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	03/06/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49854 Based on observation, interview, and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 3 (Residents #5, #16 and #26) of 9 residents reviewed for dignity. Resident #16 did not have a privacy bag on his catheter bag. Resident# 5 and Resident# 26 had their names written on their clothes with black marker across their chest. This failure could place residents at risk of diminished quality of life. Findings included: Resident #5 Record Review of Resident # 5's Admission Record dated 3/6/25 revealed he was an [AGE] year-old male with an initial admission of 8/1/23 and a readmission on 12/10/24. His diagnoses included attention and concentration deficit, depression, unspecified dementia, anxiety, cognitive communication deficit and depressive episodes. Record Review of Resident # 5's quarterly MDS dated [DATE] reflected a brief interview for mental status score of 12 (moderate cognitive impairment). It indicated he had present symptoms of depression, hopelessness, trouble falling or staying asleep and feeling bad about himself with a frequency of seven to eleven days in a period of two weeks. Record Review of Resident # 5's Care Plan revised 2/4/25 reflected Resident # 5 was at risk of depression and he was to be encouraged to socialize frequently, to participate in his decision makings, to voice his thoughts and feelings. It reflected Resident # 5 would maintain a sense of dignity by being clean, dry, odor free and well groomed. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 03/03/25 at 11:59 AM at the dining room, Resident # 5 was observed eating his lunch at the left side of the dining hall sitting by himself. Resident # 5 was eating a pureed meal at this time. He was wearing a long sleeve gray sweater, and, on his chest, he had his last name written with black marker. The letters spelling his name were between two to three inches in length and width. During an observation and interview on 03/04/25 at 02:50 PM at Resident #5's room, he was in bed watching TV. Resident # 5 had challenges with his speech. Resident # 5 was asked if he liked to have his name written on his clothes on his chest and he said no. Resident # 5 was not able to provide more information and he kept watching TV. Resident #16 Record Review of Resident #16's Admission Record dated 3/4/25 revealed he was a [AGE] year-old male with an initial admitted [DATE] and a readmitted [DATE]. His diagnoses included end stage renal disease, fluid overload, renal dialysis (a life-sustaining treatment that replaces the function of failing kidneys), urinary tract infection and type 2 diabetes. Record Review of Resident #16's initial MDS dated [DATE] reflected a brief interview for mental status score of 12 (moderate cognitive impairment). His MDS was still in progress and was not completed at this time. Record review of Resident #16's care plan dated 3/1/25 reflected Resident #16 had altered urinary elimination related to urinary retention; he was to be administered with antibiotics as prescribed. Resident #16 was at risk for edema related to his diagnosis of renal failure and refusals of dialysis. During an observation on 03/03/25 at 10:52 AM Resident # 16 was laying on his bed watching TV. Resident # 16's foley bag was hanging from his bed frame and was not covered with a privacy bag. The bag was also touching the floor. During an observation and interview on 03/04/25 at 11:36 AM Resident # 16 was laying on bed watching TV, his foley bag was not covered by a privacy bag and was touching the floor. Resident # 16 said he had not been educated to know his foley bag should not be touching the floor and said he did not know the risk of infection it posed. Resident # 16 said he did not know his foley bag should be in a privacy bag and said he would feel ashamed if other people saw the contents of the bag especially at this time since he had a urinary tract infection and blood was visible in the tubbing and inside the bag. Resident #26 Record review of Resident #26's Admission record dated 3/5/25 revealed he was an [AGE] year-old male with an admitted [DATE]. Record review of Resident #26's quarterly MDS dated [DATE] reflected a brief interview for mental status score of 14 (cognitively intact). Resident # 26's mood interview revealed symptoms of depression and hopeless for two to six days in a period of two weeks. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #26's Care Plan revised on 11/10/24 revealed he was taking antianxiety medication, and he was to be monitored for depression. It revealed Resident # 26 had cognitive impairment with memory problems and staff was to meet and anticipate his needs by maintaining his dignity encouraging him to attend activities of his preference and to encourage him to maintain a home like environment in his room. During an observation and interview on 03/03/25 at 10:17 AM with Resident # 26 in his room, he was exercising using his peddler, sitting down on his wheelchair. He was wearing a yellow and gray sweater and across his chest, he had his last name written with black marker. The letters were around 3 to 6 inches in length and width. The resident stated did not know who had written his name on his sweater and that his clothes were labeled for the most part on the back of his shirts where the brand tag could be found. Resident # 26 said he did not like to have his name displayed on the open, but that he was going to change clothes after taking a shower later in the day. In an interview on 03/04/25 at 11:40 AM with LVN A he said the facility has their own laundry and they are supposed to label the resident's clothes on the inside where only laundry staff can see it. LVN A said the facility was not supposed to label residents with their names on their chest or a visible area because it could violate their rights or dignity making them feel like they are being labeled. In an interview on 03/04/25 at 11:52 AM with CNA B, she said she the facility trained the staff to label the resident's clothes on the back where the tag or brand label is located inside of the shirts. CNA B staff was not supposed to write the residents names on a visible area because that violates their privacy. CNA B stated residents could feel ashamed and exposed if they had labels that were visible for everyone to see. In an interview on 03/04/25 03:05 PM with CNA C, stated she had been trained that clothes should have the residents name on the inside because their privacy needed to be protected. CNA C said a resident could feel labeled or ashamed by having their name displayed to the public in general and all staff was responsible for ensuring the resident's rights were respected. In an interview on 03/06/25 10:44 AM with RN D he said the residents should not have their names displayed for everyone to see because it could potentially violate their privacy or dignity making them feel as if they were labeled, signaled or identified without their consent. In an interview on 03/06/25 at 01:09 PM with the ADON, she stated the facility staff labeled the residents clothes on the back where the tag was. The ADON said she had observed on that date the resident council president wearing a shirt with the resident's name displayed. The ADON said if the resident's family [NAME] in the clothes pre-labeled, she would not tell them anything because it was their right to bring in clothes for their loved ones. In an interview on 03/06/25 at 03:37 PM the DON she said facility wrote the names of the residents inside and on the back of the clothes where the tags were. The DON said that if a resident had their name written on an exposed area such as on their chest or any part of their clothes that was visible to everyone, it could result on residents fell ing like they were singled out or signaled and this could potentially be a violation of their right to privacy. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/06/25 at 02:52 PM with the Administrator, he stated the facility label the resident's clothes on the back by the tag. The Administrator said he was not aware there were residents with their names written with their names across their chests. The Administrator said there was a dignity issue with the resident having their name written on their clothes across their chest for everyone to read. The Administrator stated if a family member was to take clothes to a resident with their name written with marker on their chest, he would have let them know that it was not acceptable and that it was a violation of their loved one's rights to privacy and dignity. The administrator said his expectation was that if a staff member observed a resident with a piece of clothing labeled like that, they needed to report it to him so the resident's dignity could be protected and for the facility to correct the issue. In an interview on 3/6/25 at 1:10 PM a policy for labeling the resident's clothes to protect their dignity and privacy was requested from the ADON. At 3:37 PM on 3/6/25, the DON went into the conference room and informed the ADON the facility did not have policies addressing these topics. Record review of the facility's policy titled Catheter Care dated 07/2022 stated in part: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. Privacy bags will be available and catheter drainage bags will be covered at all times while in use. Ensure drainage bag is located below the level of the bladder to discourage backflow of urine.

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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** 51010 51012 Based on observation, interview and record review the facility failed to provide reasonable accommodation of resident needs and preferences involving the call light for of 5 residents of 18 (Resident #76 #91, #278, #284, #286) in that: - Resident #76 had no access to his call light which was hanging behind his bed and in between the foot of his bed. - Resident #91 had no access to his call light which was lying on the floor at the foot of his bed. - Resident #278 did not have access to his call light which was lying on the floor next to his bed. - Resident #284 had no access to his call light which was lying on the floor. -Resident #286 did not have access to his call light which was hanging on the resident's bed frame. This deficient practice could affect the residents in maintaining and/or achieving independent functioning, dignity, and well-being. Findings included: Resident #76 Record Review of Resident #76's Admission Record dated 3/3/25 revealed a [AGE] year-old male with an admitted [DATE]. His diagnoses included: cerebral infraction, unsteadiness of feet, abnormalities of gait and mobility, cognitive communication deficit and muscle weakness with lack of coordination. Record Review of Resident #76's quarterly MDS dated [DATE] reflected a brief interview for mental status score of 13 (moderative cognitively impaired). Functional Abilities for Resident # 76 revealed he required moderate assistance to reposition in bed and maximal assistance to sit to stand, transfer to wheelchair to bed, transfer to toilet and for showers. Record Review of Resident #76's Care Plan revised on 11/6/24 revealed he was at fall risk, had a communication problem related to hearing deficit and the facility had to provide a safe environment by ensuring he had his call light within reach. It stated staff had to do frequent rounds and remind the resident to use his call light for assistance. Observation on 3/3/25 at 10:34 a.m. revealed resident #76's call light was hanging to the back of his bed in between the wheels of the bed and bout four inches from touching the floor. The call light was out of the resident's reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/04/25 at 11:28 AM at Resident #76's room, he stated whenever his call light was not within reach, he would have to wait for someone to check on him in his room or yell for help. Resident# 76 stated it was frustrating for him to have to wait for help whenever the call light was not within reach. Resident #278 Record Review of Resident's #278 face sheet revealed resident is a [AGE] year-old male with admitted [DATE]. His medical diagnoses included: dementia (a group of symptoms affecting behavior, memory and thinking abilities), cognitive communication deficit, muscle wasting and atrophy (the wasting or loss of muscle tissue), muscle weakness, and spondylosis (degeneration of the vertebral column) without Myelopathy or Radiculopathy (compression of spinal cord). Record Review of Resident #278's MDS dated [DATE] revealed a brief interview for mental status score of 12, meaning resident has moderate cognitive impairment. MDS revealed resident needed set up or clean-up assistance with eating and oral hygiene. MDS revealed resident needed partial to moderate assistance with toileting, showering, putting on or taking off shoewear. Record Review of Resident #278's care plan dated 03/06/2025 revealed resident had ADL Self Care Performance Deficit and intervention included encouraging resident to use call bell for assistance. Observation on 03/03/2025 at 10:39 AM revealed Resident #278's call light on the floor and out of resident's reach. Resident #284 Record Review of Resident #284's face sheet dated 03/06/2025 revealed resident is a [AGE] year-old male with admitted [DATE]. His medical diagnoses included: depression, paraplegia (a condition that causes partial or complete paralysis of the lower body, including legs, feet, and toes), osteomyelitis (an infection in the bone caused by bacteria or fungi) of vertebra lumbar region (an irregular bone that make up the spine, located in the lower back), muscle weakness, and muscle atrophy (the wasting or thinning of muscle mass). Record Review of Resident #284's Nursing Home MDS dated [DATE] revealed a Brief Interview for Mental Status of 14 indicating little to no cognitive impairment. MDS revealed resident needed partial assistance from another person to complete any activities. Record Review of Resident #284's Care Plan dated 03/06/2025 revealed resident had ADL Self Care Performance Deficit and intervention included encouraging resident to use call bell for assistance. Observation on 03/03/2025 at 02:28 PM revealed Resident #284's call light was on the floor by the head of the resident's bed. Resident #286 (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #286's face sheet dated revealed resident is [AGE] year-old male with initial admitted [DATE], and re-admitted [DATE]. Resident #286's medical diagnoses included: Chronic systolic (congestive) heart failure, acute and chronic respiratory failure with hypoxia (condition characterized by low levels of oxygen in the body tissues), and muscle wasting and atrophy (the wasting or loss of muscle). Record Review of Resident #286's Care Plan dated 11/20/2024 revealed resident had ADL Self Care Performance Deficit and intervention included encouraging resident to use call bell for assistance. Care Plan revealed resident is At Risk for Falls and intervention included for staff to be sure to leave call light is within reach and encourage resident to use for assistance as needed. Observation on 03/03/2025 at 10:09 AM revealed Resident #286's call light was hanging on resident's bed frame on the head of the bed and out of resident's reach. Resident #91 Record review of Resident #91's Admission Record dated 03/05/25 revealed an [AGE] year-old male with an admitted [DATE]. His diagnoses included: cerebral infraction unspecified, cognitive communication deficit, muscle weakness generalized, difficulty in walking, not elsewhere classified, unsteadiness on feet. Record review of Resident #91's MDS dated [DATE] reflected a brief interview for mental status score of 02(severe cognitive impairment). Resident #91 required substantial/ maximal assistance (helper does more than half the effort) for toileting hygiene (The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.). Needed substantial/ maximal assistance to shower/bathe (bathe, wash, rinse, and dry self). Record review of Resident #91's care plan dated 02/11/25 reflected Resident #91 has a communication problem related to hearing loss. Interventions included to ensure/ provide a safe environment: call light in reach, adequate low glare light, bed in lowest position and wheels locked, avoid isolation. Resident #91 was also at risk for falls, interventions included provide safe environment with even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; Slide fails as ordered, handrails on walls, personal items within reach). Observation on 3/3/25 at 10:45 a.m. revealed Resident #91's call light on floor at the foot of his bed. In an interview with RN D on 03/06/2025 at 11:07 AM revealed nursing staff round on residents every 2 hours. He stated all staff was responsible for ensuring a resident's call light was within reach, which include staff that provide care to residents in their room such as therapy, wound care, and nursing staff. RN D stated the risks of residents not having their call light within reach included falls or injuries. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with ADON on 03/06/2025 at 01:30 PM revealed that the facility conducts Angel Rounds every morning. ADON stated Angel Rounds consists of management of different departments that round on their assigned residents. ADON stated rounding on their assigned residents included ensuring that call lights are within reach. ADON stated all staff was responsible for ensuring residents have their call light within reach. ADON stated the risks of residents not having their call light within reach included residents not receiving the assistance they need or falling if attempting to reach for the call light. In an interview with DON on 03/06/2025 at 04:46 PM revealed that nursing staff was responsible for ensuring call lights are within reach. DON stated nursing staff rounds on residents every 2 hours, and management rounds every day. DON stated call lights need to be accessible to residents so they can receive the help they need. DON stated the risks of call lights that are not within the resident's reach included skin breakdown if the resident is incontinent, or the resident can fall. Record Review of facility's policy Call Lights: Accessibility and Timely Response dated 07/2022, revealed in part: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. Staff will ensure the call light is within reach of the resident and secured, as needed.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51010 Based on observation, interview, and record review, the facility failed to ensure residents received proper treatment and care to maintain good foot health for 3 (Resident #28, Resident #57, and Resident #284) of 16 residents reviewed for foot care. -The facility's CNA's and licensed nurses failed to provide foot care for Resident #28, Resident #57, and Resident #284. This failure could affect residents by placing them at risk for poor foot health, decreased personal hygiene, and a decline in their quality of life. Findings included: Resident #28 Record review of Resident #28's Admission Record dated 03/05/25 revealed a [AGE] year-old male with an original admitted [DATE] and a readmitted [DATE]. His diagnoses included: cerebral infraction unspecified, aphasia, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, cognitive communication deficit, dementia in other disease classified elsewhere, unspecified severity with other behavioral disturbance, Alzheimer's disease unspecified. Record review of Resident #2's MDS dated [DATE] reflected a brief interview for mental status score of 00(severe cognitive impairment). Resident #28 required substantial/ maximal assistance (helper does more than half the effort) for personal hygiene (combing hair, shaving, applying makeup, washing/drying face, and hands). Needed substantial/ maximal assistance to shower/bathe (bathe, wash, rinse, and dry self), required substantial/maximal assistance (helper does more than half the effort) for lower body dressing (dress/undress below the waist), and required substantial/maximal assistance (helper does more than half the effort) for putting on/taking off footwear (put on/take off socks and shoes/footwear). Record review of Resident #28's care plan dated 02/04/25 reflected Resident #28 required assistance with ADLs and was a risk for deterioration in ADLs: (bed mobility, bathing, transfer, walking in room, walking in corridor, locomotion on unit, locomotion off unit, dressing, eating, toilet use, personal hygiene) related to cognitive impairment, current functional status supervision with set up for safety. Goal included to maintain a sense of dignity by being clean, dry, odor free, well-groomed and would show no measurable decline in transferring/ bed mobility ADL functional ability. Record review of Resident #28's order summary dated 03/05/25 reflected an order for the in-house podiatrist to treat and evaluate as needed. Order date: 03/14/2024. Record review of Resident #28's progress notes from 3/14/2024 - present reflected there were no notes found that resident was seen by podiatrist. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of Resident #28 on 03/03/2025 at 10:37 a.m. revealed resident #28's toenails to be about an inch longer than nailbed and thick and yellow. Resident was non interview able. Resident # 57 Record Review of Resident #57's admission record dated 03/05/25 revealed a [AGE] year-old male with an original admitted [DATE] and a readmitted [DATE]. His diagnoses included: cerebral infraction unspecified, cognitive communication deficit, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side. Record review of Resident #57's MDS dated [DATE] reflected a brief interview for mental status score of 06(severe cognitive impairment). Resident #57 required substantial/ maximal assistance (helper does more than half the effort) for personal hygiene (combing hair, shaving, applying makeup, washing/drying face, and hands). Needed substantial/ maximal assistance to shower/bathe (bathe, wash, rinse, and dry self), required substantial/maximal assistance (helper does more than half the effort) for lower body dressing (dress/undress below the waist), and was dependent (helper does all of the effort) for putting on/taking off footwear (put on/take off socks and shoes/footwear). Record review of Resident #57's care plan dated 01/14/25 reflected Resident #57 required assistance with ADLs and was a risk for deterioration in ADLs: (bed mobility, bathing, transfer, walking in room, walking in corridor, locomotion on unit, locomotion off unit, dressing, eating, toilet use, personal hygiene) related to cognitive impairment, current functional status supervision with set up for safety. Goal included to maintain a sense of dignity by being clean, dry, odor free, well-groomed and would show no measurable decline in transferring/ bed mobility ADL functional ability. Record review of Resident #57's order summary dated 03/05/25 reflected an order for the in-house podiatrist to treat and evaluate as needed. Order date: 01/08/2025. Record review of Resident #57's progress notes dated 02/21/2025 - revealed a note entered by DON stating that resident was seen by podiatrist. Observation of Resident #57 on 03/03/2025 at 3:00 PM revealed Resident #57's toenails to be about an inch longer than nailbed and thick. Resident #284 Record Review of Resident #284's face sheet dated 03/06/2025 revealed resident was a [AGE] year-old male with admitted [DATE]. His medical diagnoses included: depression, paraplegia (a condition that causes partial or complete paralysis of the lower body, including legs, feet, and toes), osteomyelitis (an infection in the bone caused by bacteria or fungi) of vertebra lumbar region (an irregular bone that make up the spine, located in the lower back), muscle weakness, and muscle atrophy (the wasting or thinning of muscle mass). Record Review of Resident #284's MDS dated [DATE] revealed a Brief Interview for Mental Status of 14 indicating little to no cognitive impairment. MDS revealed Resident #284 required substantial/maximal assistance with showering/bathing, lower body dressing, and putting on/taking off footwear. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #284's Care Plan dated 03/06/2025 revealed resident has an ADL Self Care performance deficit and interventions included: checking nail length and trim and clean on bath day and as necessary. Observation of Resident #284 on 03/03/2025 at 02:28 PM revealed resident's toenails on both feet were approximately 1 inch longer than the nailbed and thick. Interview on 3/06/25 with RN D at 11:04 a.m. revealed that he was not aware of podiatrist coming into facility to see residents. He stated that as soon as he would identify need, he would let the physician know so that the resident could be seen by podiatrist. Risks of residents having long toenails included ingrown toenails, pain, and injury. He stated that residents having groomed toenails was part of residents' dignity. Interview on 03/06/25 with ADON at 12:56 p.m. revealed that once the nurse identifies the need for toenails to be trimmed, if the resident was not diabetic and toenails were not thick, the CNA would trim them. She stated that if toenails were identified to be thicker than normal and a regular toenail cutter would not be able to be used, then residents would get put on podiatrist list. ADON was responsible for placing residents on the list. ADON stated that podiatrist comes every 2 to 3 weeks, the last time being on February 21st. 20252/21/25. She stated that there is was no policy requiring staff to document when resident was seen by podiatrist. She stated that usually the podiatrist sends sent progress notes of all residents' who were seen, the podiatrist has been behind in sending all the progress notes. ADON stated that she recently took over podiatrist task and has asked podiatrist to send over all progress notes, podiatrist stated that she would send them by end of day tomorrow (3/7/25). Residents with long toenails were at risk of infection as bacteria breeds and grows under long nails, pain and injury. She stated that residents having groomed toenails was a part of residents' dignity. Interview on 3/06/2025 with DON at 3:30 p.m. the DON revealed podiatrist comes in 2-3 weeks, last time being on 2/21/2025. Once a need was identified, nurses would let ADON know that resident needed to be seen by podiatrist as ADON was responsible for placing residents on list to be seen. She stated that there was no specific policy requiring staff to document progress notes of when residents were seen. She stated that the podiatrist would be sending progress notes by the end of tomorrow (3/7/25). The risk of residents having long toenails were an ingrown toenail, pain, and injury. She stated that groomed toenails were a part of resident dignity. Review of facility policy Podiatry Services dated 07/2022 revealed in part, it is the policy of this facility to ensure residents receive proper treatment and care within professional standards of practice and state scope of practice, as applicable, to maintain mobility and good foot health. 51012

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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. 51012 Based on observation, interview and record review, the facility failed to ensure that drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable in that: -The facility failed to keep liquid medication bottle free from dried drippings in medication cart for 100 hall. This finding can lead to spills which obscure the label or cause the medication to be contaminated and affect the 26 residents that reside in 100 hall. Findings included Observation on 03/05/2025 at 11:30 AM of liquid medication bottle in medication cart for 100 Hall revealed red dried debris on opening of bottle. In an interview with ADON on 03/06/2025 at 01:56 PM revealed the medication aides and nurses are responsible for medication carts. She stated LVN F was also responsible for monitoring the facility's medication carts. ADON stated risks of oral medication bottles with debris around the opening include possible infection control issues as the debris can contain bacteria that can contaminate the medication administration for the next resident which can cause illness. In an interview with LVN F on 03/06/2025 at 02:40 PM revealed that nurses and medication aides are responsible for medication carts. She stated herself, ADON, and DON, are responsible for auditing the facility's medication carts. LVN F stated she was not sure how often medication carts are audited. She stated medication aides are to monitor the medication carts daily, and nurses are to monitor them per shift. She stated medication bottles are to be clean and can be an infection control issue if they have debris on opening of the bottle as dust particles can be caught in the debris. In an interview with the DON on 03/06/2025 at 04:24 PM revealed medication bottles should be clean and free from debris. DON stated nurses and medication aides are responsible for monitoring their medication cart. She stated LVN F also had the responsibility of auditing medication carts once a week. DON stated risks of medication bottles with debris on the opening included an infection control issue that can cause illness. Record Review of facility's policy for Medication Storage dated 07/2022, revealed in part: It is the policy of this facility to ensure all medications house on our premises will be stored in the pharmacy and/or medication rooms according to manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51010 Based on the observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food sanitation and storage, in that: -The facility failed to ensure gallon of liquid in the refrigerator was properly closed. -The facility failed to ensure tub of chocolate icing was free from dried drippings around lid. These failures could affect residents by placing them at risk of food borne illness. Findings include: Observation on 03/03/25 at 9:04 a.m. of the walk-in refrigerator revealed a tub of chocolate icing with dried dripping around lid and a gallon of red liquid not properly closed. During an interview on 03/06/25 at 3:30 p.m. with the kitchen cook, revealed she was trained to keep all containers clean after each use and properly sealed. She stated she was trained to clean the container with a damp cloth and sanitizer. She stated staff were supposed to make sure all containers and gallons were closed properly after each use. It was the responsibility of all the kitchen staff to make sure containers and gallons were clean and properly closed. She stated having a container with dried drippings on lid could cause bacteria to grow on container, it could cause cross contamination with other items in the refrigerator, and it was not hygienic. This could cause foodborne illnesses to the residents. During an interview on 03/06/25 at 4:34 p.m. with Dietary Manager revealed staff were trained to clean containers after every use with a damp cloth and sanitizer. Staff were also trained to make sure all containers and gallons were properly closed after each use. She stated it was the responsibility of herself, the cook and all other kitchen staff to ensure this. She stated that having open containers and gallons could lead to cross contamination and bacterial growth causing foodborne illnesses to residents. Facility did not provide policy prior to surveyors exit.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 51010 Based on the observations, interviews, and record reviews the facility failed to dispose of garbage and refuse properly for 1 of 1 dumpster reviewed for food safety requirements. -Dumpster had trash on the ground outside and around the dumpster. -Dumpster was left open and with food substance running down the side of it. This failure could result in providing harborage and breeding areas for insects, rodents and other pests which could infest the facility placing the residents at risk of illnesses, and living in an unsafe, unsanitary, and uncomfortable environment. Findings include: Observation on 03/06/2025 at 11:20 AM revealed dumpster to be open, with food left outside on the ground and an orange, brown food substance dripping down the side of it. Interview on 03/06/2025 at 12:34 p.m. with the ADON/ infection control nurse, revealed she was aware when throwing trash away staff tied up trash bags and disposes of them in dumpster. She stated the risk of leaving the dumpster open with food laying on ground outside of the dumpster would be breeding ground for bacteria, staff could possibly walk over it and track it inside building and causing cross contamination. She stated that Maintenance director does an external round every morning and picks up any trash around building. Interview on 03/06/2025 at 2:34 p.m. with Maintenance Director revealed he does morning environmental rounds every day this included the dumpster. He stated rounds include him picking up any trash around the building. He stated the risk of leaving the dumpster open with food on the ground and food running down the side of it may attract pests and create smells. Interview on 03/06/2025 at 3:16 p.m. with facility administrator revealed That the dumpster should be free from trash around it and the door should be closed. He stated that all staff were responsible for ensuring the dumpster was free from trash on the ground and closed when staff goes outside to throw trash away. Risks included the attraction of pests. Review of facility policy Disposal of Garbage and Refuse dated 7/2022 revealed in part Containers and dumpsters shall be kept covered when not being loaded. Surrounding area shall be kept clean so that the accumulation of debris and insects/rodent attraction are minimized.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49854 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. - The facility failed to ensure Residents # 13, 16 and 82's indwelling catheter tubing was not on the floor. - The facility failed to keep linen cart covers in the laundry room free of tears. These failures could affect the residents at risk for spread of infection through cross-contamination of pathogens and illness. Findings included: Resident # 13 Record Review of Resident #13's Admission Record dated 3/3/25 revealed an 82-year-female with an initial admitted [DATE] and a readmitted [DATE]. Her diagnosis included chronic kidney disease stage four severe and neuromuscular dysfunction of the bladder (occurs when the nerves that control the bladder and its related muscles don't function properly). Record Review of Resident #13's quarterly MDS dated [DATE] reflected a brief interview for mental status score of 14 (cognitively intact). Resident # 13's Functional Abilities revealed she needed moderate assistance with toileting hygiene. It revealed she had an indwelling catheter and was urinary incontinent. Record Review of Resident #13's Care Plan revised on 3/3/25 revealed the resident had an indwelling foley catheter that needed to be positioned below the bladder and away from entrance of room door. During an observation and interview on 03/03/25 at 11:27 AM Resident # 13, her foley bag was hanging from her bed frame below the bladder and it was touching the floor. Resident #13 said she did not notice the foley bag was touching the floor and said she would call staff to assist with the issue because she was worried it could result on an infection. Resident # 16 Record Review of Resident #16's Admission Record dated 3/4/25 revealed he was a [AGE] year-old male with an initial admitted [DATE] and a readmitted [DATE]. His diagnosis included end stage renal disease, fluid overload, renal dialysis (a life-sustaining treatment that replaces the function of failing kidneys), and urinary tract infection . Record Review of Resident #16's initial MDS dated [DATE] reflected a brief interview for mental status score of 12 (moderate cognitive impairment). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #16's care plan dated 3/1/25 reflected Resident #16 had altered urinary elimination related to urinary retention; he was to be administered with antibiotics as prescribed. Resident #16 was at risk for edema related to his diagnosis of renal failure and refusals of dialysis. During an observation and interview on 03/04/25 at 11:36 AM Resident # 16 was laying on bed watching TV, his foley bag was touching the floor. Resident # 16 said he had not been educated to know his foley bag should not be touching the floor and said he did not know the risk of infection it posed. Resident #82 Record Review of Resident #82's Admission Record dated 3/3/25 revealed a [AGE] year-old male with an original admitted [DATE] and a readmitted [DATE]. Resident #82 had a diagnosis of generalized edema (a medical condition characterized by widespread swelling throughout the body when excess fluid accumulates in the body's tissues), urinary tract infection and benign prostatic hyperplasia (a common condition in aging men. It involves the non-cancerous enlargement of the prostate gland). Record Review of Resident #82's quarterly MDS dated [DATE] reflected a brief interview for mental status score of 0 (severe cognitively impaired). He was urinary incontinent. Record Review of Resident #82's Care Plan revised on 2/4/25 revealed he had a history of suprapubic catheter (a type of urinary catheter that is inserted into the bladder through an incision in the abdomen) and urinary tract infection. During an observation on 03/04/25 at 11:35 AM Resident# 82 was asleep in bed. His bed was on the lowest position, and he had a fall mat beside his bed. Resident #82's foley bag was placed flat on the fall mat. In an interview on 03/04/25 at 11:37 AM with LVN A he stated the placement of the bag was not appropriate . e for Resident#16's Foley bag. LVN A said the bag was supposed to be secured and not touching the floor. LVN A said the potential outcome for a foley bag to be touching the floor could result on a resident getting an infection or there were possibilities to spread an infection that a resident had, to other residents if staff went from room to room. In an Interview on 03/04/25 at 11:50 AM with CNA B, she stated she had been trained that foley bags are not to touch the floor, said there was a risk of contamination and infection for those residents who have a catheter and that it could result in major infection. In an Interview on 03/04/25 at 03:20 PM CNA C stated foley bags need to be hanging below the bladder so that the urine can drain into the bag properly. She said if the bag was not below the bladder, the risk could be the urine could backflow and cause infection to the resident. She said the bag should never touch the floor because there was a risk of infection. During an Interview on 03/06/25 at 10:35 AM with RN D, he stated the foley bag needed to be on the lowest position and it must be inside the privacy bag. RN D said if the foley bag was touching the floor there was a risk for infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an Interview on 03/06/25 at 12:40 PM with the ADON, she said if the foley bag touching the floor there was a risk of infection for the resident and cross contamination for the rest of the residents in the facility. During an Interview on 03/06/25 at 03:33 PM with the DON, she said the bag needs to be below bladder, on the bed frame. The DON said the foley bag should not be touching the floor, and it did not matter if it was inside a privacy bag, the foley bag should not be touching the floor at any time. The DON said the risk to the resident was that they could get an infection and have health problems if infection was already present. During an Interview on 03/06/25 at 02:59 PM with the Administrator, he said the foley bag needs to be above the floor to prevent infection control The Administrator said residents could get infections if the bags were touching the floor. Linen Cart Observation on 03/05/25 at 9:40 a.m. revealed a linen cart covered with a blue cover, observed to have a tear to the left back of the cover exposing a part of the white shelf where clean linen was placed. Interview on 03/06/25 at1:40p.m. with ADON revealed she was not aware of linen cart cover being torn. The purpose of the cover was to protect clean linen from possible cross contamination. A torn linen cover could lead to contaminated linen posing a risk to residents' health. Interview on 03/06/2025 at 2:19 p.m. with housekeeping manager revealed that linin cart covers served the purpose of keeping clean linen clean and free from dust, and other microbes. She stated that laundry aide as well as other staff members were responsible for making sure that linen cart covers were intact and if they noticed wear and tear, they were to let her know immediately. She stated that linin cart covers had been torn for 5 months now. The risks of having torn linin covers were cross contamination of clean linen. Interview on 03/06/25 at 2:27 p.m. with laundry aide revealed that linen cart cover tear because it leans and scrapes against the wall. She was not sure how long the cover had been torn. She stated that she, along with other staff members, were responsible for making sure the cover was intact. The risks of cover being torn included cross contamination of clean linen and residents could get sick. Interview on 03/06/25 at 3:16 p.m. with facility administrator revealed that linen cart cover should not be torn, it was an infection control issue because clean linen would not be clean anymore. He stated that the housekeeping manager and laundry aid are responsible for making sure that the cover was intact. Risks included contaminated linen posing a risk of illness to residents because linen was not clean, and linen could fall out of cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy Infection Prevention and Control Program dated 07/2022 read in part: This facility has established and maintains 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 as per accepted national standards and guidelines. Clean linen shall be delivered to the resident care units on covered linen carts with covers down. Linen shall be stored on all resident care units on covered carts, shelves, in bins, drawers, or linen closets. Record review of the policy provided by the facility titled Catheter Care, did not mention prevention of infection on foley bags touching the floor. 51010

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49854 Based on observations, interviews, and record reviews the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 of the facility's laundry department and 1 tankless water heater reviewed for patient care equipment in safe operating condition. -The facility failed to maintain dryer in operation condition. -The facility failed to ensure the residents for hallway 200 of the facility had hot water in their showers and bathrooms. These failures could place residents at risk for harm by the facility's inability to provide clean sanitary linens and could place residents at risk for poor hygiene and health. Findings include: 1.During an observation on 03/05/25 at 09:05 AM, the facility's laundry department revealed 1 commercial was not operational. During an interview on 03/05/2025 at 09:07AM, laundry Aide stated dryers and washer had been inoperable for about 3 weeks. Laundry Aide stated she was able to provide clean linens for the facility's residents with the current operational equipment because they prioritize the linen and washed and dried residents' personal clothes daily. She also stated that laundry staff have been working at night as well to meet the demands. During an interview on 03/06/25 at 2:19 p.m. with housekeeping manager, revealed she was notified of dryer breaking down immediately after it happened by laundry aide. After she was notified, she notified maintenance director. After notifying him, she stated she prioritized washing bed linen first and personal clothes second. She stated that laundry staff washed residents' personal clothes during the nighttime to keep up with the demand. She stated residents have gotten their personal clothes back to them in about 3 to 4 days. Housekeeping manager stated that residents need to get their clothes back in a timely manner due to weather changes. During an interview on 03/06/25 at 2:34 p.m. with administrator revealed that he was made aware of dryer not working this week, he stated that the order had not been able to be placed because the company got bought by another company and the credit cards had not been working, they had been cut off since Saturday 3/1. He stated he would reach out to corporate and let them know they needed to place order for dryer part. He stated with 1 working dryer residents take longer to get their clothes back than they would usually. He stated that laundry aids have been washing and drying during the nighttime to meet the demand. During an interview on 03/06/25 at 3:16 PM with maintenance director, the dryer had been broken down for about 3 weeks. He was notified immediately after dryer broke down and he was able to troubleshoot it and find the part that was not working. He stated he had not placed the order for the part that was needed yet because it was a little more expensive. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.During an interview and Observation on 03/05/2025 at 03:00 PM with the Maintenance Director at hallway 200, he stated the facility had received complaints from residents in hallway 200 at the beginning of 2025 stating the water was too cold to shower in the morning. The facility had been taking the residents to hallway 100 to assist with showers because in that hallway, the temperature was higher and more comfortable for the residents. The Maintenance Director said the facility had waterless tanks. The Maintenance Director stated the problem with cold water was solved when the valve for the gas was ordered and replaced on the tankless water heater for hallway 200. The Maintenance Director and the Surveyor selected four rooms at random in hallway 200 to test the water temperature with a thermometer and the results were as follows: room [ROOM NUMBER] at 3:05 PM temp 97 F room [ROOM NUMBER] at 3:08 PM temp 96 F room [ROOM NUMBER] at 3:11 PM temp 91 F During and observation on 03/06/25 starting atat 11:43 AM The Maintenance Director and the Surveyor selected four rooms at random in hallway 200 to test the water temperature with a thermometer and the results were as follows: room [ROOM NUMBER] at 3:00 PM temp 84 F room [ROOM NUMBER] at 3:05 PM temp 82 F room [ROOM NUMBER] at 3:08 PM temp 89 F room [ROOM NUMBER] at 3:11 PM temp 85 F After taking the temperature for the water on the resident's showers, The Maintenance Director stated the water was not within range for a resident to have a comfortable shower and said the range had to be no lower than 100 degrees Fahrenheit and to hold the temperature not higher than 110 degrees Fahrenheit. In an Interview on 03/05/25 at 11:14 AM Resident #13, she stated the facility had been taking the residents from hallway 200 to be showered in the common bathroom of hallway 100. Resident #13 said she had overheard residents from hallway 200 complaining they had to be taken out of their room to be showered somewhere else. During an interview on 03/06/25 at 02:48 PM with the Administrator stated he received complaints about the water temperatures in January of 2025 at the beginning of the month. The complaint was the water was too cold to be taking showers in the room. He said the facility staff did not shower the residents with cold water and took residents from hallway 200 to shower in 100. The Administrator said the potential outcome could be the Residents could be inconvenienced by not having proper working equipment and not being able to shower in their own rooms. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/06/25 at 03:39 PM with the DON stated she had heard about the issues with hallway 200 and low water temperatures and that residents from that hallway were being taken to hallway 100 to be showered. She stated the potential outcome could be the residents could be frustrated because they can't take showers in their rooms Record Review of the facility's policy titled Safe Water Temperatures dated 07/2022 stated in part: Water temperatures will be set to a temperature of no more than 110 degrees for sink faucets showers and lavatories. Facility did not provide policy for the functioning essential equipment upon surveyor exit. 51010