurses Notes by MDS assessment dated [DATE] at 1:33 pm revealed, Interviews and evaluations completed for MDS: 02/29/24 quarterly .Dental Natural teeth missing several in poor condition. Review of Resident #60's Physician's Order dated 10/07/23 revealed, Consults: .Dental as needed. Interview and observation on 04/12/24 at 9:41 am, Resident #60 stated she had been at this facility for a while and needed to see the dentist. She was missing two upper front teeth and other teeth was brownish and broken and the upper left tooth was brownish and very crooked and angled very differently from the other teeth. And the bottom teeth were brownish, and several teeth was missing and broken off Review of the dental referrals for the past 6 months did not reveal any initial consults or follow-up dental visits for Residents #17 and #60. Review of Residents #17 and #60's all discipline Progress Notes did not reveal they had any dental consults. Interview on 04/11/24 at 4:40 pm, SW E stated he had just started working at this facility three weeks ago. He stated there was no dental issues he was aware of for Residents #17 and #60 and was not currently working on dental referrals for them to see the dentist. He stated he would review the dental referrals list to see if they were on the list to be seen. He stated if they were not on the list, he would talk to these two residents and do their dental assessments and go from there with getting them dental referrals. Interview on 04/12/24 1:22 pm, LVN D stated Resident #17 had no issues with his teeth and was not sure if he had missing or no teeth at all. She stated he had no issues with tolerating his meals, but he tended to eat slowly at times. She stated Resident #60 ate very good, and she had not noticed her having any missing or broken teeth. She stated anytime she noticed a resident needing dental work or complained of pain she called the resident's Doctor and notified the SW. SW. She stated they were without a SW for one or two months. She stated the DON was handling the resident's dental referrals, the new SW did them now. She stated normally when residents first admitted they assessed the residents and if they had missing or broken or no teeth, they notified the Doctor and SW for a dental consult. Interview on 04/12/24 at 12:46 pm, BOM stated she did all of the residents' financial adjustments of the residents (AI) Applied Income and Resident #60 was not paying for any dental services. She stated Resident #17 was medicaid pending and was not aware of him paying for any inhouse or outside dental provider services. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/12/24 3:15 pm, MDS Coordinator (LVN) stated the nurses did the resident's dental assessments upon their admission and quarterly assessments after that. She stated after she reviewed Residents #17 and #60's Admission Nurses assessments, the nurses did not document any issues with their teeth. She stated for the past few months the DON handled the resident's dental needs and added after review of former SW F notes revealed Resident #17 had dentures he chose not to wear and said she was not sure why. She stated not being sure if a dental referral was made to get Resident #17 a dental consult because former SW F just left a few months ago. She stated former SW F should have put he had upper and lower dentures not fitting on his 08/31/23 Admission MDS Assessment and was not sure why she did not do that. She stated Resident #60 was missing several teeth that were in poor condition and coded none of the above her Quarterly MDS Assessment 02/29/24 and Resident #60 had no SW notes to review. She stated she notified the DON about Resident #60's need for a dental checkup in February 2024 then said she honestly could not remember if she did or not. She stated she did not assess Resident 60's teeth when she first admitted and former SW F should have referred her to the dentist because of the poor condition of her teeth. She stated the DON was responsible for coordinating who received dental consults and stated she was not sure if she spoke to the DON about dental referrals for Residents #17 and #60. She stated since having this conversation with the HHSC Surveyor she was going to start going behind the nurses and SW and do her own dental assessments and not rely on what they said and did her own documentation. She stated if residents were not getting appropriate dental assessments upon admission and quarterly the residents' teeth could deteriorate and get infected, they could start having cardiac issues and poor appetite that could lead to a lot of other things. She stated she was currently emailing the DON to see about getting Residents #17 and #60 dental consults. In an interview on 04/12/24 at 4:32 pm, the DON stated when the residents admitted to this facility, the nurses had to do admission assessments including the condition of their teeth and stated there were no issues with the nurse's admission assessments being inaccurate. She stated the nurse's dental assessments depended on a lot of factors because the resident may not always open their mouths. She stated no one notified her about getting dental referrals for Resident #17 and #60 but stated she would seek getting them dental consults. She stated they were without a SW for about three or four months (since January 2023) and that she was responsible for arranging the resident's dental consults. She stated they have a new SW E who just started working here two weeks ago. She stated If the nurses did not accurately assess the resident's dental status and refer them for dental care the residents could start losing weight because of not eating, they could experience pain, or gum pain and infections. In an interview on 04/12/24 at 4:50 pm, the Administrator stated not being aware of any issues with dental referrals for Residents #17 and #60. He stated when they were without a SW, the DON was responsible for referring the residents for dental checkups. He stated, I know what can happen to the residents if they were not getting dental consults, but I don't want to say because it will be quoted in the tag . He stated his plan to prevent inaccurate MDS assessments was to ensure the MDS assessments were done accurately and done as needed. He stated he planned to solicit the assistance of corporate to develop a plan of correction and monitoring tool (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676326	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Rehabilitation and Care Center	1101 Windbell Dr Mesquite, TX 75149

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Social Services Policies and Procedures undated revealed, Subject: .Dental care providers - Resident Right For .Policy: The facility respects and upholds the patient and resident's rights to choose providers for .dental care, treatment, and services. 1. Upon admission, the facility will provide a list of .dental care providers available to the facility .Procedures: 1. Upon admission, the patient or resident receives a list of licensed providers of . dental .3. Facility staff assist with or schedule appointments and transportation arrangements for . dental care, as necessary .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070 Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for three (Residents #1, #10, and #34) of six residents reviewed for infection control. LVN A failed to disinfect the blood pressure cuff (machine used for checking blood pressure) in between blood pressure checks for Residents #10, #34, and unknown resident. LVN B and RN C failed to disinfect the glucometer machine (an instrument for measuring the concentration of glucose in the blood) between resident use, for resident #1. This failure could place residents at-risk of cross contamination which could result in infections or illness. Findings included: Review on 04/10/24 of Resident #10's EHR revealed the resident was a [AGE] year-old male that was admitted to the facility on [DATE], readmission on 02/26/24 with diagnoses including Hypertension (elevated blood pressure) and cerebral vascular disease (heart disease). Review of Resident #10's five-day MDS, dated [DATE], revealed a BIMS score of 13, indicating intact cognition for decision making, and his functional status indicated he needed one person assist only with his ADLs. Record review of Resident #10's physician orders dated 04/06/24 reflected, Hydralazine (High blood pressure medication) tablet; 25 mg, give 1 tablet by mouth one time a day for elevated blood pressure. Hydrochlorothiazide (High blood pressure medication) tablet give one tablet three times a day. Hold for systolic blood pressure less than 100. Review on 04/10/24 of Resident #34's EHR revealed the resident was an [AGE] year-old female that was admitted to the facility on [DATE], with readmission on 09/19/22 with diagnoses including Hypertension (increase in blood pressure) and Congestive heart failure (heart disease). Review of Resident #34's optional state assessment MDS, dated [DATE] revealed a BIMs score of 11, indicating she was moderately cognitively impaired for decision making, and her functional status indicated she needed assist of one staff with his activities of daily living. Record review of Resident #34's physician orders dated 04/06/24 reflected, Amlodipine (High blood pressure medication) tablet; 5mg, give one tablet every day. Hold for systolic blood pressure less than 110. Review on 04/05/23 of Resident #1's EHR revealed the resident was a [AGE] year-old female that was admitted to the facility on [DATE], with a diagnosis including Diabetes (elevated blood sugar). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's quarterly MDS, dated [DATE] revealed a BIMs score of 6, indicating severe impairment for decision making, and her functional status indicated she needed assist of one staff with her ADLs. Record review of Resident #1's physician orders dated 04/06/24 reflected, Humalog Kwik Pen subcutaneous solution pen-injector100 unit/ml (insulin) as sliding scale, before meals and at bedtime. Following checking fasting blood sugar before meals and at bedtime. Observation on 04/10/24 at 8:45 a.m. revealed an unknown resident at the medication cart with LVN A taking his blood pressure. LVN A completed taking the resident's blood pressure, and placing the blood pressure cuff back on the top of the medication cart. LVN A failed to sanitize the blood pressure cuff before or after using it on the resident. Observation on 04/10/24 at 9:00 a.m. revealed LVN A performing morning medication pass, during which time she checked the blood pressures on Resident #10. LVN A failed to sanitize the blood pressure cuff before or after using it on Resident #10. Observation on 04/10/24 at 9:26 a.m. revealed LVN A performing morning medication pass, during which time she checked the blood pressures on Resident #34. LVN A failed to sanitize the blood pressure cuff before or after using it on Resident #34. Observation on 04/11/24 at 11:30 a.m. revealed LVN B (training RN C) performed a blood sugar test on Resident #1. LVN B sanitized the glucometer machine (an instrument for measuring the concentration of glucose in the blood) without using the appropriate sanitizing wipes, using an alcohol swab instead before and after testing Resident #1's blood. In an interview on 04/10/24 at 9:45 a.m., LVN A stated she was unaware she was supposed to use the purple top sanitizing wipes to sanitize the blood pressure cuff between usage. LVN A stated she knew to use the sanitizing wipes between usage on the glucometers because that was blood. She stated there had been in-services on infection control and cleaning equipment, but she did not recall talking about blood pressure cuffs. LVN A stated that if blood pressure cuffs were not cleaned appropriately it could spread germs. Interview on 04/11/24 at 4:00 p.m., LVN B and RN C revealed LVN B stated she knew that reusable equipment, like glucometers, should be sanitized with purple top sanitizing wipes between each resident to prevent transmitting an infection from one resident to another. She stated she was supposed to cleanse the glucometer before and after using purple top sanitizing wipes, but she was just not paying attention, talking instead. LVN B stated that if the equipment that was used on the residents was not cleaned correctly it could cross contaminate causing a spread of infection. RN C did not comment when the equipment (glucometer) was cleaned with an alcohol swab. RN B stated she knew to use the purple top sanitizing wipes to cleanse the glucometers between each usage. Both nurses were asked about cleaning other equipment, they both stated the glucometers were all you used the purple top sanitizing wipes on, except to wipe down the top of the medication carts, and not on blood pressure cuffs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/11/24 at 4:36 p.m. with the DON she stated that her expectation was that staff would sanitize all reusable equipment between each resident use. She stated that not doing so placed residents at risk of cross contamination of infections from one resident to another. She stated there was plenty of supplies for the nursing staff to have the sanitization wipes that are EPA-registered disinfectant, on all the medication carts. The DON stated there had recently been conducted an in-service for the staff on infection control and cleaning equipment. Review of the in-service records dated 03/31/24 reflected in service training topic Infection control and cleaning equipment, Glucometer Acuchecks [brand name of the glucometer] disinfection, and essential equipment (blood pressure cuff) LVN A's and LVN B's names was on the list and LVN A's and RN C's name was not further review reflected follow-up activity with competencies review .there were no presented follow-up competencies reports. Review of facility's Policies and Procedure titled: Infection prevention and control cleaning and disinfection of resident care items and equipment, dated May 15, 2023. Subject: disinfection and cleaning of patient/resident care equipment: blood glucose meters, point of care testing devices: Policy: glucometers and point of care testing devices will be maintained, cleaned, and disinfected in accordance with acceptable polices . 3. Disinfection: Cleaned out with chemical germicide As a non-critical item, the blood glucose meter and point of care testing devices do come in contact with intact skin and does not make direct contact with the patient/resident. However, a contaminated device may be a source of transmission of Bloodborne pathogens and other microorganisms to the next resident/patient if the equipment is not adequately cleaned and disinfected. 2. Alcohol is not approved for disinfecting items which are potentially contaminated with blood 4. The Facility uses a two-step cleaning and disinfecting procedure between every patient resident use: 5. Use an EPA disinfectant wipe which is labeled effective against TB or HBV, HCV, and HIV to remove any visible contaminants, soil, or other debris . 6. Use a second EPA disinfectant wipe to disinfect the device surfaces, ensuring adequate contact time. A. Contact time is the total time needed for the disinfectant solution to remain wet on the surface to achieve disinfection of all the stated efficacy kill claims. The contact time requirement can be located on the product's label.