STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676347	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amarillo Center for Skilled Care	6641 W Amarillo Blvd Amarillo, TX 79106

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813 Based on observation, interview, and record review, the facility failed to ensure that the residents environment remained as free from accident hazards as was possible; and that each resident received adequate supervision to prevent accident hazards for one resident (Resident #171) of 18 residents observed for accident hazards. -Resident #171 had an oxygen bottle/cylinder left unsecured in her room. This failure could affect all the residents at the facility by placing them at risk for accidents that lead to injuries such as bruising, skin tears, fractures, and feeling of isolation. Findings include: Record review of the clinical record for Resident #171 revealed a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include aftercare following joint replacement surgery, malnutrition (lack of proper nutrition), epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), hypertension, (a condition in which the force of the blood against the artery walls is too high), and cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it). Record review of Resident #171's clinical record revealed she had been in the facility 6 days and an MDS was not due to be completed. Record review of Resident #171's clinical record revealed a care plan with the following: admitted : 11-14-2024 Focus: The resident has oxygen therapy. Date initiated - 11-14-2024. Record review of Resident #171's clinical record revealed active orders as of 11-20-2024. Resident #171 had no orders for Oxygen therapy. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676347	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #171's clinical record revealed a Medication Administration Record for the month of November 2024 with no administration of oxygen therapy listed. During an observation on 11-20-2024 at 07:18 AM revealed Resident #171 was in her room laying on her bed (Bed B) under her covers and did not wake to knocking or introduction. Resident #171's room was noted to have an oxygen bottle lying at the foot of the mattress on the second bed (Bed A that was unoccupied due to Resident #171 did not have a roommate) that was not secured. During an observation and interview on 11-20-2024 at 10:56 AM revealed Resident #171 was in her room sitting in her chair. Observation revealed the unsecured oxygen bottle had been removed from the room. Resident #171 reported that she had never used oxygen, that she was aware that someone came into her room a day or two ago and placed the oxygen bottle on the extra bed, and that she was not aware of who the oxygen bottle belonged to. Resident #171 was unable to remember who placed the oxygen bottle on the second bed. During an interview on 11-21-2024 at 10:48 AM CNA E (CNA for the hall Resident #171 was on this shift) reported that an oxygen bottle should not be left unsecured on a resident's bed because it could fall and explode and that could result in an injury to a resident. CNA E verified that she had been trained through the facility online training system on oxygen safety and that she was not the one who placed the oxygen bottle on the bed. During an interview on 11-21-2024 at 01:26 PM LVN A (a nurse from a different hall that Resident 171 was on) reported that an oxygen bottle should be stored upright and secured in the oxygen room away from any flames. LVN A reported that an oxygen bottle should never be placed unsecured on a resident's bed and that if it was the oxygen bottle could fall off the resident's bed resulting in an injury to a resident or staff. LVN A verified that he had been trained through the facility online training system on oxygen safety and that he had not worked on Resident #171's hall. During an interview on 11-21-2024 at 01:47 PM the DON reported that all oxygen tanks should be stored in a carrier either on the resident's wheelchair or in a secured carrier when transported, that if an oxygen tank was not secured such as with placing on a resident bed, then the tank could fall and explode resulting in an injury to either a resident, family, or a staff member. The DON reported that she suspected that either a hospice staff member had placed the oxygen bottle on the mattress or when the resident was admitted she entered the facility on oxygen and whoever brought her in left it on the bed. The DON stated that she could not be sure of who put the oxygen bottle on the bed. Record review of the facility provided policy titled Compressed Gas, Safe Handling of reviewed 12-10-2015, revealed the following: 11. When tanks are stored, all tanks and cylinders should be stored in a cylinder cart or securely chained in a secure storage area. Never leave cylinders free-standing. All cylinders must be individually secured.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813 Based on observation, interview, and record review, the facility failed to ensure that residents who need respiratory care were provided such care consistent with professional standards of practice for 1 (Resident #4) of 4 residents reviewed for respiratory care. The facility failed to administer oxygen at the correct dose for Resident #4. This failure could affect all resident on oxygen therapy by placing them at risk for respiratory compromise and associated complications such as shortness of breath, confusion, respiratory failure, and exacerbation of their condition. Findings include: Record review of Resident #4's clinical record revealed an [AGE] year-old female resident admitted to the facility originally on 5-8-2017 and readmitted on [DATE] with diagnoses to include chronic respiratory failure (a long-term condition that occurs when the body's respiratory system can't exchange oxygen and carbon dioxide properly) with hypoxia (low level of oxygen in your body tissue), pneumonia (lung inflammation caused by a bacterial or viral infection), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), diabetes, (a chronic condition that affects the way the body processes blood sugar (glucose), and history of pulmonary embolism (clot blocking blood flow to lungs). Record review of Resident #4's clinical record revealed her last MDS was a quarterly completed 10-4-2024 listing her with a BIMS of 11 indicating she was moderately cognitively impaired, and she had a functionality of requiring partial/moderate assistance with most of her activities of daily living. Section O-Special Treatments, Procedures, and Programs-Respiratory Programs: Oxygen Therapy-Resident #4 was marked as having oxygen While a Resident. Record review of Resident #4's Order Summary Report with Active Orders as of 11-20-2024 revealed the following order: -Oxygen @__3__l/m via nasal canula PRN as needed for Shortness of Breath related to CHRONIC RESPIRATORY FAILURE WITH HYPOXIA - Active 06-18-2021 Record review of Resident #4's clinical record revealed a care plan with the admitted [DATE], last review date of 10-8-2024 revealed the following: Focus: Resident has Oxygen Therapy R/T CHRONIC RESPIRATORY FAILURE W/ HYPOXIA, RESIDENT EXPERIENCES SOB at times Date Initiated: 07-25-2017 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Revision on: 08-03-2022 Goals: The resident will have no s/sx of poor oxygen absorption through the review date. Date Initiated: 07-25-2017 Revision on: 04-28-2023 Target Date: 12-09-2024 Procedure: Apply O2 as ordered. Date Initiated: 07-25-2017 During an observation and interview on 11-20-2024 at 07:52 AM revealed Resident #4 was in her room eating her breakfast. Resident #4 was wearing oxygen via a nasal cannula (NC) at 5L/min. Resident #4 reported that staff provided all her oxygen care, and that she had no concerns. During an observation on 11-20-2024 at 11:39 AM revealed Resident #4 was sleeping in her bed with her oxygen on via NC at 5L/min. During an observation on 11-21-2024 at 07:25 AM revealed Resident #4 was sleeping in her bed with her oxygen on via NC at 5L/min. During an observation on 11-21-2024 at 09:48 AM revealed Resident #4 was sleeping in her bed with her oxygen on via NC at 5L/min. During an observation and interview on 11-21-2024 at 10:19 AM revealed LVN A (the nurse responsible for Resident #4 this shift) entered Resident #4's room and checked her oxygen. LVN A reported that Resident #4's oxygen was currently at 5L/min via her nasal canula which Resident #4 was wearing and that to his knowledge that was too high. LVN A then turned the Oxygen level/dose down. LVN A reported he was going to verify the correct oxygen dose that Resident #4 was ordered to be on. LVN A checked Resident #4's chart and verified the current orders were for Resident #4's oxygen to be at 3L/min and reported that he would immediately ensure that Resident #4's oxygen dose was corrected. LVN A reported that oxygen that was administered at too high of a dose was a medication error and that giving a resident to much oxygen could affect a resident negatively, that it could compromise the resident's ability to breath. During an interview on 11-21-2024 at 01:49 PM the DON reported that she expects her staff to follow all physician's orders in a timely manner. The DON stated that if a staff member questions a physician order, then she expected them to call and clarify that order before implementing the order. The DON reported that she expected all orders to be checked every shift and ensure that they were accurate and implemented correctly. The DON verified that not following an oxygen order was considered a medication error and that administering too much oxygen could result in hyperinflation or O2 toxicity for a resident. Record review of the facility provided policy titled Oxygen Administration reviewed 2-13-2007, revealed the following: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Goals: 1. The resident will maintain oxygenation with safe and effective delivery of prescribed oxygen.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47159 Based on observation, interview and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for food safety. The facility failed to ensure all food in the dry pantry and cold storage areas were properly sealed, labeled and dated. These failures could place residents at risk of residents at risk of food-borne illness and a diminished quality of life. Findings included: On [DATE] at 7:08AM an initial observation of the kitchen was conducted, and the following was noted: Dry Pantry: (2) 1.57-pound of bags of cream soup base-best by date [DATE]. (5) 24-ounce containers of quick grits-best by date [DATE]. (1) partial food service bag of elbow macaroni-no date, open to air. (6) 24-ounce packages of pepper gravy mix-no date. (7) 28-ounce boxes of creamy wheat cereal-no date. Cold Storage Unit: (2) 3-count each packages of English cucumbers-no label, no date. (1) partial 3-pound bag of hot dogs-no label, out of freezer date [DATE]. (1) partial gallon container of lime juice-best by date [DATE]. (1) 1-gallon zip closure bag of sausage links-no label, date on bag [DATE]. (1) partial 5-pound bag of Queso Cotija cheese-open to air. (1) partial 5-pound bag of feta cheese-open to air. (3) 1-gallon bags of scrambled eggs-use by date [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Dietary Manager [DATE] at 1:02PM revealed the negative outcome of residents eating foods which were not labeled and dated was they could become sick if they ate foods which were expired and the quality of foods might deteriorate, if not used by the use by date. She stated she in-serviced the kitchen employees immediately after this surveyor's initial visit to the kitchen, using the following undated, Proper Food Storage training from the American Association of Nutrition and Food Service Professionals: Reseal, label and date all products. Use products within the use by dates stated on the original package. Sealed fin an airtight manner. (Containers with tight fitting lids or Ziploc bags) All leftover foods or foods removed from their original containers require proper labeling when stored, including item identification, date of preparation, and date foods are to be used or discarded. When to date: At the time food is being removed from its original container and placed in another container. At time leftover foods are removed from either hot or cold handling and placed in a container. When foods are received/dated-check the manufacturer's expiration dates upon delivery. How to Avoid a Survey Tag: Clearly label food item. Date when received, prepared, and opened. Practice First In, First Out method. Routinely check storage for proper labeling and dating. What to do: Utilize a clearly marked label. Identification of item in container/bag. Refer to storage guidelines for safe storage timeframe. Discard items by manufacturer expiration or use by date.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813 46534 Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 (Resident #45 and Resident #221) of 18 residents reviewed for infection prevention and control. 1. The facility failed to keep Resident #45's nasal cannula off the floor. 2. The facility failed to keep Resident #221's catheter bag off the floor. These failures could place residents at risk of infections, secondary infections, tissue breakdown, and communicable diseases. Findings Included: 1. Record review of Resident #45's admission record dated 11/22/24 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included but were not limited to Alzheimer's, heart failure, and major depressive disorder. Record review of Resident #45's significant change MDS completed on 11/15/24 revealed the following: Section C: Resident #45 had a BIMS of 4 which indicated severely impaired cognition. Section O: Resident #45 was receiving oxygen therapy while a resident. Record review of Resident #45's care plan revealed a completion date of 09/18/24 and no mention of oxygen therapy. Record review of Resident #45's active orders dated 11/22/24 revealed an order with start date of 11/07/24 for oxygen use via nasal cannula as needed at 2-3 liters per minute to maintain blood oxygen saturation above 90 % and an order with start date of 11/14/24 for oxygen use at 2 liters per minute twice a day as needed for shortness of breath and anxiety. During an observation and interview on 11/20/24 at 07:35 AM Resident #45 was in her room lying in her bed with an oxygen concentrator on and sitting next to the bed. The nasal cannula was rolled up on the floor under her bed with the nasal prongs in direct contact with the floor. Brownish discoloration noted to the nasal cannula. Resident #45 stated she did not need or wear oxygen. During an observation on 11/20/24 at 09:01 AM Resident #45 was observed lying in her bed receiving oxygen via nasal cannula. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/24 at 01:24 PM LVN A stated nasal cannulas used for oxygen therapy should be stored in a plastic bag off the floor, so the nasal cannula did not touch the floor. He stated if the nasal cannula did touch the floor, it would become contaminated and put the resident at risk of developing an infection. During an interview on 11/21/24 at 01:45 PM DON stated oxygen tubing and nasal cannulas were to be stored in a bag if not on the resident. She stated if the nasal cannula came into contact with the floor, then it would become contaminated and would need to be replaced. DON stated if a nasal cannula that came into contact with the floor was not replaced, the resident would be at risk for contamination and infection. 2. Record review of Resident #221's admission record dated 11/21/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, encounter for surgical aftercare following surgery on the circulatory system, cancer of tongue, gum, lung, and lymph nodes, and retention of urine. Record review of Resident #221's MDS tab in his EHR revealed an Admission MDS in process. Record review of Resident #221's care plan initiated on 11/07/24 revealed a focus area regarding enhanced barrier precautions for catheter care initiated on 11/07/24 and resolved on 11/21/24. The goal was There will not be any transmission of infection from or to the resident. Record review of Resident #221's completed orders revealed the following: An order with end date of 11/20/24 to change his Foley catheter once a month. An order with an end date of 11/20/24 for foley catheter to gravity drainage. An order with an end date of 11/20/24 to ensure the catheter strap (holds tubing for catheter to leg of resident) was in place and holding. An order with an end date of 11/20/24 to empty the catheter drainage bag. An order with an end date of 11/20/24 to monitor the catheter once a shift for leakage, blockage, sediment buildup, and low output. An order with an end date of 11/20/24 to ensure the catheter bag was in a privacy bag. During an observation and interview on 11/20/24 at 07:17 AM Resident #221 was seated in his wheelchair next to his bed and his catheter bag and approximately 1.5 feet of catheter tubing were lying on the floor next to him. He stated no one told him it was not okay to keep his catheter bag on the floor. During an observation and interview on 11/21/24 at 02:34 PM Resident #221 was lying on his back in bed. He said of his catheter, They (staff) took it out yesterday morning, thank the LORD. Stated staff had not educated him on keeping his catheter bag off the floor at any time since he had been in the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/24 at 02:35 PM CNAs B and C stated their duties as CNAs with catheters were to empty the bag and to provide perineal care. Both CNAs stated it was never okay for the catheter bag to be on the floor. CNA B stated a catheter bag on the floor could be contaminated, resident could step on it and pull it out. During an interview on 11/21/24 at 02:38 PM DON stated nurses were responsible to insert and discontinue catheters and CNAs were responsible to empty the bag and do perineal care. She stated a possible negative outcome of a catheter bag on the floor was infection control is [the] biggest one or it could leak and [create a] risk of falls, or [the catheter could] get pulled out and cause trauma. During an interview on 11/21/24 at 02:43 PM ADM stated a possible negative outcome of a catheter bag on the floor was bacteria and infection control. During an interview on 11/22/24 at 09:00 AM ADON stated there was not a possible negative outcome for a resident if their catheter bag was on the floor. She said it would not affect infection control for a catheter bag to be lying on the floor. During an interview on 11/22/24 at 09:10 AM LVN D stated she worked on Resident #221's hall. She stated since he had been in the facility she had not noticed his catheter bag on the floor. She stated a possible negative outcome of a catheter bag on the floor was, It can get a leak and it is an infection control problem. During an interview on 11/22/24 at 09:14 AM LVN D stated after she thought about the question more she remembered Resident #221 placing his catheter bag on the floor and she remembered educating him not to do so. Record review of facility policy titled Infection Control Plan: Overview and dated 03/2024 revealed the following: . The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The intent of this policy is to assure that the facility develops, implements, and maintains an Infection Prevention and Control Program in order to prevent, recognize, and control to the extent possible, the onset and spread of infection within the facility. Record review of facility policy titled Catheter Care and dated February 13, 2007 revealed the following: . 5. Check the resident frequently . Keep tubing off floor . 10. Be sure the catheter tubing and drainage bag are kept off the floor. Record review of facility policy titled Oxygen Administration and dated February 13, 2007 revealed the following: . Oxygen therapy includes the administration of oxygen (O2) in liters/minute (l min) by cannula . The policy did not address oxygen tubing storage or infection control.