

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676439	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Trinity Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 314 E Caroline St Trinity, TX 75862	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994</p> <p>Based on observation, interview, and record review the facility failed to provide a safe, clean, and comfortable environment for residents for 1 of 24 residents (Resident #29) observed for resident environment.</p> <p>The facility failed to ensure the privacy curtain and a wheelchair in the room of Resident #29 was clean and without odors on 2/24/2025.</p> <p>This failure could place residents at risk for an unsanitary environment.</p> <p>Findings included:</p> <p>Record review of an Admission Record dated 2/25/2025 for Resident # 29 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of Alzheimer's disease, PBA (a medical condition that causes sudden and uncontrollable crying or laughing), age related osteoporosis (brittle bones), and expressive language disorder (a communication disorder that causes difficulty expressing spoken language).</p> <p>Record review of a Quarterly MDS assessment dated [DATE] for Resident #29 indicated she was rarely/never understood. She required the use of a wheelchair. She was dependent with all ADL's and was always incontinent of urine and bowel.</p> <p>Record review of a care plan for Resident #29 dated 5/17/2024 indicated she had an ADL self-care performance deficit and limitations in physical mobility. Interventions included to use a Broda chair (specialized wheelchair) for positioning, comfort, and the ability to be up and eat.</p> <p>During an observation and interview on 2/24/2025 at 2:27 PM, in the room of Resident #29 CNA A and CNA D were present to transfer Resident #29 from her wheelchair to her bed using a mechanical lift. Her wheelchair had a strong urine odor. Both staff said the night shift staff were supposed to clean the wheelchairs and cushions. Both said the chair had been stinky for a while. The privacy curtain in room had a large brown splatter stain at the bottom of the curtain. Both staff said it looked like feces and said they did not know if the curtains were ever cleaned but they would tell the charge nurse.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/25/2025 at 3:00 PM, the Maintenance Supervisor said she was responsible for checking the privacy curtains along with housekeeping staff. She said some department heads were responsible during ambassador rounds to check daily for things in the room. She said the privacy curtains were cleaned when a resident discharged , or something gets on them. She said they no longer had a cleaning schedule for the privacy curtains. She said she was made aware of the privacy curtain in Resident #29's room on yesterday 2/24/2025 and it was taken down and cleaned. She said the curtain looked like it had feces on it. She said there would be a set schedule from then on with cleaning the privacy curtains. She said she would not like it if she was a resident, and her privacy curtain was not cleaned.</p> <p>During an observation and interview on 2/25/2025 at 3:14 PM, the Maintenance Supervisor was in the room of Resident #29 who was resting in bed. Her wheelchair was by the door. The Maintenance Supervisor said the wheelchair smelled like urine. She said she had a spray solution that they used to clean the wheelchairs in the facility along with the cushions. She said she was not aware of the resident's wheelchair not being cleaned and would be very upset about it if she had to sit in a chair that smelled of urine.</p> <p>During an interview on 2/27/2025 at 10:06 AM, the DON said the Transport Driver was responsible for cleaning the wheelchairs at nights along with housekeeping staff. She said she did not know if they had a schedule for cleaning the wheelchairs. She said the housekeeping staff were responsible for cleaning the privacy curtains.</p> <p>During an interview on 2/27/2025 at 10:16 AM, the Transport Driver said he had been employed at the facility since May 2024 and was responsible for cleaning the wheelchairs monthly and he last cleaned them last month January 2025. He said he cleaned all of the wheelchairs in the facility. He said he did not have any documentation to reflect that he had cleaned them. He said if the wheelchairs were not cleaned there could be a risk for staph (a type of skin infection) or other infections and would not want to sit in a wheelchair that was filthy or had an odor.</p> <p>During an interview on 2/27/2025 at 10:32 AM, HSK E said she had been employed at the facility for 2 weeks. She said they rotated the halls they worked daily. She said they clean everything that included the lights, air conditioners, under beds, side tables, bathrooms, mirrors, closets and the swept and mopped the floors. She said no one told her about doing anything to the privacy curtains and she was trained by another housekeeper and was never told about the privacy curtains in the rooms nor the wheelchairs.</p> <p>During an interview on 2/27/2025 at 10:37 AM, HSK F said she had been employed at the facility for 2 years, but she mostly worked in laundry and helped as needed in housekeeping. She said she helped to train new staff in housekeeping and laundry. She said they had to clean under beds, touchable surfaces, toilets, sinks, mirrors, high dust, sweep and mop the rooms. She said they took the privacy curtains down once a month unless something got on them before and washed them. She said she was made aware of a privacy curtain in Resident #29 room, and it was washed and hung back up. She said the housekeepers were supposed to check the privacy curtains daily. She said if a privacy curtain was not cleaned, it would make her feel like the room was not getting cleaned.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/27/2025 at 2:12 PM, the Administrator said she was not aware of Resident #29's privacy curtain being dirty or her wheelchair having an odor. She said the Maintenance Supervisor was responsible for cleaning the wheelchairs and they should be checked daily. She said housekeeping were responsible for cleaning the privacy curtains and they should be checked daily when they were in the rooms cleaning. She said it would not make her feel good if she had to sit in a wheelchair that had an odor or if she was a resident and the privacy curtain was dirty with feces. She said she planned to reeducate the housekeepers to check privacy curtains daily and getting the wheelchairs cleaned along with ensuring the monthly wheelchair cleanings were done.</p> <p>Record review of a facility policy titled Cleaning and Disinfection of Environmental Surfaces revised August 2019 indicated, .Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSHA Bloodborne Pathogens Standard .</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50071</p> <p>Based on interview and record review, the facility failed to ensure the right to be free from misappropriation of property was provided for 1 of 3 residents reviewed for misappropriation of property. (Resident #17)</p> <p>The facility failed to prevent a diversion (misappropriation) of Resident #17's Hydrocodone-Acetaminophen 10-325mg tablets (a combined hydrocodone/acetaminophen narcotic pain reliever) on December 31, 2024.</p> <p>This failure could place residents at risk for decreased quality of life, unrelieved pain, misappropriation of property, and dignity.</p> <p>Findings include:</p> <p>Record review of an undated face sheet for Resident #17 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: Unspecified Fracture of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing, Urinary Tract Infection, Cognitive Communication Deficit, Repeated Falls.</p> <p>Record review of an Annual MDS dated [DATE] for Resident #17 indicated that he had a BIMS score of 09, indicating that he was moderately cognitively impaired. He was documented as receiving an opioid for the entire 7 day look back period.</p> <p>Record review of physician's orders for Resident #17 indicated that he had an active order for hydrocodone-acetaminophen 10-325mg, 1 tablet by mouth every 6 hours (prn) dated 11/22/24.</p> <p>Record review of a medication administration record for Resident #17 for the month of December 2024 indicated the resident received hydrocodone routinely at 12:00 am, 6:00 am, 12:00 pm, and 6:00 pm.</p> <p>During an interview on 2/24/25 11:00am with MA L she said she's aware of the incident with Resident #17 medication(narcotic) count being off. She said the procedure for receiving medication (narcotics) from pharmacy delivery is for two nurses and the pharmacy representative to count, checks for discrepancies, and make sure all medication (narcotics) is accounted for. She said they all will sign two forms verifying the medication and count is correct. One form stays at the facility and be placed in the facility's records and one form is given to the pharmacy representative for their record. She said if there are discrepancies the nurses should have caught it and not signed for the medication.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/24/25 10:50am with LVN K she said she was on duty the day Resident #17's medications were reported missing. She said the medication came into the facility right at shift change. She said that she was informed of the incident by the administrator, DON and police interviewing her about the incident. She said the procedure to check in medications is to look at the name of the medication ordered, check the amount of medication delivered and log it in on medication. She said two nurses and the pharmacy delivery person are to check the medications together and all are to sign a medication log indicating the medication and count are correct. She said the facility will keep one copy for their records and the pharmacy delivery person will take a copy with him. She said medications are always to be kept locked up at all times. One blister pack is kept in a locked med cart and if there are extra blister packs, they are to be locked in the overflow box in the locked medication room.</p> <p>During an interview on 2/24/25 11:15am with LVN G said she's a full-time employee and is aware of the medication for resident #17 being missing. She said during report she was told that a whole card of Narco's (Hydrocodone-Acetaminophen 10-325mg tablets, a combined hydrocodone/acetaminophen narcotic pain reliever) were missing. She said she was not aware how many pills were on the card. She said two nurses and the pharmacy delivery person should have counted, and signed off on a medication log that all medications were accounted for. The medication should have then been put in a locked med cart or in their overflow lock box. She said there were a break in the process as all nurses are trained on delivery and storage of all medications including narcotics.</p> <p>During an interview on 2/24/25 12:56 am with RN H she said she's aware that Narco's (Hydrocodone-Acetaminophen 10-325mg tablets, a combined hydrocodone/acetaminophen narcotic pain reliever) for resident #17 went missing. She said all the nurses have been questioned about resident 17's missing medication and in-serviced on the process of medication storage, missing medications, drug administration and accepting and delivery of medications. She said two nurses are supposed to get with the person delivering the medication, count the medication and assure they are correct. Then sign an inventory form verifying the receipt of the medications and that the count and medications are correct and put a copy of the inventory form in the facility binder and give one to the person delivering the medications from the pharmacy.</p> <p>During an interview on 2/24/25 3:30 pm with the DON she said she was notified about the missing Narco's (Hydrocodone-Acetaminophen 10-325mg tablets, a combined hydrocodone/acetaminophen narcotic pain reliever) of resident #17 by the nurses on duty. Once she and the other staff realized the medication could not be found they called the police who came and searched for the missing medication by questioning the staff that was present. She said they also contacted the pharmacy who stated the medication was delivered and signed for. She said the nurses did not appropriately sign off on the medications correctly or as trained. She said two nurses along with the pharmacy representative are supposed to make sure the name of medication, dosage and amount of medication is correct, and the correct medications are present and all three are to sign a consent agreeing the medications are correct and place the medication in a locked storage cart or a locked medication room. She said the staff is to place the signed consent in the facility logbook and give the pharmacy staff a copy.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/24/25 3:45 pm with the ADMN, she said she's very aware of the missing medication for resident #17. She said 116 Narco's (Hydrocodone-Acetaminophen 10-325mg tablets, a combined hydrocodone/acetaminophen narcotic pain reliever) were delivered to the facility on [DATE] and only 58 Narco's were found in the medication cart. She said there were two blister packs of Narco's with 58 pills each according to the sign in sheet. She said she called the police and reported the missing Narco's. She said the police came and questioned the staff and provided her a case number did not give her a police report. She said when medications are delivered two nurses along with the pharmacy delivery person should have identified, counted, and assured the medication were correct. Once the count and medication are deemed correct all three should sign a consent form verifying the medication and count are correct. One copy of the signed consent is to be put in the facility binder for Narcotics and a copy provided to the pharmacy delivery person.</p> <p>Record review of a facility policy titled Facility Abuse Prevention and Prohibition Policy dated 2001 with revision of December 2022 indicated CMS defines misappropriation of resident property as, the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.</p> <p>Record review of a facility policy titled Accepting Delivery of Medications dated 2001 with revision date of February 2001 indicated Upon Receipt</p> <p>a. Two licensed nurses and the individual delivering the medication verify the name of the medication, dose and quality of each controlled substance being delivered.</p> <p>b. All individuals sign the controlled substance record of receipt.</p> <p>C. An individual resident-controlled substance record is made for each resident who is receiving a controlled substance. The record contains:1). name of resident; 20. Name and strength of the medication.</p> <p>Record review of a facility policy titled Abuse Prevention Program dated 2001 with revision date of June 2021 indicated .2. Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation .</p> <p>Record review of a facility policy titled Accepting Delivery of Medications dated 2001 with revision date of April 2019 indicated .</p> <p>Policy heading</p> <p>1. All staff shall follow a consistent procedure in accepting medications.</p> <p>2. Any errors noted in receiving medications shall be brought to the attention of the pharmacist and director of nursing services.</p> <p>Policy Interpretation and Implementation</p> <p>1. Each medication delivery shall be personally accepted by two licensed personnel.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Before signing to accept the delivery, both licensed personnel must reconcile the medications in the package with the delivery ticket/order receipt.</p> <p>4. Both nurses and the delivery personnel shall sign the delivery ticket, indicating review and acceptance of the delivery, and shall keep a copy of the delivery ticket. Both receiving nurses and the delivery agent must sign and make any notations about errors.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994</p> <p>Based on interviews and record review, the facility failed to refer all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change of condition for 1 of 6 Residents (Resident #4) reviewed for PASARR (Preadmission Screening and Resident Review Services).</p> <p>The facility failed to ensure Resident #4 had a new level 1 PASARR completed with a new diagnosis of major depressive disorder added on 10/28/2024.</p> <p>These failures could place residents at risk of not receiving the needed PASARR services to meet their individual needs and could result in a decreased quality of life.</p> <p>The findings were:</p> <p>Record review of an Admission Record dated 2/26/2025 for Resident #4 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of adjustment disorder with depressed mood (a condition where a person had depression as a result of a life change or stress), major depressive disorder (a mood disorder that caused persistent feeling of sadness or loss of interest) dementia and age related osteoporosis (brittle bones).</p> <p>Record review of a Quarterly MDS assessment dated [DATE] indicated she had moderate impairment in thinking with a BIMS score of 12. Her primary medical condition was adjustment disorder with depressed mood and had non-Alzheimer's dementia. No referral was made to the local contact agency.</p> <p>Record review of a care plan for Resident #4 dated 11/5/2024 indicated she had impaired cognitive function, memory loss and/or impaired thought processes related to depression/adjustment disorder.</p> <p>Record review of a behavioral hospital discharge summary dated 10/28/2024 indicated her principal diagnosis was major depressive disorder.</p> <p>Record review of a PASARR Level 1 (PL1) dated 10/28/2024 for Resident #4 indicated she had dementia and mental illness was negative.</p> <p>Record review of a PL1 dated 10/11/2024 for Resident #4 indicated she had dementia and mental illness was negative.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/26/2025 at 11:48 AM, the MDS Coordinator said she had been employed at the facility since the end of October 2024. She said Resident #4 went out to a behavioral hospital at the end of October 2024 and when she returned, she had a new mental illness diagnosis from the behavioral hospital. She said her PL1 that was completed by the behavioral hospital dated 10/28/2024 indicated she was positive for dementia. She said the resident's primary physician did not give the resident the mental illness diagnosis and she did not complete a form 1012 (used to determine whether to submit a new positive PL1 screening form on the Long-Term Care Portal because further evaluation was needed) and was not aware of what the form was. She said Resident #4's primary diagnoses were dementia and thinks she should have had a new evaluation after Resident #4 returned with a new diagnosis of mental illness. She said residents may not get the required services needed if the forms were not completed. She said she would get a form 1012 completed for the physician to review and sign.</p> <p>During an interview on 2/27/2025 at 1:51 PM, the DON said the MDS Coordinator was responsible for coordinating all things PASARR related. She said she was not familiar with the PASARR process and what documents were required to be completed. She said she was aware that Resident #4 did discharge from the facility to a behavioral hospital some months ago.</p> <p>During an interview on 2/27/2025 at 2:12 PM, the Administrator said the MDS Coordinator was responsible for any updates for PASARR. She said she was not aware of any new diagnoses for Resident #4. She said residents might not get the services that PASARR provided if evaluations were not completed.</p> <p>Record review of a Facility policy titled Pre-Admission Screening/Processing revised on December 2024 indicated, .Our facility admits only residents whose medical and nursing care needs can be met. 14. All new admission and readmission are screened for mental disorder (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process .</p> <p>Record review of a Mental Illness/Dementia Resident Review for Resident #4 undated was completed by the MDS Coordinator but was not signed by the physician.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273</p> <p>Based on interview and record review, the facility failed to ensure the baseline care plan that included the instructions for resident care needed to provide effective and person-centered care was completed for 3 of 6 residents reviewed for new admissions (Resident #167, #174, and #175).</p> <p>The facility failed to complete baseline care plans within 48 hours of admission for Residents #167, #174, and #175.</p> <p>This failure could place residents at risk of not receiving care and services to meet their needs.</p> <p>Findings included:</p> <p>Record review of a facility face sheet dated 2/25/25 for Resident #167 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis of cellulitis (skin infection).</p> <p>Review of an electronic medical record for Resident #167 indicated that no baseline care plan was completed.</p> <p>Review of a Nursing Home PPS MDS assessment dated [DATE] for Resident #167 indicated she had a BIMS score of 14 indicating that she was cognitively intact. She required partial/moderate assistance with toileting, showering, and dressing. She was occasionally incontinent of bowel and bladder. She had a diabetic foot ulcer, an infection of the foot, and was receiving application of dressings to feet (with or without topical medications).</p> <p>Record review of a facility face sheet dated 2/27/25 for Resident #174 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis of displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing (hip fracture at the top part of the thigh bone).</p> <p>Record review of an electronic medical record on 2/27/25 for Resident #174 indicated that no comprehensive MDS assessment had not yet been completed.</p> <p>Record review of a baseline care plan initiated 2/26/25 for Resident #174 indicated that it was not implemented within 48 hours of admission.</p> <p>Record review of a facility face sheet dated 2/24/25 for Resident #175 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including sepsis due to methicillin resistant staphylococcus aureus (Methicillin-resistant Staphylococcus aureus or MRSA is a staph infection that has become immune to many types of antibiotics; sepsis is when the body has a severe, inflammatory response to bacteria or other germs).</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a comprehensive MDS assessment dated [DATE] for Resident #175 indicated that she had a BIMS score of 15, which indicated that she was cognitively intact. She had a surgical wound and was receiving IV medications.</p> <p>Record review of a baseline care plan indicate that it was not initiated until 2/24/25 for Resident #175 and had the following special treatments/needs: IV Medications and Isolation.</p> <p>During an interview on 2/27/25 at 1:31 pm MDS nurse said DON was responsible for baseline care plans. She said the baseline care plans tell staff which necessities are needed, communicates with family and could affect discharge planning. She said going forward she would be doing admission chart checks to ensure they were completed. She said an LVN could not do them, and they must be done by an RN.</p> <p>During an interview on 2/27/25 at 1:38 pm DON said she was responsible for baseline care plans. She said the weekend RN was responsible for doing baseline care plans for admissions that came in on the weekend. She said if baseline care plans were not done, it could cause issues for resident care as the baseline care plan communicates residents' needs to the staff. She said she would ensure baseline care plans were done going forward.</p> <p>During an interview on 2/27/25 at 2:04 pm Administrator said if baseline care plans were not initiated appropriately that staff might not know how to care for the resident. She said going forward she would be implementing an audit process for new admissions.</p> <p>Record review of a facility policy titled Care Plans - Baseline dated 2001 and revised December 2016 read: . To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission .</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273</p> <p>Based on observation, interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain grooming, and personal and oral hygiene were provided for 2 of 6 residents (Resident #1 and #173) reviewed for ADL care.</p> <p>The facility failed to follow care plan for Resident #1 and assist her with showers on 2/17/25, 2/21/25, and 2/25/25.</p> <p>The facility failed to ensure Resident #173 had clean and trimmed nails on 2/24/25 and 2/25/25.</p> <p>This failure could place residents at risk of not receiving care/services, decreased quality of life, and loss of dignity.</p> <p>Findings included:</p> <p>Record review of a facility face sheet dated 2/26/25 for Resident #1 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis of chronic obstructive pulmonary disease (a common lung disease causing restricted airflow and breathing problems).</p> <p>Record review of a Quarterly MDS assessment dated [DATE] for Resident #1 indicated that she had a BIMS score of 15, which indicated she was cognitively intact. According to MDS assessment she required supervision or touching assistance with showering/bathing and for tub/shower transfers. She was independently ambulatory with a manual wheelchair. She was always continent to bowel and bladder.</p> <p>Record review of a comprehensive care plan dated 6/6/22 for Resident #1 indicated that she had an ADL self-care performance deficit and limitations in physical mobility related to obesity and had an intervention for extensive assist X 1 staff member with bathing/showering at least 3 times weekly and as necessary and sponge bath could be provided when a shower could not be tolerated.</p> <p>Record review of shower sheets for Resident #1 dated 2/17/25, 2/21/25, and 2/25/25 indicated that all three sheets documented that resident bathed self and none were signed by charge nurse.</p> <p>During an observation and interview on 2/24/25 at 10:05 am Resident #1 was observed lying in bed in her room. She said she had not had a shower or a bed bath in probably over a year. She said the staff would not get her up on the shower bed, and she could not use the shower chair because she was so large that the aide would not be able to reach her private areas to properly clean in the chair. She said she normally just gets wipes and wipes herself off, she said they had never offered a bed bath to her. She said she would like to take a shower, or at the very least a bed bath. She said it would make her feel a lot better. No odors were observed.</p> <p>Record review of a facility face sheet dated 2/24/25 for Resident #173 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis of cerebral infarction (stroke).</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident had not had an MDS assessment completed yet.</p> <p>Record review of a baseline care plan dated 2/21/25 for Resident #173 read .Resident will have all needs anticipated and met to ensure the highest practicable level of well-being and dignity preservation .</p> <p>Record review of facility shower sheets indicated on 2/25/25 Resident #173 was showered, had hair washed and a wound documented to right leg. There was no documentation of nail care.</p> <p>During an observation and interview on 2/24/25 at 9:35 am Resident #173 was observed lying in bed. She had long, dirty nails with a brown substance observed underneath majority of nails. She said it had been a while since she had a shower, said staff had not cleaned her nails and said it would make her feel better to be clean.</p> <p>During an interview on 2/27/25 at 1:38 pm DON said if nail care and showers were not done, residents could easily transfer bacteria and get infections. She said she would not be happy if she had dirty nails and did not get a proper shower. She said she was ultimately responsible for ensuring showers and nail care were done and she would work to ensure all residents were clean and properly showered going forward by providing education with shower staff.</p> <p>During an interview on 2/27/25 at 2:04 PM Administrator said if residents were not being properly showered or receiving nail care, it could cause them to feel dirty, could increase risk for infections and rashes. She said it would make them feel better if they received a proper shower and were clean. She said staff should be following care plans when assisting residents with ADLs. She said going forward, administrative staff would be making rounds to ensure showers and nail care were truly being offered and staff were not just documenting self or refused.</p> <p>Record review of a facility policy titled Bath, Shower/Tub dated 2001, and revised February 2018 read .The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin . and .if feasible, the resident may bathe him- or her-self. Assist as needed .</p> <p>Record review of a facility policy titled Fingernails/Toenails, Care of dated 2001 and revised February 2018 read .Nail care includes daily cleaning and regular trimming .</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure each resident received adequate supervision with smoking materials to prevent accidents for 1 of 8 residents (Resident #27) reviewed for accidents and hazards.</p> <p>The facility failed to ensure Resident #27 returned his lighter and cigarettes to the staff when returning from smoking.</p> <p>This failure could place residents at risk of harm or injury and contribute to avoidable accidents.</p> <p>Findings included:</p> <p>Record review of an Admission Record for Resident #27 dated 2/27/2025 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of dementia, pneumonia (lung infection), and bipolar (extreme mood swings).</p> <p>Record review of a Quarterly MDS Assessment for Resident #27 dated 1/13/2025 indicated he did not have any impairment in thinking with a BIMS score of 15. He was independent with all ADLs.</p> <p>Record review of a care plan for Resident #27 dated 11/11/2024 indicated he was a smoker. Interventions included he required supervision while smoking. Instruct resident about the facility policy on smoking.</p> <p>Record review of a smoking safety screen assessment for Resident #27 dated 11/4/2024 indicated he was safe to smoke with supervision. Resident needed the facility to store lighter and cigarettes.</p> <p>During an observation on 2/27/2025 at 8:40 AM, in the smoking area outside of the facility, 2 staff led 5 residents outside for smoke break. Smoking materials were with the staff who handed cigarettes and lighters to the residents. Resident #27 came out a few minutes late and had his own lighter and cigarettes on him in a pocket that were in a metal container. He pulled out cigarettes that were in a metal container and lit it with a lighter he had in his pocket.</p> <p>During an observation and interview on 2/27/2025 at 11:00 AM, Resident #27 was in his room and a lighter was on his over bed table. The metal container was empty and did not have any cigarettes in it. He said he had been at the facility for 2 years and he had just come back in from smoke break. He said he kept his cigarettes and lighter with him but never smoked in the facility. He said every once in a while, the staff would take away his cigarettes and lighter, but he would get them back. He said he rolled his own cigarettes, and he kept the tobacco in the activity room.</p> <p>During an observation and interview on 2/27/2025 at 11:05 AM, Resident #27 walked to the activity room and said he kept his tobacco in the cabinet under the sink. Observed a bag of tobacco and papers in a clear plastic bag under the sink. He said he kept them there because it was easy for him to have access to it.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/27/2025 at 11:14 AM, the DON said that there were not any residents that were deemed safe smokers and that were allowed to keep their smoking materials on them. She said the smoking materials should be kept in the medication room locked. She said residents could be at risk for starting a fire or harming themselves or other residents having an allergic reaction from cigarette smoking and destroying property. She said they had problems with Resident #27 before and was care planned for behavioral problems related to having smoking materials on him. She said Resident #27 was supposed to get his cigarettes from the nurse and when he finished rolling them to take them back to the nurse. She said the person who collected the smoking materials during smoke break were supposed to ensure they were picking back up the smoking materials.</p> <p>During an interview on 2/27/2025 at 2:12 PM, the Administrator said no residents in the facility were able to keep their smoking materials in their rooms. She said she was not aware of Resident #27 having smoking materials on him. She said there could be a risk for fire or injury and would make sure that he knew that he cannot keep material on him and would educate his family when they take him out to make sure they give materials back to nurse to lock up. She said the smoking materials should be kept in a locked room and not kept in a cabinet that was not locked.</p> <p>Record review of a facility policy titled Smoking Policy-Residents revised December 2011 indicated, .This facility shall establish and maintain safe resident smoking/vaping/electronic cigarette practices. 12. Smoking articles: a. Residents may not have or keep any types of smoking articles, including cigarettes, tobacco, etc., except when they are under direct supervision .</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>49017</p> <p>Based on interview and record review the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and follow a policy to provide pharmacy services for 2 of 12 months (January 2025 and February 2025) reviewed for pharmacy services.</p> <p>The facility failed to document the required number of 2 witness signatures for drug destruction on 1/28/2025 and 2/20/2025.</p> <p>This failure could put residents at risk for misappropriation and drug diversion.</p> <p>Findings included:</p> <p>Record review of facility drug destruction records for the last 12 months (3/2024 to 2/2025) reflected that on 1/28/2025 the cover page and the attached page were only signed by the DON and the Pharmacist and did not include any additional witness signatures. Record review of cover page dated 2/20/2025 was signed by the Pharmacist only with no witness signatures.</p> <p>During an interview on 2/27/2025 at 9:15 AM, the DON who said the drug destruction sheets were normally signed by the Pharmacist, ADON and herself. She said in January 2025 she did not have an ADON at that time and that February 2025 the ADON had just started and that it was an oversight that the form was not signed. She said the drug destruction sheets needed the Pharmacist signature and 2 witness signatures. The DON believed that the witness signatures had be the DON and the ADON. She stated that she was not aware that other staff could be witness to the drug destruction. She said 2 witness signatures are needed for accountability and prevent possible drug diversions.</p> <p>During an interview on 2/27/2025 at 9:35 AM, the Administrator who said she was not part of the drug destruction process in the facility. She said she knew the sheets had to be signed by at least 2 witnesses. She was not aware that the January and February 2025 sheets was missing witness signatures. She said there was a risk for drug diversion if they did not have the appropriate signatures on the drug destruction pages.</p> <p>Record review of a facility policy titled Discarding and Destroying Medications revised April 2019 reflected, For unused, non-hazardous controlled substances that are not disposed of by an authorized collector, the EPA recommends destruction and disposal of the substance with other solid waste following the steps below .Include the signature(s) of at least two witnesses.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49017</p> <p>Based on observations, interviews, and record review, the facility failed to ensure drugs and biologicals used in the facility were stored in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 1 of 26 residents (Resident #5) reviewed for medication storage.</p> <p>The facility did not ensure Nystatin powder was not stored at the bedside for Resident #5 on 2/24/25.</p> <p>This failure could place all residents at risk of misuse of medication and decreased quality of life.</p> <p>Findings included:</p> <p>Record review indicated that Resident #5 was an [AGE] year-old female admitted to the facility on [DATE]. Diagnosis includes congestive heart failure, hypertension, cognitive communication deficit, and cognitive decline.</p> <p>Record review of a quarterly MDS dated [DATE] indicated that Resident #5 had a BIMS score 13 indicating that the resident has cognitively intact. She required moderate to maximal assistance for all ADL's. Resident was continent of bowel and bladder.</p> <p>Record review of a physician's order summary report dated 2/24/25 for Resident #5 indicated that she had an order for Nystatin external cream 100000 unit/GM topical cream. Apply to legs, hands, abdominal folds topically one time a day for antifungal treatment with a start date of 2/8/2025. Resident #5 did not have an order to self-administer medications or to keep medication at bedside.</p> <p>Record review of Resident #5 assessments indicated that she did not have a self-administration of medications assessment form. Resident #5 did not have a care plan reflecting that she could self-administer medications.</p> <p>During observation on 2/24/25 at 9:03 AM, a bottle of Nystatin powder 100000 units/GM external powder was on resident nightstand. Resident #5 was lying in her bed with her eyes closed.</p> <p>During an observation on 2/24/25 at 2:20 PM bottle of Nystatin powder was on the resident's bedside table located next to resident. Resident was lying in bed. She stated that she did not know what was in the bottle. LVN G was in the resident's room, when asked about the Nystatin powder on the bedside table she stated that the medication should not be in the resident's room. She stated the resident did not have an order to keep medication at the bedside. LVN G removed Nystatin powder from the room and secured it on the medication cart.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the DON at 9:15 AM on 2/27/2025, she stated that there was one resident in the facility that was assessed to self-administer medications, but it was not Resident #5. She stated the facility did have a policy, she stated the resident would have to have an order to self-administer medication, an assessment for self-administering medications would have to be completed and that the resident would need to be care planned for self-administration of medications. She was not aware that resident #5 had medications in her room for self-administration. She stated there should not be any medications in the resident rooms at this time. She expects staff to remove any medications found in the resident's rooms. She said that a possible outcome of medications at the bedside could be not using medications as directed and that the nurse would not know when or how much medication the resident is taking or using.</p> <p>During an interview on 2/27/2025 at 9:35 PM, the Administrator stated she was only aware of one resident in the facility that was able to self-administer medications. She said Resident #5 did not have an order or an assessment needed to self-administer medications. She said that nursing staff should remove any medications found in the room immediately. She said that medications are to be kept secured in the medication cart. She said possible outcomes is that medications could be taken incorrectly and that other residents could have access to the medications.</p> <p>Record review of facility policy titled Self- Administration of Medications revised February 2021 read .Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. and .As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident .</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994</p> <p>Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food under sanitary conditions in 1 of 1 kitchen.</p> <p>The facility failed to ensure the temperature for the dish machine was at the appropriate temperature of 120 degrees according to the manufacturer's guidelines on [DATE].</p> <p>The facility failed to remove 9 cups of yogurt from the refrigerator that were dated [DATE] on [DATE].</p> <p>The facility failed to ensure a box of white onions, a box of cucumbers and tomatoes were removed from the refrigerator when they had white, hairy, and black substances present on [DATE].</p> <p>These failures could place residents who eat from the kitchen at risk of foodborne illnesses.</p> <p>Findings included:</p> <p>During an initial observation on [DATE] at 8:33 AM, the DM, DA B and [NAME] were present in the kitchen. The dish machine was checked by DA B who ran a cycle three times and the temperature would not reach 120 degrees as per manufacturer's guidelines. The temperature gauge at the top of the dish machine would not go past 108 degrees. DA B said she did not know how to check the temperature of the machine or where she could find the temperature. The DM said DA B was a fairly new employee and was still being trained. DM said the dish machine had been getting hot and reached 120 degrees according to the dish machine log but would contact the company to come and check it out, in the meantime, they would use paper products if it would not be repaired before lunch on that day.</p> <p>Record review of a dishwasher sanitizing log dated February 2025 from [DATE]-[DATE] indicated the temperatures for the dish machine for breakfast, lunch and dinner all had 120 degrees recorded.</p> <p>During an observation on [DATE] at 8:42 am, the refrigerators were checked with the DM present: 9 containers of yogurt dated [DATE], a box of cabbages with yellow, brown leaves that had a strong, pungent smell coming from the box, box of white onions had a white, hairy substance present, box of cucumbers had a white, hairy substance present, box of tomatoes were mushy, with black substances present.</p> <p>DM said she was not aware of the items in the refrigerator and would remove the expired yogurt and rotten vegetables. She said the cooks and tray aides were responsible for checking the refrigerators for expired and old foods daily. She said if a resident was served foods past the dates, it could make them sick and would hope the staff would not serve residents foods that were rotten as it could make them sick as well.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation and interview on [DATE] at 8:20 AM, the DA C said the dish machine had been having problems for a while with the temp not reaching 120 degrees. DA C ran the dish machine and the temperature reached 120 degrees. She said the cooks or tray aides were responsible for checking the refrigerators and freezers for old or expired foods daily and it could make residents sick if they ate them.</p> <p>During an interview on ,d+[DATE] at 11:50 AM, the [NAME] said she had been employed at the facility since [DATE] and the tray aides and cooks were responsible for checking the refrigerators and freezers for foods that were outdated or had started to mold. She said the DM checked them as well sometimes. She said the kitchen staff had been short staffed with only 2 staff in the kitchen at a time and the DM would not help them. She said it was hard to check the refrigerators and freezers daily being short staffed. She said residents could get sick if they ate foods that were outdated or had mold on them.</p> <p>During a phone interview on [DATE] at 2:15 PM, the RD said she visited the facility about every 2 weeks. She said she conducted a formal inspection of the kitchen monthly. She said she checked for overall cleanliness, dating/labeling of food and proper plating of foods. She said she had not conducted a formal inspection this month yet. She said all foods should be labeled and dated and expired or old foods removed. She said residents could get sick if they ate foods that were expired or old.</p> <p>During an interview on [DATE] at 3:00 PM, the Maintenance Supervisor said she had been employed at the facility for 5 years and had been in maintenance for 3 months. She said she kept a maintenance logbook in the past at the nurse station, but it always would come up missing, so the facility no longer had a book to log in maintenance issues. She said the facility would verbally notify her and she would get the repairs done. She said she currently had a list that she reviewed for maintenance issues that the Administrator gave to her, and the last list was [DATE]. She said that the kitchen issues were not on the list. She said she dish machine not reaching the required temperature was notified by the Administrator on yesterday [DATE]. She said they contacted the company to come and check it. She said when she was notified on [DATE], she went to the kitchen and checked it, and it would only reach between ,d+[DATE] degrees and should reach 120 degrees. She said she had a dial thermometer and ran the dish machine a couple of times, and the temperature gauge would not move. She said the company came out to the facility on yesterday [DATE] and repaired it. She said she was not aware of any issues with the dish machine until on yesterday [DATE]. She said the company visited the facility monthly and checked the dish machine and had not reported any issues with it not reaching the required temperature. She said if the dish machine did not reach the temperature, residents could get germs if the dishes were not sanitized properly.</p> <p>During an interview on [DATE] at 3:08 PM, the Administrator said she started at the facility on [DATE]. She said the Dietary Manager was responsible for the kitchen but ultimately, she was, and the RD was another oversight. She said they should be checking for old and expired foods daily. She said maintenance issues in the kitchen staff should be communicated with the Maintenance Supervisor and notifying her if anything was not resolved. She said she was not aware of the dish machine not reaching temperatures. She said the dietary manager was not informing her of any issues going on in the kitchen. She said there could be risk for food borne illnesses in the kitchen with the issues found and planned to educate the staff on maintenance issues and to communicate issues to her. She said her expectations were for the kitchen to be clean.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Record review of a facility policy titled Dishwashing Machine Use revised [DATE] indicated, .Food Service staff required to operate the dishwashing machine will be trained in all steps of dishwashing machine use by the supervisor or a designee proficient in all aspects of proper use and sanitation. 7. The operator will check temperatures using the machine gauge with each dishwashing machine cycle and will record the results in a facility approved log. The operator will monitor the gauge frequently during the dishwashing machine cycle. Inadequate temperatures will be reported to the supervisor and corrected immediately. 9. If hot water temperatures or chemical sanitation concentrations do not meet requirements, cease use of dishwashing machine immediately until temperatures or PPM are adjusted .</p> <p>Record review of a facility policy titled Food Ordering, Receiving and Storage revised [DATE] indicated, . Foods shall be received and stored in a manner that complies with safe food handling practices. 8. All foods stored in the refrigerator will be covered, labeled, and dated (use by date) .</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676439	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994</p> <p>46273</p> <p>Based on observations, interviews, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 6 residents (Resident #9, Resident #117, and Resident #175) and 3 of 5 staff (CNA A, CNA D, and LVN G) reviewed for infection control.</p> <p>The facility failed to ensure CNA D washed or sanitized her hands when passing out meal trays to residents on Hall 100 on 2/24/2025.</p> <p>CNA A did not wear appropriate PPE for enhanced barrier precautions when care was provided to Resident #117 on 2/24/2025.</p> <p>The facility failed to implement contact isolation per physician orders for Resident #175 from 2/13/25 until 2/25/25.</p> <p>CNA D and LVN G failed to wear appropriate PPE for enhanced barrier precautions when providing care to Resident #9 on 2/27/25.</p> <p>These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices.</p> <p>Findings included:</p> <p>1. During an observation of meal service on 2/24/2025 from 12:33 PM to 12:44 PM, CNA D did not wash or sanitize her hands prior to entering/exiting rooms or handling meal trays for the next room for the following rooms on Hall 100: entered room [ROOM NUMBER] and took the meal tray into the room and set up the tray and opened the utensils and exited. She then entered room [ROOM NUMBER] and placed the meal tray on over bed table and exited. She then entered room [ROOM NUMBER] and placed the meal tray on the over bed table and touched a cup that was on the table and placed it in the trash and then she repositioned the resident in bed using the bed controls to raise the head of bed. She then opened the seasoning packets and sprinkled them on the food and opened the utensils and exited the room. She entered room [ROOM NUMBER] set up the meal tray on over bed table and exited. She entered room [ROOM NUMBER] set up the meal tray on the over bed table and exited. She then entered room [ROOM NUMBER] and set up the meal tray on the over bed table and when she exited that room she sanitized her hands.</p> <p>During an interview on 2/24/2025 at 12:46 PM, CNA D said she had been employed at the facility for 2 years. She was assigned to work halls 200 and 300 and was helping to pass lunch trays for hall 100. She said she should have sanitized her hands before and after passing the lunch trays. She said there could be a risk of cross contamination if they did not wash or sanitize their hands between residents and passing meal trays. She said they did not have training on infection control during meal service, but she knew she should have sanitized her hands.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a skills check off for CNA D dated 8/29/24 indicated she was successful with hand washing.</p> <p>2. Record review of an Admission Record for Resident #117 dated 2/25/2025 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of hemorrhage from tracheostomy stoma (bleeding from opening in throat for breathing), pneumonia (lung infection), and gastrostomy status (feeding tube in the stomach).</p> <p>Record review of a care plan revised on 2/24/2025 indicated he required tube feeding related to dysphagia and is NPO. Interventions included he required EBP (enhanced barrier precautions). Gown and gloves were required to be worn during high contact care.</p> <p>Record review of a Quarterly MDS Assessment for Resident #117 dated 1/30/2025 indicated he did not have any impairment in thinking with a BIMS score of 14. He required substantial/maximal assistance with ADL's. He was always incontinent of urine and bowel. He had a feeding tube while a resident in the facility during the last 7 days during the look back period.</p> <p>During an observation on 2/24/2025 at 2:49 PM, CNA A was in the room of Resident #117 who had a sign on the door that read EBP. She assisted Resident #117 with repositioning in bed and only wore a pair of gloves and did not have on a gown. She moved Resident #117 up in bed and placed an under pad under the resident and covered him with a clean sheet and a blanket.</p> <p>During an interview on 2/25/2025 at 4:40 PM, CNA A said Resident #117 was on EBP since he had a feeding tube and if residents were on EBP, staff providing care should wear a gown, gloves, and a mask. She said during the care provided to Resident #117 when she repositioned him in bed and placed clean linens on his bed, she should have been wearing a gown and a mask. She said they kept the PPE in the room closet. She said she did not know why she did not put the gown and mask on but knew that she should have. She said she had received training on infection control and EBP sometime at the end of last year. She said if staff did not wear the PPE required, they could risk passing germs to other residents.</p> <p>Record review of a CNA competency skills check off for CNA A dated 8/28/2024 indicated she was successful with infection control and use of PPE.</p> <p>3. Record review of a facility face sheet dated 2/24/25 for Resident #175 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including sepsis due to methicillin resistant staphylococcus aureus (Methicillin-resistant Staphylococcus aureus or MRSA is a staph infection that has become immune to many types of antibiotics; sepsis is when the body has a severe, inflammatory response to bacteria or other germs).</p> <p>Record review of a comprehensive MDS assessment dated [DATE] for Resident #175 indicated that she had a BIMS score of 15, which indicated that she was cognitively intact. She had a surgical wound and was receiving IV medications.</p> <p>Record review of a baseline care plan indicate that it was not initiated until 2/24/25 for Resident #175 and had the following special treatments/needs: IV Medications and Isolation.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a physician's order summary report dated 2/24/25 for Resident #175 indicated that she had the following physician's order dated 2/13/25: .Resident is on contact isolation, all meals and activities are to be completed in the room. Staff to wear appropriate personal protective equipment while performing tasks every shift .</p> <p>During an observation on 2/24/25 at 12:30 pm CNA A was observed to enter room of Resident #175 to serve lunch tray. There was no sign on doorway to indicate any kind of isolation precautions. She entered room, served tray, and exited without donning any kind of PPE, she was observed to sanitize her hands upon exit from room.</p> <p>During an interview on 2/24/25 at 4:35 pm CNA A said she was unaware when she was passing trays that resident was on any kind of precautions.</p> <p>4. Record review of a facility face sheet dated 2/24/25 for Resident #9 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including urinary tract infection.</p> <p>Record review of a Quarterly MDS assessment dated [DATE] for Resident #9 indicated that he had a BIMS score of 14, which indicated that he was cognitively intact. He was dependent with toileting hygiene and he had a colostomy (an opening in the stomach allowing stool to pass from the intestines into a bag connected to stomach opening) and an indwelling urinary catheter (tubing inserted into the bladder and allows urine to drain into a bag).</p> <p>Record review of a comprehensive care plan dated 10/15/24 for Resident #9 indicated that he had an intervention that read: .resident requires EBP (enhanced barrier precautions). Gown and gloves are required to be worn during high contact care .</p> <p>Record review of a physician's order summary report dated 2/24/25 for Resident #9 indicated he had the following order dated 11/20/24: .resident requires enhanced barrier precautions during episodes of high-contact care. Ensure signage is visible and supplies are available every shift for resident has an additional portal of entry for infection .</p> <p>During an observation on 2/25/25 at 10:50 am LVN G was observed providing colostomy care on Resident #9 without wearing gown as required for EBP. Sign was observed on wall at head of Resident's bed indicated that he required EBP.</p> <p>During an observation on 2/25/25 at 11:10 am CNA D was observed performing foley catheter care on Resident #9 without wearing a gown as required for EBP.</p> <p>During an interview on 2/25/25 at 11:20 am LVN G said she just forgot to put her PPE on while providing care. She said she had been trained on infection control and PPE requirements. She said residents could be at risk of infections if EBP precautions were not followed.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 2/27/2025 at 10:01 AM, the DON said she had been in her position since August 2024 but had been employed at the facility since 2023. She was the IP. She said she conducted training on EBP and hand washing with staff and inserviced them often. She said they also conducted spot follow ups by nurses and management with the staff. She said staff should wash or sanitize their hands between residents. Resident #117 was on EBP due to his feeding tube and staff should place a gown and gloves on when they provided care. She said there could be a risk for infections if staff did not clean hands or wear appropriate PPE. She said staff should sanitize between residents when passing meal trays. She planned to in-service and monitor staff and provide 1:1 education on staff that did not follow infection control procedures.</p> <p>During an interview on 2/27/2025 at 2:12 PM, the Administrator said there was a risk of spreading and giving infections to other residents if staff did not follow infection control procedures. She said EBP was a prevention in place to prevent staff from spreading infections to residents. She said she and the DON were responsible for ensuring staff were provided education on hire, as needed, and annually. She said staff were supposed to sanitize hands between residents and training was part of hand washing. She said residents who had tracheostomies, foley catheters, ostomies, colostomies, feeding tubes, or anyone with pressure injuries and chronic open wounds should be on EBP. She said if staff were providing direct care to a resident who was on EBP, they must wear a gown and gloves and if they don't they could spread an infection.</p> <p>Record review of a facility policy titled Handwashing/Hand Hygiene revised August 2019 indicated, .This facility considers hand hygiene the primary means to prevent the spread of infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: b. Before and after direct contact with residents; p. Before and after assisting a resident with meals .</p> <p>Record review of a facility policy titled Personal Protective Equipment-Enhanced Barrier Precautions revised April 2024 indicated, .To ensure personal protective equipment appropriate to specific task requirements is available at all times for staff residents when rendering high-contact direct activities for residents with chronic wounds or indwelling medical devices. 5. High-contact resident care activities that require Enhanced Barrier Precautions (EBP): e. changing linens .</p> <p>Record review of a facility policy titled Isolation - Categories of Transmission-Based Precautions dated 2001 and revised September 2021 read: .Contact Precautions may be implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment . and .staff and visitors will wear gloves (clean, non-sterile) when entering the room . and .staff and visitors will wear a disposable gown upon entering the room .</p> <p>Record review of a facility policy titled Infection Prevention and Control Program dated 2001 and revised February 2022 read: .Prevention of Infection: a. Important facets of infection prevention include: .(3) educating staff and ensuring that they adhere to proper techniques and procedures; .(7) implementing appropriate isolation precautions when necessary .</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>43994</p> <p>Based on observations, interviews, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 kitchen reviewed for essential equipment.</p> <p>The facility did not ensure the gas stove was in safe operating condition with the pilot light staying lit and allowing gas to leak on 2/24/2025.</p> <p>This failure could place the residents at risk of a fire and not receiving their meals in a timely manner.</p> <p>Findings included:</p> <p>During an observation and interview on 2/24/2025 at 8:40 AM, the DM lit the burners on the stove. 1 of the 6 burners (front left burner) did not light using the pilot light and then would not light with a lighter. She said she would report this to the Maintenance Supervisor.</p> <p>During an interview on 2/25/2025 at 3:00 PM, the Maintenance Supervisor said she had been employed at the facility for 5 years and been in maintenance for 3 months. She said she kept a maintenance logbook in the past at the nurse station, but it always would come up missing, so the facility no longer had a book to log in maintenance issues. She said the facility would verbally notify her and she would get the repairs done. She said she currently had a list that she reviewed for maintenance issues that the Administrator gave to her, and the last list was January 2025. She said that the kitchen issues were not on the list. She said she was made aware that morning 2/25/2025 that one side of the oven was not working and did not know anything about one of the burners on the stove not working. She said in November 2024 they had a gas pressure test performed in the kitchen and that was the last time she had any dealing with the stove after the pilot light was relit. She said if the oven or burners were not working properly the staff would not be able to cook effectively.</p> <p>During an interview on 2/26/2025 at 3:08 PM, the Administrator said she started on September 3, 2024, and was not aware of the stove in the kitchen with all of the burners not lighting. She said the dietary manager was not informing her of any issues going on in the kitchen and as a result was no longer employed with the facility. She said her expectation were for equipment in the kitchen to work properly.</p> <p>A copy of a facility policy for essential equipment was requested from the Administrator however, prior to exit on 2/27/2025, no policy was provided.</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>43994</p> <p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>Based on observations, interviews, and record review, the facility failed to maintain an effective pest control program and ensure it was free of pests for 1 of 1 Kitchen reviewed for pest control.</p> <p>The facility failed to ensure an effective pest control program was in place to keep roaches out of the kitchen from 2/24/2025-2/25/2025.</p> <p>This failure could place residents at risk for injury due to an ineffective pest control program at the facility.</p> <p>Findings included:</p> <p>During an observation on 2/24/2025 at 3:47 PM, in the kitchen, 2 roaches crawled up the wall by the hand sink. The DM said pest control visited the facility monthly and sprayed the kitchen.</p> <p>During an observation on 2/24/2025 at 4:14 PM, 1 roach crawled on the floor by the 3-compartment skin and dish machine.</p> <p>During an observation on 2/24/2025 at 4:24 PM, 1 roach crawled on the recipe binder that was less than a foot from the robo coupe (blender) on the prep table. DM notified and took the binder and shook it out in the garbage disposal and turned it on and then brought back the binder and placed it back on the prep table by the robo coupe where the [NAME] was blending food. The DM said she had noticed creepy crawlers recently due to warmer weather and said pest control sprayed monthly.</p> <p>During an interview on 2/25/2025 at 8:20 AM, DA C was present in the kitchen and said has had roaches for a while and pest control visited the facility monthly and sprayed the kitchen.</p> <p>During an observation on 2/25/2025 at 8:28 AM, in the kitchen, the steam table had 1 of 5 pans with water inside with 3 roaches present. There were multiple roaches that crawled on the steam table and on the wall by the fire extinguisher. The DM was present and said she would notify the Administrator. The Administrator entered the kitchen and observed roaches actively crawling and instructed the DM to have her staff clean the kitchen and that lunch would be served that day on paper.</p> <p>During an interview on 2/25/2025 at 2:15 PM, the RD said she visited the facility about every 2 weeks. She said she conducted a formal inspection of the kitchen monthly. She said she checked for overall cleanliness, dating/labeling of food and proper plating of foods. She said she had not conducted a formal inspection that month yet. She said she had never seen any roaches in the kitchen.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 2/25/2025 at 2:39 PM, the Pest Control Representative said he visited the facility on a monthly basis and treated the entire facility and it depended on what pests they had been seeing. He said the Maintenance Supervisor would let him know if they had any specific areas in the facility that needed treatments. He said they normally treated for German Roaches and that the kitchen had a problem area with food being loose and that was a breeding ground for roaches. He said the kitchen also had catch basins that attracted roaches. He said they had been using 3 different chemicals and a growth regulator which disrupted the life cycle of the roaches. He said they sprayed a residual spray that lasted 3 months and sprayed a quick kill that lasted 2-3 hours. He said he treated the kitchen earlier that day and used all 3 chemicals. He said the facility needed to keep the kitchen clean and sanitized to help keep the roaches out.</p> <p>During an interview on 2/25/2025 at 3:00 PM, the Maintenance Supervisor said she had been employed at the facility for 5 years and been in maintenance for 3 months. She said she knew the kitchen had an issue with roaches and saw some last week. She said last week the kitchen was cleaned with a floor machine and she sprayed a residual bug spray in the kitchen using home defense. She said the facility was already scheduled for pest control to come out that Thursday 2/27/2025. She said pest control came out monthly. She said having roaches in the kitchen could potentially cause rodent diseases and she would not want to eat foods that came out of the kitchen. She said they planned to spray the kitchen weekly for pests.</p> <p>During an interview on 2/26/2025 at 3:08 PM, the Administrator said she started at the facility on September 3, 2024, and the Dietary Manager was responsible for the kitchen along with her and RD was another oversight. She said she had seen a couple roaches in the past but not to the extent of how they were on yesterday and pest control come monthly and now weekly as of yesterday 2/25/2025. She said she would not want to eat anything coming out of the kitchen. She said there could be risk for food borne illnesses in the kitchen with the issues found. She said her expectation were for the kitchen to be clean and pest free.</p> <p>Record review of a pest control service order invoice dated 1/23/2025 indicated the facility was treated for roaches using Suspend SC 1.50 gal .06 %, Exciter 1.50 gal .12% and Gentrol 1.50 gal .08%</p> <p>Record review of a facility policy titled Sanitization dated October 2018 indicated, .The food service area shall be maintained in a clean and sanitary manner. 1. All kitchen, kitchen areas and dining areas shall be kept clean, free from roaches and other insects .</p>		

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<p>F 0941</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members.</p> <p>46273</p> <p>Based on interviews and record review, the facility failed to ensure employees received the required training effective communications for 6 of 15 new employees (LVN M, LVN N, SW, CNA O, CNA P, CNA Q) reviewed for training.</p> <p>The facility did not ensure an effective communication training was completed on hire for LVN M, LVN N, SW, CNA O, CNA P, CNA Q.</p> <p>This failure could place residents at risk of miscommunication and social isolation due to lack of staff training.</p> <p>Findings included:</p> <p>Record review of employee files indicated the following staff had not completed training during orientation on effective communication:</p> <ul style="list-style-type: none"> * LVN M, hire date 3/16/24; * LVN N, hire date 12/03/24; * SW, hire date 11/21/24; * CNA O, hire date 12/02/24; * CNA P, hire date 10/01/24; and * CNA Q, hire date 02/12/2025. <p>During an interview on 2/27/25 at 9:00 am the Administrator said she did not know all these trainings were required.</p> <p>During an interview on 2/27/25 at 1:38 pm the DON said the ADON had been responsible in the past for staff training, but she (DON) would now be responsible for it. The DON said staff could possibly not understand how to deescalate situations, and residents could be at risk for harm due to this.</p> <p>During an interview on 2/27/25 at 2:04 pm the Administrator said she was ultimately responsible for ensuring all staff received proper training on hire and annually. She said staff may not know how to effectively communicate with residents with certain risk factors or dementia. She said she had now made a binder to keep up with trainings and would be keeping up with them better going forward.</p> <p>Record review of a facility assessment tool dated 10/1/24 read .Staff training/education and competencies .Training topics (upon hire, annually and as needed): *Communication - effective communications for direct care staff .* infection control .*required in-service training for nurse aides.</p> <p>(continued on next page)</p>

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<p>F 0941</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In-service must . *include dementia management training .and . *Dementia care .</p>		

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<p>F 0945</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>46273</p> <p>Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program.</p> <p>Based on interview and record review, the facility failed to provide the mandatory training on standards, policies, and procedures for an infection prevention and control program for 5 of 15 staff (LVN N, SW, CNA O, CNA P, CNA Q) reviewed for training.</p> <p>The facility failed to ensure infection prevention and control training was provided to LVN N, SW, CNA O, CNA P, CNA Q on hire.</p> <p>This failure could place residents at risk of the spread of illness due to lack of staff training.</p> <p>The findings were:</p> <p>Record review of employee files indicated the following staff had not completed training during orientation on infection control:</p> <ul style="list-style-type: none"> * LVN N, hire date 12/03/24; * SW, hire date 11/21/24; * CNA O, hire date 12/02/24; * CNA P, hire date 10/01/24; and * CNA Q, hire date 02/12/2025. <p>During an interview on 2/27/25 at 9:00 am Administrator said she did not know all these trainings were required.</p> <p>During an interview on 2/27/25 at 1:38 pm DON said the ADON had been responsible in the past for staff training, but she (DON) would now be responsible for it. DON said staff could be at risk of putting residents at increased risk of infections if they are not properly trained in infection control.</p> <p>During an interview on 2/27/25 at 2:04 pm Administrator said she was ultimately responsible for ensuring all staff received proper training on hire and annually. She said residents could be at increased risk of infections if proper trainings were not provided to staff. She said she had now made a binder to keep up with trainings and would be keeping up with them better going forward.</p> <p>Record review of personnel files for above staff members indicated they were missing the above trainings.</p> <p>Record review of a facility policy titled Staff Development Program dated 2001 and revised in December 2009 read .the following in-service training classes are mandatory .b) AIDS; d) infection control; e) resident rights .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676439	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Trinity Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 314 E Caroline St Trinity, TX 75862	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0945</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a facility assessment tool dated 10/1/24 read .Staff training/education and competencies . Training topics (upon hire, annually and as needed): *Communication - effective communications for direct care staff . * infection control . *required in-service training for nurse aides. In-service must: . *include dementia management training .and . *Dementia care .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676439	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>46273</p> <p>Based on interviews and record review, the facility failed to ensure CNAs completed Abuse, Neglect, and Exploitation (ANE) and dementia management trainings for 3 of 5 CNAs (CNA O, CNA P, and CNA Q) reviewed for training.</p> <p>The facility did not ensure ANE, and dementia management trainings were completed by CNA O, CNA P, and CNA Q during orientation.</p> <p>This failure could place residents with dementia at risk of abuse, neglect, and exploitation and a poor quality of care by staff with inadequate training when caring for dementia residents.</p> <p>Findings included:</p> <p>Record review of employee files indicated:</p> <p>CNA O, hire date 12/02/24, had not completed Abuse, Neglect, and Exploitation (ANE) and dementia management trainings during orientation.</p> <p>CNA P, hire date 10/1/24, had not completed Abuse, Neglect, and Exploitation (ANE) and dementia management trainings during orientation.</p> <p>CNA Q, hire date 2/12/25, had not completed Abuse, Neglect, and Exploitation (ANE) and dementia management trainings during orientation.</p> <p>During an interview on 2/27/25 at 9:00 am Administrator said she did not know all these trainings were required.</p> <p>During an interview on 2/27/25 at 1:38 pm DON said the ADON had been responsible in the past for staff training, but she (DON) would now be responsible for it. DON said residents could be at risk of being cared for by untrained staff.</p> <p>During an interview on 2/27/25 at 2:04 pm Administrator said she was ultimately responsible for ensuring all staff received proper training on hire and annually. She said residents could be at increased risk of harm if proper trainings were not provided to staff. She said she had now made a binder to keep up with trainings and would be keeping up with them better going forward.</p> <p>Record review of personnel files for above staff members indicated they were missing the above trainings.</p> <p>Record review of a facility assessment tool dated 10/1/24 read .Staff training/education and competencies . Training topics (upon hire, annually and as needed): *Communication - effective communications for direct care staff .* infection control .*required in-service training for nurse aides. In-service must: .*include dementia management training .and . *Dementia care .</p>

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<p>F 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide behavior health training consistent with the requirements and as determined by a facility assessment.</p> <p>46273</p> <p>Based on interviews and record review, the facility failed to provide mandatory effective behavioral health training for 6 of 15 employees (LVN M, LVN N, SW, CNA O, CNA P, CNA Q) reviewed for training.</p> <p>The facility failed to ensure effective behavioral health training was provided to LVN M, LVN N, SW, CNA O, CNA P, CNA Q S on hire.</p> <p>This failure could place residents with behaviors at risk of not receiving care to attain or maintain their highest practicable physical, mental, and psychosocial well-being due to lack of staff training.</p> <p>Findings included:</p> <p>Record review of LVN M's personnel file revealed a hire date of 3/16/24 and she had not completed on hire behavioral health training as required by policy and regulation.</p> <p>Record review of LVN N's personnel file revealed a hire date of 12/3/24 and she had not completed on hire behavioral health training as required by policy and regulation.</p> <p>Record review of SW's personnel file revealed a hire date of 11/21/24 and she had not completed on hire behavioral health training as required by policy and regulation.</p> <p>Record review of CNA O's personnel file revealed a hire date of 12/2/24 and she had not completed on hire behavioral health training as required by policy and regulation.</p> <p>Record review of CNA P's personnel file revealed a hire date of 10/1/24 and he had not completed on hire behavioral health training as required by policy and regulation.</p> <p>Record review of CNA Q's personnel file revealed a hire date of 2/12/25 and she had not completed on hire behavioral health training as required by policy and regulation.</p> <p>During an interview on 2/27/25 at 9:00 am Administrator said she did not know all these trainings were required.</p> <p>During an interview on 2/27/25 at 1:38 pm DON said the ADON had been responsible in the past for staff training, but she (DON) would now be responsible for it. DON said residents could be at risk of being cared for by untrained staff.</p> <p>During an interview on 2/27/25 at 2:04 pm Administrator said she was ultimately responsible for ensuring all staff received proper training on hire and annually. She said residents could be at increased risk of harm if proper trainings were not provided to staff. She said she had now made a binder to keep up with trainings and would be keeping up with them better going forward.</p> <p>(continued on next page)</p>		

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<p>F 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a facility assessment tool dated 10/1/24 read .Staff training/education and competencies . Training topics (upon hire, annually and as needed): *Communication - effective communications for direct care staff . * infection control . *required in-service training for nurse aides. In-service must: . *include dementia management training .and . *Dementia care .</p>		