STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676431	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cimarron Park Nursing and Rehabilitation Center	7441 Paseo Del Norte El Paso, TX 79911

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on interview and record review the facility failed to develop a baseline care plan for each resident within 48 hours of a resident's admission for one (Resident #1) of seven residents reviewed for baseline care plan. The facility failed to complete Resident #1's baseline care plan until 04/09/2024 although he was admitted on [DATE]. This failure could put residents at risk of not having their care needs met. Finding included: Record review of Resident #1's face sheet dated 05/06/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Record review of Resident #1's physician's admission note dated 04/08/2024 revealed that resident had a history of diabetes, hypertension (high blood pressure) and paraplegia (lower body paralysis). He had been in the hospital for surgeries for his right knee and for an infected pressure wound (injury to the skin from extended pressure) on the sacral area (tail bone). Record review of Resident #1's baseline care plan dated 04/09/2024 revealed he had a wound on his sacrum. Skin checks were to be done weekly, he was to be turned and repositioned frequently to decrease pressure, a cushion was too be put in his wheelchair, he was to have a pressure relieving mattress and staff were to notify the physician of changes in wound or emerging wounds. He was totally dependent of one staff member to transfer between surfaces and for bathing. He needed limited help from one person to move around in bed, use the toilet, and move around the facility in a wheelchair. He was to receive occupational and physical therapies. His risk for falls was not assessed. He had current skin concerns including pressures ulcer to his sacrum and right knee. He had an infection to wound/skin and staff were to observe for signs of increased infection, such as redness, warmth, drainage, increased pain, or fever. He was to be discharged to the community and the facility was to arrange for home health services. Discharge planning meetings were to be held every quarter or as needed, and referrals were to be made to local agencies or other entities. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's admission MDS assessment dated [DATE] revealed his BIMS score was 15 (cognitively intact). He had no symptoms of delirium, depression or psychosis. He had no symptomatic behaviors. He had impairment to his upper and lower extremities and needed moderate assistance to eat, dress, and toilet. He needed substantial assistance to bathe. He had no pressure ulcers but had open lesions, surgical wounds and skin tears. He was receiving insulin injections and antibiotics. Record review of Resident #1's comprehensive care plan dated 04/08/2024 revealed plans to address the resident's DNR (Do Not Resuscitate - does not want medical treatments to restart the heart) code status, activities preferences and limited physical mobility secondary to recent surgery. No other care plans were documented. Record review of grievances revealed a grievance from Resident #1 dated 05/02/2024 stating the resident asked for a copy of his care plan and asked when a care plan meeting was scheduled. The summary of findings stated that the resident's care plan was incomplete, and the care plan meeting had been rescheduled. The resident was advised that the assigned MDS Coordinator had resigned and had not completed the resident's care plan. The ADON was to update the care plan and provide a copy to the resident. The care plan meeting was to be rescheduled for the next week [date not indicated]. The resident was in agreement. In an interview and record review on 05/04/2024 at 9:34 AM Resident #1 stated that the facility did not have a care plan for him. He stated that the facility was not doing anything for him that he could not do for himself at home and had been asking about plans to discharge him back to the community but that nothing was happening. He said he had been told that there would be a care plan meeting but that then it did not happen. The Resident presented a printed e-mail indicating that a care plan meeting had been scheduled for him on 04/23/2024. He stated that the care plan meeting did not take place and that another one was planned for later in the week of 05/06/2024. In an interview on 05/07/2024 at 4:15 AM the DON revealed that the baseline care plan was used to determine resident's care until the comprehensive care plan was developed. She stated that the risk of not having a care plan was that care that was needed could be missed. In an interview on 05/08/2024 at 1:35 PM the Administrator revealed that if a baseline care plan was not in place staff would not know how to care for residents. Record review of the facility policy Baseline Care Plan dated 2023 revealed the facility would develop and implement a baseline care plan for each resident that included instructions needed to provide effective and person-centered care of the resident that met professional standards of care. The baseline care plan would be developed within 48 hours of the resident's admission.

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on interview and record review the facility failed to implement an effective discharge planning process that focused on the resident's discharge goals and ensured that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident for one (Resident #1) of seven residents reviewed for development of a discharge plan. The facility failed to develop a discharge plan for Resident #1 who was admitted on [DATE] until the day before he was discharged on [DATE]. This failure increased resident's risks for not having their care needs addressed after discharge. Findings included: Record review of Resident #1's face sheet dated 05/06/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Record review of Resident #1's physician's admission note dated 04/08/2024 revealed that resident had a history of diabetes, hypertension (high blood pressure) and paraplegia (lower body paralysis). He had been in the hospital for surgeries for his right knee and for an infected pressure wound (injury to the skin from extended pressure) on the sacral area (tail bone). Record review of Resident #1's baseline care plan dated 04/09/2024 revealed he was to be discharged to the community and the facility was to arrange for home health services. Discharge planning meetings were to be held every quarter or as needed, and referrals were to be made to local agencies or other entities. Record review of Resident #1's admission MDS assessment dated [DATE] revealed his BIMS score was 15 (cognitively intact). He had no symptoms of delirium, depression, or psychosis. He had no symptomatic behaviors. He had impairment to his upper and lower extremities and needed moderate assistance to eat, dress, and toilet. He needed substantial assistance to bathe. He had no pressure ulcers but had open lesions, surgical wounds, and skin tears. He was receiving insulin injections and antibiotics. He participated in his assessment and goal setting. His overall goal was discharge to another facility or institution. Active discharge planning for the resident to return to the community had not yet begun. No referrals had been made to a local contact agency because the referral was not wanted. Record review of Resident #1's comprehensive care plan dated 04/08/2024 revealed plans to address the resident's code status, activities preferences and limited physical mobility secondary to recent surgery. No other care plans were documented. Record review of Resident #1's progress notes dated from 04/05/2024 to 05/07/2024 revealed no notes regarding discharge planning until a note from Social Services dated 05/06/2024 stating the resident said he wanted to go home. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and record review on 05/04/2024 at 9:34 AM Resident #1 stated that the facility did not have a care plan for him. He stated the facility did not have a social worker and this hindered his efforts to plan for discharge. He said he had been asking about discharge back to the community but that nothing was happening, and that the facility was not doing anything for him that he could not do for himself at home. He said he had been told that there would be a care plan meeting scheduled for him on 04/23/2024 but that did not happen, and another was planned for the week of 05/06/2024. In an interview on 05/06/2024 at 2:38 PM the Social Work Trainee revealed that the social worker did not have input into resident's care plan, and that it was the responsibility of the rehabilitation director, the DON, and physicians to make decisions about discharges. She said she had assessed Resident #1 and that he was not happy with being here, that he said he had his own personal care team at home, and he did not understand why he was sent to the facility. The Social Work Trainee said she told Resident #1 that the nurses would give him information about the timeline for his discharge. She said that she had not documented her interactions with the resident regarding discharge planning. She stated that when she did document, she did so under the name of the PRN social worker. In an interview on 05/07/2024 at 4:15 AM the DON revealed that the PRN social worker had been helping with resident's discharge planning. For Resident #1 she stated that she was not aware of the risk of not having a discharge plan in place because the resident was from another state that did not require a social worker. She said that discharge planning for Resident #1 had been done including setting up home health and transportation. In an interview on 05/08/2024 at 1:35 PM the Administrator revealed that if a baseline care plan was not in place staff would not know how to care for residents. This included planning for the resident's discharge. In an interview on 05/08/2024 at 2:20 PM the DON stated that Resident #1 was discharged at 1:00 PM on 05/07/2024 and discharge materials were faxed to [Name] home health. In a telephone interview on 05/08/2024 at 3:07 PM with Resident #1's home health company, the Home Health Company Employee revealed that although Resident #1 had been in touch with the home health company regarding his discharge, the facility had not been in touch with the Home Health Company on 05/07/2024. Record review of the facility policy Discharge Planning Process dated 2023 revealed that discharge planning generally began at admission and included identifying resident's discharge goals and needs, developing and implementing interventions to address goals and needs, and evaluating throughout the resident's stay to ensure a successful discharge. The facility would identify the resident's discharge goals upon admission and include them in the comprehensive care plan. An active individualized discharge care plan would address discharge destination, identified needs, caregiver/support availability and resident's goals of care and treatment preferences. The facility would document any referrals to local agencies or other entities. The facility would update the resident's comprehensive care plan and discharge plan in response to information received from referrals to local agencies.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on observation, interview and record review the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan for 5 (Resident # 1, 2, 3, 4, 5 and 6) of 7 residents reviewed for wound treatment of wounds, 1. Resident #1 did not receive physician-ordered wound treatment on 6 occasions: for physician's order 04/09/2024 provision of care was not documented on 04/21/2024; for physician's order 04/09/2024 through 04/24/2024 provision of care was not documented on 04/14/2024, 04/20/2024, 04/21/2024, 04/24/2024; for physician's order dated 04/09/2024 through 04/19/2024 for provision of care was not documented on 04/19/2024. 2. Resident #2 did not receive physician-ordered wound treatment on 16 occasions: for physician's order dated 3/4/24 to 3/11/24 provision of care was not documented on 03/10/2024 or 03/11/1024: for physician's order dated 03/12/2024 to 4/8/2024 provision of care was not documented on 03/16/24, 03/17/24 or 03/23/24; for physician's order dated 04/04/24 to 04/08/24, provision of care was not documented on 04/07/24; for physician order dated 04/10/24 provision of care was not documented on 04/14/24, 04/21/2024 or 04/28/2024; for physician's order dated 04/11/2024 to 4/16/2024, provision of care was not documented on 04/12/2024, 04/14/2024, 04/15/2024, or 04/16/2024; for physician's order dated 04/19/2024, provision of care was not documented on 04/28/2024; for physician's order dated 04/17/24 was not documented on 04/21/24 or 04/29/2024; and for physician's order dated 04/20/24 to 04/24/24 provision of care was not documented on 04/28/2024. 3.Resident #3 did not receive physician-ordered wound treatment on 6 occasions: for physician's order dated 04/15/2024 through 04/17/2024, provision of care was not documented on 04/15/2024, 04/16/2024 or 04/17/2024; for physician's order dated 04/20/2024, provision of care was not documented on 04/21/2024 or 04/29/2024;.for physician's order dated 04/20/2024, provision of care was not documented on 05/05/2024. 4.Resident #4 did not receive physician-ordered wound treatment on 3 occasions: for physician order dated 04/26/2024 through 05/01/2024 provision of care was not documented on 04/29/2024; for physician order dated 04/26/2024 provision of care was not documented on 04/29/2024; for physician order dated 04/26/2024 through 05/01/2024 provision of care was not documented on 04/29/2024 5.Resident #5 did not receive physician-ordered wound treatment on 16 occasions: for physician's orders dated 03/06/2024 through 03/27/2024 provision of care was not documented on 3/10/24, 3/16/24, 3/17/24, and 3/23/24; for physician's orders dated 03/06/2024 through 03/11/2024 provision of care was not documented on 03/10/2024; for physician's orders dated 04/02/2024 through 05/03/2024 provision of care was not documented on 4/6/2024, 4/7/2024, 4/14/2024, 4/20/2023, 4/21/2024, and 4/29/2024; for physician's order dated 05/04/2024 provision of care was not documented on 05/04/2024. 6.Resident #6 did not receive physician-ordered wound treatment on 2 occasions: for physician's orders dated 04/05/2024 through 04/15/2024 provision of care was not documented on 04/07/2024; provision of care was not documented 04/21/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This failure put residents at increased risk of slow wound healing and infection of wounds. Findings included: 1. Record review of Resident #1's face sheet dated 05/06/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Record review of Resident #1's physician's admission note dated 04/08/2024 revealed that resident had a history of diabetes, hypertension (high blood pressure) and paraplegia (lower body paralysis). He had been in the hospital for surgeries for his right knee and for an infected pressure wound (injury to the skin from extended pressure) on the sacral area (tail bone). Record review of Resident #1's baseline care plan dated 04/09/2024 revealed he had a wound on his sacrum. Skin checks were to be done weekly, he was to be turned and repositioned frequently to decrease pressure, a cushion was too be put in his wheelchair, he was to have a pressure relieving mattress and staff were to notify the physician of changes in wound or emerging wounds. He was totally dependent of one staff member to transfer between surfaces and for bathing. He needed limited help from one person to move around in bed, use the toilet, and move around the facility in a wheelchair. He was to receive occupational and physical therapies. His risk for falls was not assessed. He had current skin concerns including pressures ulcer to his sacrum and right knee. He had an infection to wound/skin and staff were to observe for signs of increased infection, such as redness, warmth, drainage, increased pain, or fever. He was to be discharged to the community and the facility was to arrange for home health services. Discharge planning meetings were to be held every quarter or as needed, and referrals were to be made to local agencies or other entities. Record review of Resident #1's admission MDS assessment dated [DATE] revealed his BIMS score was 15 (cognitively intact). He had no symptoms of delirium, depression, or psychosis. He had no symptomatic behaviors. He had impairment to his upper and lower extremities and needed moderate assistance to eat, dress, and toilet. He needed substantial assistance to bathe. He had no pressure ulcers but had open lesions, surgical wounds, and skin tears. He was receiving insulin injections and antibiotics. Record review of Resident #1's comprehensive care plan dated 04/08/2024 revealed plans to address the resident's code status, activities preferences and limited physical mobility secondary to recent surgery. No other care plans were documented. Record review of Resident #1's active physician's order dated 04/09/2024 revealed that every other day the resident was to have his left trochanter (widest part of the hip at the top of the thighbone) surgical incision, status post skin flap (a surgery where healthy skin is placed over a wound), cleansed with normal saline (salt water), patted dry, covered with xeroform (a special kind of gauze) and then covered with a dry dressing. Record review of Resident #1's physician's order dated 04/09/2024 through 04/24/2024 revealed that every day the resident was to have his right knee surgical incision with dehisce (a wound from surgery that had reopened) cleansed with normal saline, patted dry, have Medihoney (medical honey specially formulated for wound care) applied to the eschar area (dried blood and tissue), and covered with a dry dressing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's physician's order dated 04/09/2024 through 04/19/2024 revealed that every other day the resident was to have a skin tear on his right thigh cleansed with normal saline, patted dry, covered with xeroform and then covered with a dry dressing. Record review of grievances revealed a grievance dated 04/16/2024 from Resident #1 that stated in part that he was having to clean his own wounds. The facility response stated the grievance was resolved by speaking to staff and putting the resident on 2-hour checks. In an interview and record review on 05/04/2024 at 9:34 AM Resident #1 stated that he had a wound flap (a surgery where healthy skin is placed over a wound) and had a dehisced knee wound (a surgical wound that has reopened). He said he was not getting wound care that had been ordered and that he had to do his own wound care on several occasions. Record review of Resident #1's April 2024 MAR/TAR revealed provision of wound care was not documented as follows: For physician's order dated 04/09/2024 for treatment every other day of left trochanter surgical incision, status post skin flap, provision of care was not documented on 04/21/2024. For physician's order dated 04/09/2024 through 04/24/2024 for daily treatment of right knee surgical incision with dehisce, provision of care was not documented on 04/14/2024, 04/20/2024, 04/21/2024, 04/24/2024. For physician's order dated 04/09/2024 through 04/19/2024 for treatment of skin tear on his right thigh provision of care was not documented on 04/19/2024. 2. Record review of Resident #2's face sheet dated 05/06/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Record review of Resident #2's physician's Progress Note dated 01/19/2024 revealed he had a medical history including high blood pressure, coronary artery disease (partial blockage of the arteries of the heart) AD, atrial fibrillation (when the upper chambers of the heart quiver instead of contract), diabetes, and dementia. He had a supra-pubic catheter (a tube into the bladder to drain urine). Record review of Resident #2's Admission assessment dated [DATE] revealed he had a Stage II pressure ulcer (injury to the skin from extended pressure) to his coccyx (tail bone). He was bedfast all or most of the time and required two people to help him move between surfaces, eat, use the toilet, and move around in bed. Record review of Resident #2's admission MDS dated [DATE] revealed he had a BIMS of 7 (severe cognitive impairment). He had no symptoms of delirium, depression, or psychosis and no symptomatic behaviors. He needed to substantial assistance to toilet, shower, dress, move in bed, sit up, stand, transfer between surfaces, and move around in a wheelchair. He had a Stage II pressure ulcer. He had no other wounds. He had fallen once since he was admitted to the facility with no wounds. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's care plan dated 01/22/2024 revealed he had a Stage II pressure ulcer to the sacrum (upper part of tail bone or lower back), and a DTI (a pressure injury where the skin was purple but the depth was unknown because the skin has not opened) to his right heel. Interventions included to follow orders for prevention and treatment of skin breakdown and to monitor dressings to ensure they remained intact. Weekly treatment was to include documentation of the size of each area of skin breakdown. Record review of Resident #2's care plan dated 04/19/2024 revealed he had a skin tear or potential for skin tear of his left shin and right elbow. Interventions included to keep his skin clean and dry. Record review of Resident #2's physician's order dated 3/4/24 to 3/11/24 revealed that every day the resident was to have the Stage II wound on his coccyx cleaned, patted dry, Traid cream with collagen particles (a type of wound treatment to stimulate healing) applied and it was to be covered with a dry protective dressing. Record review of Resident #2's physician's order dated 03/12/2024 to 4/8/2024 revealed that every day the resident was to have the Stage II wound on his coccyx cleaned with normal saline, patted dry, Traid cream and collagen particles applied and left open to the air until resolved. Record review of Resident #2's physician's order dated 04/11/2024 to 4/16/2024 revealed that every day the resident was to have the Stage II wound on his coccyx cleaned with normal saline, patted dry, santyl (medication that removes damaged skin to allow for wound healing) and calcium alginate (a wound dressing that absorbs wound fluids to create a protective gel) applied and covered with a dry dressing. Record review of Resident #2's active physician's order dated 04/19/2024 revealed that every day the resident was to have the Stage II wound on his coccyx cleaned with hypochlorous acid (a treatment that fights bacteria, viruses and fungus), patted dry, Anacept (an antimicrobial) with collagen particles applied and covered with a dry dressing. Record review of Resident #2's active physician's order dated 04/17/24 revealed that every other day the resident was to have the skin tear to his left lower extremity (leg) cleansed with normal saline, patted dry, have xeroform applied, and covered with a dry dressing. Record review of Resident #2's physician's order dated 04/04/24 to 04/08/24 revealed that every day the resident was to have the redness to his right heel cleaned with normal saline, patted dry, painted with betadine and covered with a dry protective dressing. Record review of Resident #2's active physician's order dated 04/10/24 revealed that every other day the resident was to have the DTI on his right heel cleaned with normal saline, patted dry, painted with betadine, and left open to the air. Record review of Resident #2's physician's order dated 04/20/24 to 04/24/24 revealed that every other day the resident was to have the skin tear to his right elbow cleansed with normal saline, patted dry, have xeroform applied, and covered with a dry dressing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's MAR/TAR for March 2024 revealed provision of wound treatment was not documented as follows: For physician's order dated 3/4/24 to 3/11/24 for daily treatment daily of Stage II wound to the coccyx was not documented on 03/10/2024 or 03/11/1024. For physician's order dated 03/12/2024 to 4/8/2024 for daily treatment of Stage II wound on his coccyx provision of treatment was not documented on 03/16/24, 03/17/24 or 03/23/24. Record review of Resident #2's MAR/TAR for April 2024 revealed provision of wound treatment was not documented as follows: For physician's order dated 04/04/24 to 04/08/24, daily treatment of the redness to his right heel was not documented on 04/07/24. For physician order dated 04/10/24 for treatment of DTI to right heel every other day, treatment was not documented on 04/14/24, 04/21/2024 or 04/28/2024. For physician's order dated 04/11/2024 to 4/16/2024, daily treatment of Stage II wound on the coccyx was not documented on 04/12/2024, 04/14/2024, 04/15/2024, or 04/16/2024. For physician's order dated 04/19/2024, daily treatment of Stage II wound on the coccyx was not documented on 04/28/2024. For physician's order dated 04/17/24 for treatment to the skin tear to the left lower extremity treatment was not documented on 04/21/24 or 04/29/2024. For physician's order dated 04/20/24 to 04/24/24 for treatment every other day to the skin tear to the right elbow, treatment was not documented on 04/28/2024. In observation and interview on 05/04/2024 at 8:40 AM Resident #2 was seated in bed receiving assistance with dining. He had several stiches in his right eyebrow. No blood or exudate was noted. The number of stiches could not be determined as they were partially obscured by his eyebrows. He had an adhesive patch on his left mid-arm that was partially obscured by loosely wrapped gauze. The resident was not able to recall how he cut his eyebrow or why he had a bandage on his left arm. 3. Record review of Resident #3's face sheet dated 05/06/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Record review of Resident #3's Medical Visit physician's note dated 03/19/2024 revealed he had a history of recurrent nephrolithiasis (kidney stones), and diagnoses including acute pyelonephritis (kidney infection), and gross hematuria (visible blood in the urine). (continued on next page)

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	676431	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's Admission MDS dated [DATE] revealed he a BIMS score of 10 (moderate cognitive impairment). He required substantial assistance to toilet, bathe, and dress his upper body, to move around in bed, sit up, stand, and transfer between surfaces. He was dependent on staff to dress his lower body. Diagnoses included deep vein thrombosis (blood clot in a deep vein, usually the leg), BPH (enlarged prostate), and septicemia (blood poisoning), He had no existing skin injuries. Record review of Resident #3's care plan dated 04/24/2024 revealed a care plan for a Stage II pressure ulcer to the sacrum. Interventions included to monitor dressings to ensure they remained intact, and that treatment was to include documentation of the area of skin breakdown. Record review of Resident #3's physician's order dated 04/15/2024 through 04/17/2024 revealed that he was to receive daily treatment to address MASD (moisture-associated skin damage) to the sacrum which included cleaning with wound cleanser, pat dry, application of Triad cream with collagen and cover with protective dressing. Record review of Resident #3's active physician's order dated 04/20/2024 revealed he was to receive daily treatment to a Stage II pressure ulcer to the Sacrum which included to cleanse area with normal saline, pat dry, apply calcium alginate and cover with a dry dressing of choice. Record review of Resident #3's MAR/TAR for April 2024 revealed provision of wound treatment was not documented as follows: For physician's order dated 04/15/2024 through 04/17/2024, daily treatment to address MASD to the sacrum was not documented on 04/15/2024, 04/16/2024 or 04/17/2024. For physician's order dated 04/20/2024, daily treatment to a Stage II pressure ulcer to the sacrum was not documented on 04/21/2024 or 04/29/2024. Record review of Resident #3's MAR/TAR for May 2024 revealed provision of wound treatment was documented as follows: For physician's order dated 04/20/2024, daily treatment to a Stage II pressure ulcer to the sacrum was not documented on 05/05/2024. 4. Record review of Resident #4's face sheet dated 05/07/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Record review of Resident #4's Medical Visit doctor's note dated 04/25/2024 revealed he had a medical history that included encephalopathy (disturbance of the brain function), hypertension (high blood pressure), diabetes, and Parkinson's Disease. During his previous hospitalization he had developed multiple pressure wounds and was transferred to the skilled nursing facility to continue wound care and resume rehabilitation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's admission MDS dated [DATE] documented he was not able to participate in the BIMS assessment interview and was assessed by staff as having long- and short-term memory problems. He was dependent on staff for eating, toileting, bathing, dressing, and needed substantial assistance from staff to move around in bed, sit up, and transfer between surfaces. He had one Stage II pressure ulcer, one ulcer that was unstageable because it was covered by eschar (dried blood or tissue), and one deep tissue injury. He also had surgical wounds and MASD. Record review of Resident #4's base-line care plan dated 4/24/2024 revealed he had current skin concerns as evidenced by abrasions, pressure ulcer and being at risk for skin breakdown related to immobility and incontinence. Interventions included providing wound care and preventative skin care. Record review of Resident #4's physician order dated 04/26/2024 through 05/01/2024 revealed he was to receive daily treatment to the left Ischium Stage II wound including cleansing with normal saline, pat dry, paint with skin prep and leave open to the air. Record review of Resident #4's active physician order dated 04/26/2024 revealed he was to receive treatment every day to a right Medial Ankle (inside of the right ankle) DTI including cleansing it with normal saline, pat dry, paint with betadine (an antiseptic) and leave open to the air. Record review of Resident #4's physician order dated 04/26/2024 through 05/01/2024 revealed he was to receive daily treatment to an unstageable pressure ulcer to the Coccyx including cleansing with Dakin's (an antiseptic), pat dry, apply Santyl to slough area (area with yellow/white material in the wound), pack with calcium alginate and cover with dry dressing. Record review of Resident #4's MAR/TAR for April 2024 revealed provision of wound treatment was not documented as follows: For physician order dated 04/26/2024 through 05/01/2024 daily treatment to the left Ischium Stage II wound was not documented on 04/29/2024. For physician order dated 04/26/2024 daily treatment to the right Medial Ankle DTI was not documented on 04/29/2024. For physician order dated 04/26/2024 through 05/01/2024 daily treatment to an unstageable pressure ulcer to the Coccyx was not documented on 04/29/2024. 5. Record review of Resident #5's face sheet dated 05/07/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Record review of Resident #5's physician's Medical Visit Note dated 11/15/2022 revealed he had a medical history including stroke, vascular dementia, hypertension (high blood pressure), BPH and diabetes. Record review of Resident #5's quarterly MDS dated [DATE] revealed he had a BIMS score of 6 (severe cognitive impairment). He required supervision for eating, toileting, and bathing, and moderate assistance for dressing. He required moderate assistance for moving in bed, sitting up and standing, and moderate assistance for transfers. He had no skin impairment although he was at risk for pressure ulcers. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's care plan 03/06/2024 and revised on 04/24/2024 revealed he had a left heel DTI that had resolved, and a Stage II to his sacrum. No goals or interventions for the DTI or Stage II were in place. Record review of Resident #5's physician order dated 03/06/2024 through 03/27/2024 revealed he was to receive treatment daily to his left L great toe for a traumatic wound including wound cleansed with normal saline, patted dry, painted with betadine and left open to air until it was resolved. Record review of Resident #5's physician order dated 03/06/2024 through 03/27/2024 revealed he was to receive treatment every other day to a left Heel DTI including wound cleansed with normal saline, patted dry, painted with betadine and left open to air until it was resolved. Record review of Resident #5's physician order dated 03/06/2024 through 03/11/2024 revealed he was to receive treatment daily to a left lateral (outside) knee scab including wound cleansed with normal saline, patted dry, painted with betadine and left open to air until it was resolved. Record review of Resident #5's physician order dated 04/02/2024 through 05/03/2024 revealed he was to receive treatment every day to a Stage II pressure ulcer to sacrum including wound cleansed with normal saline, patted dry, apply triad cream with collagen particles and cover with dry dressing of choice. Record review of Resident #5's active physician order dated 05/04/2024 revealed he was to receive treatment every two days for a Stage II to sacrum including cleansed with normal saline, patted dry, apply hydrocolloid dressing. Record review of Resident #5's MAR/TAR for March 2024 revealed that on 3/10/24, 3/16/24, 3/17/24, and 3/23/24 he did not receive treatment as ordered 03/06/2024 through 03/27/2024 for daily treatment to his left L great toe for a traumatic wound including wound cleansed with normal saline, patted dry, painted with betadine and left open to air until it was resolved. Record review of Resident #5's MAR/TAR for March 2024 revealed that on 3/10/24, 3/16/24, 3/17/24, and 3/23/24 he did not receive treatment as ordered for 03/06/2024 through 03/27/2024 for treatment every other day to a left Heel DTI including wound cleansed with normal saline, patted dry, painted with betadine and left open to air until it was resolved. Record review of Resident #5's MAR/TAR for March 2024 revealed that on 03/10/2024 he did not received treatment as ordered for 03/06/2024 through 03/11/2024 for treatment daily to a left lateral (outside) knee scab including wound cleansed with normal saline, patted dry, painted with betadine and left open to air until it was resolved. Record review of Resident #5's MAR/TAR for April 2024 revealed that on 4/6/2024, 4/7/2024, 4/14/2024, 4/20/2023, 4/21/2024, and 4/29/2024 he did not receive treatment as ordered for 04/02/2024 through 05/03/2024 daily to a Stage II pressure ulcer to sacrum including wound cleansed with normal saline, patted dry, apply triad cream with collagen particles and cover with dry dressing of choice. Record review of Resident #5's MAR/TAR for May 2024 revealed that on 05/04/2024 he did not receive treatment every two days as ordered for 05/04/2024 for a Stage II to sacrum including cleansed with normal saline, patted dry, apply hydrocolloid dressing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Record review of Resident #6's face sheet dated 05/06/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Record review of Resident #6's physician's Medical Visit note dated 04/09/2024 revealed he had diagnoses including Alzheimer's disease and fall resulting in left-sided subcapital displaced femur fracture (left leg broken at the hip), chronic kidney disease. He had a skin tear to his left hand. Record review of Resident #6's admission MDS dated [DATE] revealed he had a BIMS score of 3 (severe cognitive impairment). He required substantial assistance with bathing, and upper body dressing and substantial assistance for lower body dressing. He required substantial assistance for moving around in bed, sitting up, standing and transferring between surfaces. He had a skin tear. Record review of Resident #6's care plan dated 04/04/2024 revealed he had a skin tear on the left dorsal hand (back of the left hand). The goal was that the skin tear would be healed by the next review date. Record review of Resident #6's nursing progress noted dated 04/15/2024 revealed he slipped out of bed and had a skin tear to his right dorsal hand. Record review of Resident #6's physician's order dated 04/05/2024 through 04/15/2024 revealed an order for treatment every other day for the skin tear to left dorsal hand to cleanse with ns, pat dry, apply xeroform and cover with dry dressing of choice. Record review of Resident #6's physician's order dated 04/19/2024 through 05/03/2024 revealed an order for treatment every other day for the skin tear to right dorsal hand to cleanse with ns, pat dry, apply xeroform and cover with dry dressing. Record review of Resident #6's MAR/TAR for April 2024 revealed that on 04/07/2024 he did not receive treatment every other day as ordered for 04/05/2024 through 04/15/2024 for the skin tear to left dorsal hand to cleanse with ns, pat dry, apply xeroform and cover with dry dressing of choice. Record review of Resident #6's MAR/TAR for May 2024 revealed on 04/21/2024 he did not receive treatment every other day as ordered for 04/05/2024 through 04/15/2024 for the skin tear to left dorsal hand to cleanse with normal saline, pat dry, apply xeroform and cover with dry dressing of choice. In an interview on 05/04/2024 at 12:04 PM LVN C revealed that on the weekends the floor nurses provided wound care because there were no wound care nurses on the weekends. She stated that if she did wound care, it would be documented in the MAR/TAR. In an interview on 05/04/2024 the Weekend Supervisor said the Wound Care nurse was not working that day (05/04/2024) and so the floor nurses would be providing wound care. She stated all wound care would be documented in the MAR/TAR. In an interview on 05/04/2024 at 12:25 PM Wound Care Nurse A revealed she worked on weekdays only and that all treatments provided were documented on the MAR/TAR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/04/2024 at 2:16 PM Wound Care Nurse B revealed he worked every other weekend. He stated he always documented all wound care provided in the MAR/TAR. He stated that the risk of skipping wound treatment was the at some wound that drain a lot could get maceration (softening and breaking down due to prolonged exposure to moisture) around the edges and so get bigger. He stated that if a treatment was skipped the physician would be notified and it would be documented in the progress notes. Wound Care Nurse A stated that Resident #1 had not mentioned that his wound care had been missed. In an interview on 05/07/2024 at 1:20 PM LVN D revealed she was familiar with Resident #2 but had never done a wound dressing change for him. She stated that the Wound Care nurse was responsible for providing wound care, although she would change a dressing if she was told to do so. LVN D stated she did not know how to do wound care and was afraid [she] would mess up a dressing if she had to do one. In an interview on 05/07/2024 at 1:36 PM LVN E revealed he sometimes worked Sunday mornings. He stated he was familiar with Residents #2, #3, #4, and #5, but that he had not provided wound care to any of them. He stated he did do any routine wound care but would clean and change a dressing if it was soiled, wet or falling off. He stated that the risk to residents of skipped wound care was that the wound could take longer to heal, that there was risk of the wound getting infected, including possible sepsis (infection in the blood causing inflammation throughout the body). In an interview on 05/07/2024 at 2:03 PM LVN F revealed that she usually worked Saturdays. She said that she would do wound care if she was told that there was no one to do wound care. She said she thought she did wound care one weekend, but that she would expect to be told if she needed to do wound care. In an interview and observation on 05/07/2024 at 10:40 AM Resident #1 revealed he had had to do wound care on his knee two times. He was not able to state which days this was necessary but said he had 4X4 gauze squares that he would put on his wound. An open package of 4X4 kerlix was observed on the resident's over-bed table. In an interview on 05/07/2024 at 4:15 PM the DON revealed that if a wound care nurse was not available, floor nurses were expected to provide wound care, and would document it in the MAR/TAR. She said the weekend supervisor was notified if a weekend wound care nurse was not scheduled, the weekend supervisor was advised so wound care would be provided. The DON was not aware that wound care was being missed for some residents on the weekends. She stated that the facility did not have a system for tracking whether wound care was being provided. She said that the risk to the residents of not getting scheduled wound care was that that wound could get infected or get worse. In an interview on 05/08/2024 at 1:35 PM the Administrator revealed that missing wound care treatments was a quality-of-care issue. She stated that the floor nurses should be providing wound care when the wound care nurse was not available. She stated she had not been aware that treatments were being missed until the DON discussed it with her in response to concerns raised during the investigation. She stated that if wound care was not provided, the wound might not heal and get work, and that there was a risk of infection. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/09/2024 at 8:08 AM Wound Care Nurse A revealed that while providing wound care on Mondays, sometimes she would find residents with dressing she herself had placed on Fridays, although the physician's order was for daily wound care. She was not able to provide a specific date or resident to who this occurred. She stated that treatment was not provided wounds could deteriorate and could get infected. Record review of the facility policy Wound Treatment Management dated 06/2022 revealed that the policy of the facility was to provide evidence-based treatments in accordance with current standards of practice and physician orders. Wound treatments would be provided in accordance with physician orders, including the cleansing method, type of dressing and frequency of dressing change. Treatments would be documented on the TAR or in the electronic health record.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 34486 Based on observation, interview and record review the facility failed to store all drugs and biologicals in locked compartments for one of four medication carts (Medication Cart 100 Hall) and four Treatment Carts (Treatment Carts in 300 hall, facility rotunda, 200 hall, 100 hall) of five Treatment carts observed for being locked when staff were absent from the area. On 05/04/2024 the 300 hall Treatment cart was unlocked and unattended. On 05/04/2024 Rotunda Treatment Cart was unlocked and unattended. On 05/04/2024 The 200 Hall Treatment Cart was unlocked and unattended. On 05/04/2024 The 100 Hall Medication Cart was unlocked and unattended. On 05/04/2024 The 100 Hall Treatment Cart was unlocked and unattended. This failure put residents at risk of unauthorized and unsupervised access to medications and medical equipment. Findings included: Observation on 05/04/2024 at 12:03 PM in the 300 hall revealed a cart labeled Treatment. A lock for a key was observed to be protruding from the front of the cart. No staff were observed at or near the cart. Opening the top drawer of the cart revealed containers of nasal spray, eye drops, suppositories, boxes labeled insulin Lispro Injection (insulin), Humalog (insulin), Solostar100 Unit/ML(insulin), Lantus Insulin glargine Injections (insulin), acetaminophen, stool softener, magnesium oxide (dietary supplement), and pyridostigmine BR 50 mg (medication to treat muscle weakness). The second drawer contained scissors, lacets, Enoxaparin 40 MG/0.4 ML syringes (anticoagulant), alcohol swabs and insulin syringes. The third drawer contained ipratropium Bromide Inhalation Solution 0.5 MG/3MG per 3 ML (breathing treatment); Albuterol sulfate inhalation solution 1.25 mg/3 ML (breathing treatment); Diclofenac Sodium Topical Gel, 1% (gel for pain relief); and triple antibiotic ointment. In an interview and observation on 05/04/2024 at 12:05 PM, LVN C revealed that the wound care cart in the 300 hall labeled Treatment should not be unlocked. She said that having the cart unlocked was a threat to resident safety because a confused resident could get into the cart and eat the creams or cut themselves. She was observed to push the protruding lock in, thus locking the treatment cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/04/2024 at 12:07 AM revealed an unattended Treatment cart in the facility rotunda area. A lock for a key was observed to be protruding from the front of the cart. No staff were observed at or near the cart. Opening the top drawer of the cart revealed Dermaprep wound barrier skin prep, silver nitrate applicators (wound treatment), bandage scissors, and a hypodermic needle. The second drawer contained Collagenase Santyl ointment 250 units/g (wound treatment); ammonium lactate cream 12% (wound treatment), and wound dressings. Observation on 05/04/2024 at 12:20 PM in the 200 hall revealed an unlocked, unattended treatment cart. Opening the top drawer of the cart revealed bottles of ibuprofen, laxatives, expectorants (thins mucus or sputum from the airways), boxes of antihistamine, famotidine (for heart burn), antidiarrheal, cranberry pills, bottles of vitamin D, vitamin B-6, vitamin B complex with vitamin C; Calcium with Vitamin D; Ferrex 150 (iron supplement), Zinc, meclizine (antihistamine), pyridostigmine, eye drops, and latanoprost 0.005% eye drops. Observation on 05/04/2024 at 12:11 PM in the 100 hall revealed an unlocked, unattended medication cart. Opening the second drawer of the cart revealed medication cards for residents the 100 hall. In an interview and observation on 05/04/2024 at 12:12 PM the Weekend Supervisor said the unlocked, unattended medication cart on the 100 hall posed a threat to residents because they could get into the medications that were not prescribed for them and might be dangerous for them. Observation with the Weekend Supervisor of the second and third drawer of the 100 hall medication cart which had been unlocked and unattended revealed they contained medication. Observation on 05/04/2024 at 12:12 PM of the 100 hall revealed an unlocked, unattended treatment cart. Observation of the top drawer revealed had sanitizer, surgical tape, exam gloves. The second drawer contained lancets, insulin syringes, Novolog Flex pens, Lantus SoloStar insulin pens, a bottle of insulin Glargine. The third drawer contained ipratropium Bromide and albuterol sulfate inhalation solution, fluticasone Propionate nasal spray, Trelegy Ellipta inhalation power (breathing treatment), and medication cards. In an interview on 05/04/2024 at 12:25 PM the Wound Care Nurse revealed that wound care carts should be locked because they contained items such as scissors, scalpels, and wound care creams. She said if a confused resident gained access to these items, the resident could get injured. In an interview on 5/7/24 at 4:15 PM the DON revealed that she had been made aware by staff that medication and wound care carts had been discovered open. She said the carts should be locked because anyone could get in and take out medications if they are not locked. She said that the med aides and nurses were responsible for making sure they were locked. In an interview on 05/08/2024 at 1:35 PM the Administrator revealed that medication and treatment carts should not be left open and unattended. She said that residents could get into the carte and grab things that could be harmful Record review of the facility policy Medication Storage sated 07/2022 revealed that the policy of the facility would be stored in the pharmacy and/or medication rooms to ensure proper security. All drugs and biologicals will be stored in locked compartments such as medication carts. During medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage cart.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on observation, interview and record review the facility failed to ensure that, in accordance with accepted professional standards and practices, the facility maintained medical records on each resident that were complete and accurately documented for four (Residents #1, #3, #4 and #6) of seven residents reviewed for documentation of provision of assistance with bathing. The CNAs software for documentation of bathing assistance was incorrectly set up at admission/readmission for Residents #1, #3, #4 and #6 so there was no documentation showing bathing assistance had been provided. This failure put residents at risk of diminished self-image, poor self-hygiene, and impaired skin integrity as a result of undetected lapses in the provision of assistance with bathing. Findings included: Record review of Resident #1's face sheet dated 05/06/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Record review of Resident #1's physician's admission note dated 04/08/2024 revealed that resident had a history of diabetes, hypertension (high blood pressure) and paraplegia (lower body paralysis). He had been in the hospital for surgeries for his right knee and for an infected pressure wound (injury to the skin from extended pressure) on the sacral area (tail bone). Record review of Resident #1's baseline care plan dated 04/09/2024 revealed he had a wound on his sacrum. Skin checks were to be done weekly, he was to be turned and repositioned frequently to decrease pressure, a cushion was too be put in his wheelchair, he was to have a pressure relieving mattress and staff were to notify the physician of changes in wound or emerging wounds. He was totally dependent of one staff member to transfer between surfaces and for bathing. He needed limited help from one person to move around in bed, use the toilet, and move around the facility in a wheelchair. He was to receive occupational and physical therapies. His risk for falls was not assessed. He had current skin concerns including pressures ulcer to his sacrum and right knee. He had an infection to wound/skin and staff were to observe for signs of increased infection, such as redness, warmth, drainage, increased pain, or fever. He was to be discharged to the community and the facility was to arrange for home health services. Discharge planning meetings were to be held every quarter or as needed, and referrals were to be made to local agencies or other entities. Record review of Resident #1's admission MDS assessment dated [DATE] revealed his BIMS score was 15 (cognitively intact). He had no symptoms of delirium, depression, or psychosis. He had no symptomatic behaviors. He had impairment to his upper and lower extremities and needed moderate assistance to eat, dress, and toilet. He needed substantial assistance to bathe. He had no pressure ulcers but had open lesions, surgical wounds, and skin tears. He was receiving insulin injections and antibiotics. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cimarron Park Nursing and Rehabilitation Center	7441 Paseo Del Norte El Paso, TX 79911

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's comprehensive care plan dated 04/08/2024 revealed plans to address the resident's code status, activities preferences and limited physical mobility secondary to recent surgery. No other care plans were documented. In an interview on 05/04/2024 at 9:30 AM Resident #1 revealed that sometimes the staff missed his baths. He stated he was supposed to have baths every three days but had only been bathed a few times since he had been in the facility. Record review of Resident #1's Point of Care ADL Bathing Task sheet accessed on 05/04/2024 showed no responses to the question regarding bathing self-performance for the 30-day look-back period. Record review of Resident #3's face sheet dated 05/06/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Record review of Resident #3's Medical Visit physician's note dated 03/19/2024 revealed he had a history of recurrent nephrolithiasis (kidney stones), and diagnoses including acute pyelonephritis (kidney infection), and gross hematuria (visible blood in the urine). Record review of Resident #3's Admission MDS dated [DATE] revealed he a BIMS score of 10 (moderate cognitive impairment). He required substantial assistance to toilet, bathe, and dress his upper body, to move around in bed, sit up, stand, and transfer between surfaces. He was dependent on staff to dress his lower body. Diagnoses included deep vein thrombosis (blood clot in a deep vein, usually the leg), BPH (enlarged prostate), and septicemia (blood poisoning), He had no existing skin injuries. Record review of Resident #3's care plan dated 04/24/2024 revealed no care plan indicating his need for assistance with bathing. He had a care plan for a Stage II pressure ulcer to the sacrum. Interventions included to monitor dressings to ensure they remained intact, and that treatment was to include documentation of the area of skin breakdown. Record review of Resident #3's Point of Care ADL Bathing Task sheet accessed on 05/06/2024 showed no responses to the question regarding bathing self-performance for the 30-day look-back period. Record review of Resident #4's face sheet dated 05/07/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Record review of Resident #4's Medical Visit doctor's note dated 04/25/2024 revealed he had a medical history that included encephalopathy (disturbance of the brain function), hypertension (high blood pressure), diabetes, and Parkinson's Disease. During his previous hospitalization he had developed multiple pressure wounds and was transferred to the skilled nursing facility to continue wound care and resume rehabilitation. Record review of Resident #4's admission MDS dated [DATE] documented he was not able to participate in the BIMS assessment interview and was assessed by staff as having long- and short-term memory problems. He was dependent on staff for eating, toileting, bathing, dressing, and needed substantial assistance from staff to move around in bed, sit up, and transfer between surfaces. He had one Stage II pressure ulcer, one ulcer that was unstageable because it was covered by eschar (dried blood or tissue), and one deep tissue injury. He also had surgical wounds and MASD. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's base-line care plan dated 4/24/2024 revealed he had current skin concerns as evidenced by abrasions, pressure ulcer and being at risk for skin breakdown related to immobility and incontinence. Interventions included providing wound care and preventative skin care. Record review of Resident #4's Point of Care ADL Bathing Task sheet accessed on 05/07/2024 showed no responses to the question regarding bathing self-performance for the 30-day look-back period. Record review of Resident #6's face sheet dated 05/06/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Record review of Resident #6's physician's Medical Visit note dated 04/09/2024 revealed he had diagnoses including Alzheimer's disease and fall resulting in left-sided subcapital displaced femur fracture (left leg broken at the hip), chronic kidney disease. He had a skin tear to his left hand. Record review of Resident #6's admission MDS dated [DATE] revealed he had a BIMS score of 3 (severe cognitive impairment). He required substantial assistance with bathing, and upper body dressing and substantial assistance for lower body dressing. He required substantial assistance for moving around in bed, sitting up, standing, and transferring between surfaces. He had a skin tear. Record review of Resident #6's Point of Care ADL Bathing Task sheet accessed on 05/06/2024 showed no responses to the question regarding bathing self-performance for the 30-day look-back period. In an interview on 05/6/2024 at 1:20 PM CNA H revealed that there were times when the icon for assistance with bathing (a bathtub) did not appear on the computer screen although she did provide a resident a bath. She said that she thought it was because some residents would have a room change. She said the facility used to document baths using a bath sheet that had a drawing of a person on it, but that they were no longer doing that. In an interview on 05/06/2024 at 1:34 PM the DON revealed that at admission the MDS nurse was supposed to input information about resident's bath time preference in the point of care software, and that triggered the appearance of the bathtub icon on the CNAs documentation screen. The DON said that since they no longer had an MDS nurse, resident's bathing preference was not being put in the computer, so CNAs were not able to record resident's bathing status. The DON said although CNAs might be assisting residents with baths if it is not documented, it didn't happen. She said the risks to residents included issues related to dignity, infection control issues, quality of life and quality of care and risks to skin integrity. She said CNAs should report problems with documenting to the charge nurse, the ADON, or DON. In an interview on 05/06/2024 at 1:44 PM the ADON revealed that the nurse admitting a new resident should put in the resident's bathing preference in the computer or there would be problem with the documenting baths. She said without access to the bathing icon CNAs would be unable to document that assistance with bathing had been provided. She said that without documentation it was like it did not happen. She said residents need showers because of basic hygiene issues, residents' rights, and increased risk of skin breakdown. The ADON said she usually audited new admissions to make sure they were complete but had not been able to audits recently. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/06/2024 at 3:21 PM CNA I revealed that the bathtub icon [assistance with bathing] did not appear on the computer screen for every resident, and that when this happened there was no place to document that a bath had been given. She stated she had told LVN E about this in the past. She said that up until about a month ago they filled out a sheet to show they showered a resident but that they were no longer using the sheet. In an interview and observation on 05/06/2024 at 3:32 PM CNA J revealed there were residents for whom the bathtub icon did not appear, so there was no way to document that a bath had been provided. She demonstrated how documentation was completed in the computer kiosk used by the CNAs. She reviewed the shower status of residents assigned to her that day, none of whom had icons for assistance with bathing except for the PRN bath icon which CNA J said she did not use. In an interview on 05/06/2024 at 3:40 PM CNA K revealed that she worked frequently with Resident #1 and that she had never missed bathing him. She stated that his regular bath schedule was Tuesday, Thursday and Saturday, but that the bathtub icon did not appear for him when she documented assisting him with ADLs, so she was not able to document that she had helped him with a bath. She said that baths used to be documented on a form that they did not use any more. In an interview on 05/06/2024 at 3:47 PM LVN L revealed that problems documenting provision of assistance with bathing had not been reported to her by the CNAs. She stated that she did admissions of new residents but that this did not include documenting the resident's bath schedule or anything else that was associated with the CNAs documentation of assistance with ADLs. In a follow-up interview on 05/07/2024 at 4:15 PM the DON said the bathing task was not being scheduled in the computer system so the provision of assistance with bathing did not appear in the point of care software so CNAs were not able to document that assistance could be provided. She said that as a result there was no way to determine if residents were being bathed and that missing baths posed a risk to cleanliness, dignity and could result in skin issues. caused In an interview on 05/08/2024 at 1:35 PM the Administrator revealed that there was an issue with the documentation of bathing assistance. She said that if baths were not tracked baths might be missed which could negatively affect resident's hygiene and overall health. Record review of the facility policy Documentation in Medical Record dated 07/2022 revealed that each resident's medical record would provide an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate and timely documentation.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. 34486 Based on interview and record review the facility failed to ensure that it employed a qualified social worker on a full-time basis for one of one social worker positions reviewed. The facility, which was licensed for 124 beds, failed to employ qualified social worker on a full-time basis since on 02/29/2024 This failure put facility residents at risk of not having their psychosocial or discharge planning needs met. Findings included: Record review of the facility census dated 05/07/2024 revealed that the facility had 124 beds. In an interview on 05/06/2024 at 1:44 PM the ADON revealed that the facility did not have a full-time social worker and that the person who currently occupied the social work office [Social Work Trainee] was not licensed. In an interview on 05/06/2024 at 2:38 PM the Social Work Trainee revealed that she had worked at the facility for about two months. She said she was working on completing her Bachelor of Social Work degree and was not yet licensed as a social worker. She said she was responsible for assessments of residents at admission and was helping residents with discharge planning. In an interview on 05/06/2024 at 4:55 PM the HR Manager revealed that on 02/29/2024 the facility's licensed social worker had changed from full-time to PRN status. He stated that he and the administrator had sought applicants for the position on Indeed and talked to other facilities to see if they knew of a social worker that could be hired. He stated that a new full time social worker was scheduled to start work on 05/15/2024. In an interview on 05/07/2024 at 4:15 PM the DON revealed that the facility had not had a full-time social worker since February of 2024. She said that the duties of a social worker included discharge planning and arranging care plan meetings, but these needs were being addressed by other staff members. She stated that the facility had a PRN Social Worker who was available 24 hours a day by telephone and a student social work student. In an interview on 05/08/2024 at 1:35 PM the Administrator revealed that the facility did not have a Social Worker in place. She stated that the facility's previous full-time social worker was no longer full time but was accessible. She stated that in the absence of a full-time social worker, residents might not get their needs met for help with family issues, or with discharge planning. (continued on next page)

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy Social Services dated 07/2022 revealed that a facility with more than 120 beds would employ a qualified social work on a full-time basis. A qualified social worker was a person with a bachelors' degree in social work or a bachelor's degree in a human services field including but not limited to sociology, gerontology, special educations, rehabilitation counseling and psychology and one year of supervised social work experience in a health care setting working directly with individuals.

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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** 34486 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 two (Resident #4 and #7) of seven reviewed for infection prevention and control. The facility failed to ensure that Resident #4's catheter tubing and catheter drainage bag was not touching the floor on 5/4/2024. The facility failed to ensure that Resident #7's catheter tubing and catheter drainage bag was not touching the floor on 5/6/2024. This failure put residents at increased risk of infection. Findings included: Record review of Resident #4's face sheet dated 05/07/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Record review of Resident #4's Medical Visit doctor's note dated 04/25/2024 revealed he had a medical history that included a urinary tract infection, encephalopathy (disturbance of the brain function), hypertension (high blood pressure), diabetes, and Parkinson's Disease. During his previous hospitalization he had developed multiple pressure wounds and was transferred to the skilled nursing facility to continue wound care and resume rehabilitation. He had a long-term history of using a urinary catheter. Record review of Resident #4's admission MDS dated [DATE] documented he was not able to participate in the BIMS assessment interview and was assessed by staff as having long- and short-term memory problems. He was dependent on staff for eating, toileting, bathing, dressing, and needed substantial assistance from staff to move around in bed, sit up, and transfer between surfaces. He had an indwelling catheter. Record review of Resident #4's base-line care plan dated 4/24/2024 revealed he had current skin concerns as evidenced by abrasions, pressure ulcer and being at risk for skin breakdown related to immobility and incontinence. Interventions included providing wound care and preventative skin care. Record review of Resident #4's physician's order dated 04/28/2024 revealed he was to receive foley catheter care every shift and as needed. Observation on 05/04/2024 at 9:11 revealed that Resident #4 was in bed. He responded to questions about how he was with unintelligible vocalizations. It was observed that a catheter tube ran from under his brief onto the floor and into a catheter drainage bag that was lying on the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview and observation on 05/04/2024 at 9:20 CNA N observed the position of Resident #4's catheter tubing and catheter drainage bag. She stated that the catheter tubing and catheter drainage bag should not be on the floor. She said she had emptied Resident #4's catheter drainage bag earlier in the morning and forgot to reposition the bag and tubing. She said that having the catheter tubing and catheter drainage bag on the floor put the resident at risk for infection. In an interview on 05/04/2024 at 9:24 AM LVN O revealed that Resident #4's catheter tubing and catheter drainage bag should not be on the floor because of infection control issues. She said that CNAs empty catheter bags, but nurses do catheter care and so the bag and tubing on floor should have been noticed and corrected. Record Review of Resident #7's face sheet dated 05/07/2024 revealed she was [AGE] years old and was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #7's Physicians admission Medical Visit note dated 04/19/2024 revealed she had a history of UTIs and was using a urinary catheter. Record review of Resident #7's Baseline Care plan dated 04/18/2024 revealed she had a catheter for elimination. The goal of the care plan was that she would be free of catheter-related complications. Record review of Resident 37's MDS admission assessment dated [DATE] revealed she had a BIMS score of 10 (moderate cognitive impairment). She used a wheelchair and needed substantial assistance to wheel 50 feet with two turns. She had an indwelling urinary catheter. Record review of Resident #7's physician order dated 04/19/2024 revealed she was to receive foley catheter care every shift and as needed. Observation on 05/06/2024 at 4:51 PM in the facility rotunda revealed that Resident #7 was wheeling herself in a wheelchair from the rotunda toward the 200 hall. Urinary catheter tubing was observed running from under her clothing. The tubing was dragging on the floor as was the catheter drainage bag. In an interview and observation on 05/06/2024 at 4:52 PM the DON observed the position of Resident #7's catheter bag and catheter drainage bag and revealed that the catheter tubing and catheter drainage bag should not be touching the floor due to infection control issues. The DON was observed inviting the resident to go with her to the resident's room so they could reposition the catheter. Record review of the facility policy Catheter Care dated 07/2022 revealed that it was the facility policy to ensure that residents with indwelling catheters received appropriate catheter care and maintained their dignity and privacy while indwelling catheters were in use. In an interview on 05/07/2024 at 4:45 PM with the DON a policy on infection control related to catheter positioning was requested. A policy for infection control related to catheter positioning was not received prior to exit.