STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676375	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Giles Nursing and Rehabilitation Center	950 Camino Del Rey Drive El Paso, TX 79927

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51012 Based on observation, interview and record review, the facility failed to ensure the resident resided and received services in the facility with reasonable accommodation of resident needs and preferences for 3 (Resident #41, Resident #60, Resident #250) of 12 residents reviewed for call lights. The facility failed to ensure Resident #41, and Resident #60 had their call lights within reach. The facility failed to ensure Resident #250 had a call light in her room. These failures could place residents at risk for decreased quality of life, self-worth, and dignity. Findings included: Resident #41 Review of Resident #41's face sheet dated 02/13/2025 reflected a [AGE] year-old female admitted to the facility on 11/17/2023, with diagnoses of Other abnormalities of gait and mobility (walking patterns that deviate from normal), other lack of coordination, cognitive communication deficit (communication difficultly) and weakness. Review of Resident #41's quarterly MDS assessment dated [DATE] reflected brief interview for mental status score of 03/15 indicating severe cognitive impairment. Review of Resident #41's Comprehensive Care Plan revised 11/28/2024 reflected Resident #41 was a risk for falls, interventions included making sure the residents' call light was within reach and to encourage resident to use it for assistance as needed. Observation on 02/10/2025 at 10:15 am revealed Resident #41 was asleep in her bed and her call light was on the floor, on fall mat. Observation on 02/10/2025 at 1:15 PM revealed Resident #41 still asleep in bed with call light still on floor on fall mat. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #60 Record Review of Resident #60's face sheet dated 02/10/25 revealed resident is an [AGE] year-old female initially admitted to the facility 09/16/2022 and readmitted [DATE]. Resident #60 has diagnoses of Muscle Wasting and Atrophy (gradual shrinking or wasting away of muscle tissue), abnormalities of gait (a manner of walking or moving on foot) and mobility, and lack of coordination. Record Review of Resident #60's quarterly MDS dated [DATE] revealed BIMS score of 2 out of 15 indicating severe cognitive impairment. Record Review of Resident #60's Comprehensive Care Plan dated 2/13/25 revealed that Resident #60 is at risk for falls related to muscle weakness, poor safety awareness, psychotropic medication use. The interventions per the Care Plan include for staff to ensure Resident #60 has her call light within reach. Resident #250 Record Review of Resident #250's face sheet dated 02/13/25 revealed that resident is a [AGE] year-old female with initial admitted [DATE], and re-admitted [DATE]. Record Review of Resident #250's quarterly MDS dated [DATE] revealed her BIMS score of 7 out of 15, indicating severe cognitive impairment. Record review of Resident #250's Comprehensive Care Plan dated 2/13/25 revealed resident is at risk for falls related to impaired mobility and interventions include for staff to ensure resident has a working and reachable call light. In an observation on 02/10/25 at 09:44 AM, Resident #60 was in bed and her call light was clipped on the wall light cord located behind resident's bed, and out of her reach. In an observation on 02/10/25 at 09:20 AM, Resident #250 was in bed and there was no call light in her room for her use. An interview On 02/12/2025 at 11:00 am with CNA G, revealed that she had been working at the facility for [AGE] years. She stated that the purpose of the call light was for the resident to use to ask for help. She stated that it Should always be within reach for the resident, meaning it was easily accessible for the resident to use if needed. For example, the resident should have had it on the bed next to them. She stated that everyone was responsible for making sure call light in within reach, especially CNA staff. She also stated that rounding every 2 hours to make sure call lights were within reach. She recalled that the facility did conduct Inservice on call lights regularly with the last one being approximately one month ago. She stated that If call light was not within reach, residents could fall or would not be able to call for assistance because they would not be able to call for help. She stated that Resident #41's and #60's call light was not considered to be within reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 02/12/2025 at 11:13 am with CNA H revealed that she had been working at the facility for a year. She stated that call lights should be within reach so residents could call whenever they needed something. She stated that everyone as in facility staff, CNAs especially are responsible to make sure call lights were within reach. She states that she frequently did walk rounds to make sure that call lights were within reach. She stated that the last Inservice regarding call lights was held approximately 2 months ago. She stated that they were required to do a monthly training online. She stated that residents could fall when trying to reach for the call light, and it was not within reach. She stated Resident #41's and #60's call light was not considered to be within reach. An interview on 2/12/2025 at 11:30 am with LVN E revealed that she had been working at the facility for 2 years. She stated that the purpose of the call light was to notify staff that resident needed assistance. She stated that call lights should be within residents reach. She stated that all staff was responsible including nursing assistants, and anyone who goes into room was responsible to make sure call lights were within reach. She stated that residents needs may have not be met, if residents call light was within reach. She stated that unless resident was unable to stand then it was not a fall risk for resident if call light was not to be in their reach. She stated Resident #41 had a fall mat next to her bed, she was considered a fall risk and she agreed that call light was considered not to be within reach for her. She stated that Resident #60's call light is not considered within reach. An interview with the DON on 2/12/2025 at 12:32 pm revealed that staff was trained that all call lights should be within residents reach, meaning the call light should be next to resident on bed. She stated that department heads do champion rounds throughout their shift. She explained that they were assigned to different rooms throughout the different halls to check call lights, and maintenance issues daily. She stated that other than those rounds the DON, CNA's, and LVNs all had the responsibility to make sure call lights were within reach for the residents. She stated that there in an emergency, residents could not call for help. She stated that residents could fall trying to get up themselves, and there could also be a delay in care. She stated Resident #41's and #60's call light was not within reach. On 2/11/25 at 9:20 am, DON stated that the facility does not have a specific policy regarding call lights.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 49854 Based on observation, interview, and record review the facility failed to have a safe, clean, comfortable and homelike environment for 1 (room # 104) of 12 rooms reviewed for environment in that: A brown and thick substance was on the floor of room [ROOM NUMBER]' entry way. This failure could have placed residents at risk of residing in an unsafe, unsanitary, and uncomfortable environment. Findings included: Record review of Resident #49's face sheet dated 02/18/25 revealed he was admitted on [DATE]. Record review of Resident #49's history and physical dated 12/27/24 revealed he was a [AGE] year-old male diagnosed with obsessive-compulsive disorder, muscle atrophy and dementia. Record review of Resident #49's MDS dated [DATE] revealed he had a BIMS score of 13 indicating he was cognitively intact. It indicated in the Care Area Assessment that Resident # 49 had triggered the care area for falls and that it was care planned. Record review of Resident #49's care plan reviewed reviewed by the facility on 02/12/25 revealed Resident # 49 was at risk for falls related to weakness. It revealed the facility needed to anticipate and meet the resident's needs by ensuring the resident was wearing appropriate footwear when ambulating or mobilizing to avoid falls. The care plan revealed Resident #49 required antidepressant medication related to obsessive-compulsive disorder and insomnia and for staff to document and monitor the resident for signs of irritability, feelings of shame and worthlessness. In an observation of room [ROOM NUMBER] and interview on 02/10/25 at 9:26 AM with Resident # 49 he reported a spill of a thick, brown substance, resembling maple syrup, at the entrance to his room. He denied knowing what it was and stated he had not handled food in that area. Resident # 49 said the staff who delivered his breakfast that morning might have spilled it , though he was not certain. Resident # 49 added that staff sometimes took a while to clean his room, and he disliked seeing it dirty as it made him uncomfortable. In an interview on 02/12/25 at 10:48 PM with the Administrator, he stated the process to ensure the facility was clean started with housekeeping and it was followed by rounds conducted by nurses and CNAs to ensure cleanliness. The Administrator stated it was expected all staff to either clean themselves or to report it to housekeeping if it was something they could not clean on their own. The Administrator said there was a risk of making a resident feel depressed living in an environment that looked dirty. He said that a spill like the one observed at Resident # 49 doorway could pose a risk of falls and potentially injure other residents and staff. He stated that another potential outcome could be that food residues such as the sugar in the corn syrup or coffee, could potentially attract pests such as ants and roaches. The Administrator stated he believed the facility staff failed to closely monitor the resident's room to make sure they were clean and sanitary. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/12/25 at 11:02 AM with the DON she explained the facility's protocol to ensure the resident's rooms are clean. DON said the department heads such as charge nurses, assigned rooms and through rounds, nurses and CNAs checked for cleanliness. She stated if through round check staff detected something needed to be cleaned and they did not have the time to do it, it was expected for them to notify housekeeping so they could go in and clean the residents' rooms. The DON stated the potential for resident discomfort in dirty environments, as well as the risk of slips, falls, and pest attraction because of not cleaning spills like the one observed at Resident # 49 doorway. Record review of the facility's policy, not dated, titled Fundamentals of Infection Control Precautions, read in part: The room and beside equipment of residents on standard precautions is cleaned and disinfected with an approved cleaning agent.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51010 Based on observations, interviews, and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice for 2 (Resident #20 and Resident #87) of 12 residents observed for oxygen management. The facility failed to clean the oxygen concentrator air filter for Resident #20 while the oxygen was in use. The facility failed to post an Oxygen sign outside Resident # 87's room who received oxygen. The facility failed to ensure Resident # 87's oxygen tank was properly stored when not in use. This failure could place residents at risk of being exposed to combustion or flammability that may lead to physical harm. Findings included: Resident #20 Record review of Resident #20's face sheet dated 02/13/2025, revealed the [AGE] year-old resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Respiratory failure, unspecified with hypercapnia (body fails to remove carbon dioxide from the blood leading to elevated levels of carbon dioxide). Record review of Resident # 20's MDS dated [DATE] revealed a brief interview for mental status score of 0, indicating severe cognitive impairment. Record review of Resident #20's Physician's orders, dated 02/13/2025, revealed an order for continuous oxygen use at 2 liters per min via nasal canula every shift for shortness of breath/ dyspnea (trouble breathing) related to respiratory failure, unspecified with hypercapnia effective 05/28/2018. During an observation of Resident #20 in her room on 02/10/25 at 10:32 AM noted that the resident's oxygen concentrator was in operation and the air filter had dust collected on it along with a couple of strands of hair. During an interview with LVN F on 02/12/2025 at 1:00 PM, LVN F stated that the nurses on the unit are responsible for cleaning oxygen concentrator air filters. He stated that the CNA's will notice sometimes and will alert the nurses, the nurses will then clean it under running water. She stated that the machine itself would also start beeping and that would alert the nurse that filter may needed to be changed. During an interview with the DON on 02/12/25 at 2:00 PM, the DON stated that she did was not sure about how often oxygen concentrator filters needed to be changed because it depended on the manufacturer. Risks of having a dirty filter were, reduced efficiency of machine. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Central supply personnel on 1/25/24 at 1:45 PM, she stated that oxygen concentrator filters were cleaned back in December 2024, filters were changed every 6 to 12 months or as needed per manufacture depending on concentrator being used. She stated Resident # 20's air filter did look dirty, and since it was a machine from hospice, she would have to contact the hospice provider to let them know that filter needed cleaning. She was not aware of risks to the resident of oxygen concentrator air filters being dirty. Record review of the Oxygen Administration Policy and procedure revised 07/21/2023 revealed in part change or clean concentrator filters according to manufacturer recommendations. Facility did not provide manufacuturer recomendations to surveyor prior to exit. Resident # 87 Record review of Resident #87's face sheet dated 12/13/25 revealed he was admitted on [DATE]. Record review of Resident #87's history and physical dated 02/04/25 revealed he was a [AGE] year-old male diagnosed with pulmonary embolism (a serious medical condition that occurs when a blood clot lodges in an artery in the lungs, blocking blood flow), acute respiratory failure with hypoxia(a condition in which the body or a region of the body is deprived of adequate oxygen supply), muscle wasting atrophy and cognitive communication deficit. Record review of Resident #87's MDS dated [DATE] revealed he had a BIMS score of 00 indicating severe cognitive impairment. It indicated the resident had respiratory failure with hypoxia (a deficiency in the amount of oxygen reaching the tissues of the body), and indicated he required oxygen therapy. Record review of Resident #87's care plan reviewed on 01/27/25 revealed Resident # 87 was receiving oxygen therapy ordered to be maintained on oxygen saturations (a measure of how much oxygen your blood is carrying as a percentage) of 90% or greater. In an observation on 02/10/25 at 11:23 AM in Resident # 87's room, an oxygen tank was observed next to the entrance door. A hissing sound came from the oxygen tank. There was no oxygen sign posted outside the room. Resident # 87 was in the hallway near the nurses' station at this time. LVN E stated she had just exchanged Resident # 87's oxygen tank with a full tank and had left the used one inside the room by mistake. She stated the tank was open, and the leftover oxygen in the tank was escaping the cylinder. LVN E closed the valve and took the cylinder outside the room and to storage. In an interview on 02/11/25 at 02:10 PM with RN B, she said every resident who received oxygen needed to have an oxygen sign posted outside of the door and the tank needed to be on a caddy. She stated posting oxygen signs needed to be posted so staff could be able to tell which residents are on oxygen to monitor them closely for their saturations and oxygen levels and for people to know there were tanks inside the residents' rooms. RN B said the tank was making hissing sounds because it was either broken or not closed correctly and this would also pose a potential fire hazard if oxygen was escaping the tank and there was a spark, the tank could potentially explode harming residents and staff from the facility. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/11/25 at 02:34 PM with CNA C she stated whenever a resident was receiving oxygen in their room there should be an oxygen sign posted outside of their room. She said the purpose of the oxygen sign was for all residents and visitors to take caution and be advised there was oxygen in use inside the room to avoid fire hazards and be careful not to drop a tank. CNA C said it was a non-smoking facility but there were fire hazards as long as there was oxygen in use. CNA C stated regarding the oxygen tank found in room [ROOM NUMBER] there could be a risk of fire or explosion because the tank was open and flowing with leftover oxygen inside the cylinder. In an interview on 02/11/25 at 03:10 PM with LVN D she said oxygen signs needed to be put up by the door where there was oxygen in use. She stated this was for safety purposes and to remind and let other staff know to check on residents in those rooms to make sure they had their head elevated, monitored their oxygen levels and checked for vitals. They also served as a warning for other residents and family members to be aware not to smoke in the facility or introduce anything that could create a spark. LVN D said by having an open oxygen tank left inside the room open, there could be a risk of explosions or fire hazards which could affect residents and staff members equally. LVN D said oxygen tanks needed to be stored in the storage room and not left in a resident's room when not in use. In an interview on 02/12/25 at 10:53 AM with the Administrator, he stated there had to be an oxygen sign posted outside of a room where a resident receives oxygen therapy. The Administrator said the purpose of the sign was to make everybody aware that there was oxygen in use inside of the room to avoid potential fire hazards. The Administrator said by not having an oxygen sign posted there was a potential for fire hazards or there could potentially be an exploding hazard from a tank who had oxygen escaping the tank. The Administrator stated the nursing department was responsible for making sure that oxygen signs were posted outside of the rooms and that oxygen tanks were closed and secured. In an interview on 02/12/25 at 11:10 AM with the DON regarding the open oxygen tank that was found Resident # 87's room, she said there was risk of a fire hazard or even explosion if there was a spark near the oxygen tank. DON said there was also a potential risk that somebody could take the tank out of the room and put other individuals at risk. DON said oxygen signs had to be outside the rooms of those residents who received oxygen therapy so that it would caution whoever goes near the room that there is oxygen in use. DON said the potential risks for not posting oxygen signs outside a resident room would be the same; there would be fire risks or staff would potentially not check for oxygen levels for the resident in that room. DON said RNs and LVNs receive training on how to properly store oxygen tanks and how to change them when the residents need a new tank full of oxygen. In an interview on 02/12/25 at 11:32 AM with LVN E she stated oxygen signs needed to be posted outside a resident's room who has oxygen inside the room. LVN E said the purpose of the sign was to alert anyone who comes near the room that there was oxygen in use. LVN E said there was a potential for a fire hazard of explosion if there was an oxygen tank left inside of a room. She said it was the nurse's responsibility to check oxygen signs were posted and also to make sure the tanks were closed and secure. LVN E said she had received training on how to change oxygen tanks and how to properly store them when not in use but did not recall when she received this training. Record Review of the facility's policy and procedures dated 3/21/2023 titled Oxygen Administration read in part: Place no smoking signs in area when oxygen is administered and stored. Store oxygen canister in an area free of flammable substances. Avoid the use of electrical appliances in the area of oxygen use as well.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51010 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 (Resident #33) of six residents observed for infection control. -Med Aide A failed to don gloves before removing Resident #33's lidocaine 4% patch and before applying new lidocaine 4% patch. Theses failure could place residents at risk for infection and cross contamination. Findings include: Resident #33 Record review of Resident #33's, face sheet dated 02/13/2025 reflected a [AGE] year-old female with an admitted [DATE] and a readmitted [DATE]. Record Review of Resident #33's diagnosis list dated 02/13/2025 reflected osteoarthritis of hip. Record Review of Resident #33's quarterly MDS dated [DATE] revealed resident with Brief interview for mental status score of 03 indicating severe cognitive impairment. Record Review of Resident #33's care plan dated 12/18/2024 revealed potential for uncontrolled pain, interventions included administer pain medication per medical doctor orders. Record Review of Resident #33's orders dated 02/01/2025 revealed Lidocaine Pain Relief External Patch 4 % (Lidocaine) Apply to right thigh topically one time a day for pain relief. An observation on 02/11/25 at 12:53 p.m. revealed Med Aide A in resident room preparing to apply lidocaine 4% patch to residents' right thigh. She took off old lidocaine patch without donning gloves. She then proceeded to apply new lidocaine patch with bare hands. She performed hand hygiene before exiting residents' room. In an interview with Med Aide A on 02/13/2025 at 10:45 a.m. she stated she was trained to wear gloves when applying transdermal patches, but she personally did not like to wear gloves because the patch sticks to the gloves and makes it hard to apply. She stated the importance of wearing gloves includes infection control especially when coming into contact with residents skin. She stated if she noticed an open wound or anything like that on the resident she would wear gloves. She stated medication could transfer from patch to her person in the absence of gloves, but that is why she tried to peel it from the very tip of patch and she tried to touch it around the corners, minimizing the contact she had with the medication on the patch. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with DON on 02/12/2025 at 1:45 p.m., she stated the procedure for applying transdermal medications included, checking orders to verify site to be placed, hand hygiene, preparing patch with date and initials, applying gloves, removing the old patch if there was one present, and applying the new patch, removing gloves and preform hand hygiene. She stated the risks to the resident if staff did not apply transdermal medication with gloves included infection control because staff was coming into contact with resident exposed skin. The risk to the staff also included staff could absorb medication from transdermal patch causing medication to enter their systems. Record review of facility's undated policy on Transdermal Patch Administration revealed in part to wash your hands and put on clean disposable gloves or avoid touching medication side of patch to prevent absorption through skin.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49854 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 8 residents (Resident #94) reviewed for pharmacy services. Resident #94 had a dixie cup at bed side with Zinc Oxide pomade (skin ointment) and a tongue depressor in it, exposed and within reach of other residents. This failure could place residents at risk of inaccurate drug administration and not having appropriate therapeutic effects. Findings included: Record review of Resident #94's face sheet dated 02/10/25 revealed he admitted on [DATE]. Record review of Resident #94's history and physical dated 08/11/24 revealed he was a [AGE] year-old male diagnosed with cerebral palsy (a group of disorders that affect movement and muscle tone or posture), neuromuscular dysfunction of bladder (problems that occur when the nerves and muscles that control the bladder don't work together properly), seizures, kidney failure and urinary tract infection. Record review of Resident #94's MDS dated [DATE] revealed he had a BIMS score of 13 indicating he was cognitively intact. It indicated the resident required application of ointments and medications other than the feet and that he was at risk of developing pressure ulcers or injuries. Record review of Resident #94's care plan reviewed on 11/22/24 revealed Resident # 94 had hemiplegia (total paralysis of limbs) and hemiparesis (weakness of the limbs). The care plan stated the resident would remain free of complications or discomfort related to these conditions. An intervention was for Resident # 94 to be assisted with ADLs and mobility as needed. Resident # 94 care plan revealed he was admitted with a pressure ulcer to the sacrum (a large, triangular bone at the base of the spine, forming the back of the pelvis), an intervention was to administer zinc oxide (a mineral that is used in a variety of over-the-counter medications. It is most used to treat skin irritations) as ordered. * (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676375	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Giles Nursing and Rehabilitation Center	950 Camino Del Rey Drive El Paso, TX 79927

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/11/25 at 02:10 PM RN B stated staff would request Zinc Oxide from her and she would pour a portion in a cup, then staff would go to the residents' room and the medication would be applied to Resident #94 when doing peri care (refers to the cleaning and hygiene of the perineum which is the area between the genitals and the anus). RN B said after the medication was applied, if there was any medication left in the cup it had to be discarded in the biohazard trash bins the facility had on the medication carts. RN B stated the cup found at bedside should not have been left in the nightstand for infection control purposes. RN B said the potential outcome of leaving medication at bedside could result in another resident taking the medication by mistake or getting their hands into the cream and getting infected if the resident on which the medication was applied had any infections. In an interview on 02/11/25 at 02:27 PM with CNA C , she said the procedure was to dispose of the cup with the medication after it has been applied to the resident. The risk of leaving medication on a cup like this on top of a dresser would be infection control. There's also that a resident could ingest it or put it in their [NAME] or grab it. In an interview on 02/11/25 at 03:10 PM, LVN D said the risk of leaving a medication in the open and at bed side could result on a violation for infection control because another resident could take it and use it improperly or apply it somewhere they are not supposed to like in their eyes or put it in their mouth. LVN D stated the medication should not have been left at bedside and it had to be disposed in the biohazard trash located on their med carts once the medication had been supervised for Resident # 94. In an interview on 02/12/25 at 11:02 AM with DON, she said the medication aide, or the nurse were responsible for disposing if a medication or for checking that they were properly stored. The DON stated if medications are left at bed side there could be a potential risk for another resident taking the medications and potentially creating a health risk. DON stated another outcome could be infection transmitted from one resident to another or could result in poisoning or over ingestions for a resident taking a medication that was not prescribed for them. DON stated medications are never supposed to be left at bedside and they should always be discarded following protocols. In an interview on 02/12/25 at 10:45 AM with the Administrator, he said the charge nurse, ADON or DON were responsible for checking that medications that have been administered or supervised, were correctly discarded once they are done providing services to a resident. The Administrator said it was important to make sure that the medications had been supervised and correctly discarded to make sure that other residents did not get their hands on them or ingest them by mistake. He said there could be an adverse effect if another resident took a medication that did not belong to them. The Administrator stated no medications should have been left at bed side once the medication has been supervised for a resident. He also stated there could be a risk for infection control with this medication if it was used on a perineal area. In an interview on 02/13/25 at 10:25 AM the DON stated facility did not have a specific policy addressing supervising medications and the steps for disposing of a medication. The DON reiterated that no medications should be left at bed side once they had been supervised for a resident. Record review of the policy, not dated, titled Medication Administration, did not include information on procedures for supervising medications and the steps for disposing of a medication after it had been supervised.

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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 - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51012 Based on observation, interviews 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 kitchen sanitation in that: -4 of 4 oil containers were not labeled or dated. -The seal of the Pork meat stored in the refrigerator was had a ripped hole in foil covering. These deficient practices could place residents who received meals and snacks from the kitchen at risk for food borne illness. The findings include: During an initial kitchen tour and interview on 02/10/25 at 08:15 AM with the Director of Food and Nutrition, revealed the following: 4 of 4 Pan & Grill frying oil containers were not dated or labeled in the dry food pantry. The Director of Food and Nutrition stated the oil containers should be dated, and would dispose of them. Observation during the walk-in fridge had a metallic container with foil covering labeled PORK, the foil covering had a ripped opening in middle of foil cover. The Director of Food and Nutrition stated that it would be covered properly. During an interview with the Director of Food and Nutrition on 02/12/25 at 02:18 PM, he stated the procedure when receiving food items includes dating all items once received and out of the box. He stated the responsibility to ensure all food items are dated and labeled belong to all kitchen staff. The Director of Food and Nutrition stated he knew the oil containers had just come in but if food items are not dated or labeled, then they are disposed of, which the oils were. He stated he does not think there are risks to the residents if the oil was not dated because it was oil. He stated all food items are to be completely sealed. He stated the risk of food not being properly sealed includes contamination through falling debris, and bacteria or food borne illnesses depending on the food not being properly stored in a safe area. He stated the pork, however, was in a safe area.