STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676468	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Patriot Rehabilitation and Wellness Center	11490 Gateway North Blvd. El Paso, TX 79934

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46998 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 1 (Resident #2) of 3 residents reviewed for dignity. Resident #2 did not have a privacy bag on his catheter bag. This failure could place residents at risk of diminished quality of life. Findings included: Record review of Resident #2's face sheet dated 04/23/24, revealed, admission on 02/29/24 to the facility. Record review of Resident #2's facility history and physical dated 03/01/24, revealed, an [AGE] year-old male diagnosed with Dementia, Diabetes, Urinary Tract Infection. Record review of Resident #2's admission MDS dated [DATE], revealed, a severe cognitive impairment to be able to recall and make daily decisions BIMS (used to get a quick snapshot of how well you are functioning cognitively at the moment) score of a 4. Resident #2 was not rated for urinary continence but did have an indwelling catheter. Was diagnosed with Diabetes Mellitus, Metabolic encephalopathy (a problem in the brain), and Dementia. Record review of Resident #2's care plan dated 03//04/24, revealed, foley catheter 16 French10 cc (measures the diameter of the tube, larger sizes will be a higher number. Smaller sizes will be a lower number). Monitor and document intake and output as per facility policy, discomfort on urination and frequency, pain/comfort due to catheter. Record review of Resident #2's order recap dated 03/01/24, revealed, Privacy bag for urinary drainage at all times while in bed, while walking or in wheelchair every shift. Observation on 04/17/24 at 11:26 AM, revealed, Resident #2's catheter bag hung on the side of his bag. The catheter bag could be seen from the hallway with no privacy bag cover on. The catheter bag had dark yellow brownish urine in it about half ways. (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 - Few	During an interview on 04/23/24 at 1:54 PM, with LVN I, she stated all catheter bags needed to have privacy covers on at all times. LVN I stated the privacy covers were meant to be on for the residents dignity and infection control. Observation on 04/23/24 at 2:59 PM, revealed, Resident #2 lying down in bed. Catheter bag was hung off the side of the bed. Catheter bag was tilted, the urine inside was dark yellow brownish indicating leveled at 7-100 milliliters. Off the foot board of the bed was Resident #2's wheelchair with the privacy bag clipped onto the back of the wheelchair bars. During an interview on 04/23/24 at 4:41 PM, with the DON, she stated resident catheter bags need to have a privacy cover. The DON stated Resident #2 needed to have a privacy cover on his catheter bag. The DON stated the reason for the privacy cover was for their dignity and so they could keep their medical issues private. Record review of the facility Catheter Care policy dated 01/31/24, revealed, It was 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 (per resident preference).

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on interviews and record reviews the facility failed to coordinate the assessment following the PASRR Completion PCSP for 1 (Resident #8) of 2 residents with the pre-admission screening and resident review (PASRR) program, of resident assessments reviewed for PASRR services. The facility to provide PASRR services for Resident #8 who was PASRR positive for intellectual disabilities by not submitting a request to the state agency for PASRR services. This failure could affect residents who are PASRR positive of not receiving needed PASRR services which could lead to a decline in health and well-being. Findings included: Record review of Resident #8's face sheet dated 04/17/24, revealed, admission on 09/25/23 and re-admission on 11/13/23 to the facility. Record review of Resident #8's facility history and physical dated 10/02/23, revealed, a [AGE] year-old female diagnosed with Epilepsy (a chronic noncommunicable disease of the brain that affects people of all ages), delusional disorders (an unshakable belief in something that's untrue), history of traumatic brain injury (a sudden injury that causes damage to the brain), seizures (a sudden, uncontrolled burst of electrical activity in the brain). Record review of Resident #8's quarterly MDS dated [DATE], revealed, no BIMS score was taken due to the resident not being interviewed. Unknown severity of cognition Resident #8 diagnosed with anxiety disorder, traumatic brain injury, seizure disorder, altered mental status (a change in mental function that stems from illnesses, disorders and injuries affecting your brain), surgery on nervous system. Record review of Resident #8's PASRR Level 1 Screening dated 09/25/23, revealed, positive for mental illness, intellectual disability, and developmental disability. Record review of Resident #8's orders dated 09/25/23, revealed, physical therapy, occupational therapy, and speech therapy to evaluated and treat as indicated. Record review of Resident #8's PASRR Evaluation dated 10/05/23, revealed, PASRR positive for intellectual disability and developmental disability. Negative for mental illness. Record review of Resident #8's PSCP dated 10/17/23, revealed, the local mental health authority B & C, Resident #8, RN A, Director of Rehabilitation, and the Social Worker met to discuss PASRR services. PASRR Services were marked as not needed. Nursing Facility Comments - Care plan goals reviewed: Plan of Care reviewed, not eligible for state PASRR Services at this time. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Local Authority Specialized Services Comments - Resident #8 as per nursing required extensive assistance for dressing, supervision for eating and frequently incontinent. Resident #8 had behaviors of hitting herself, fall(s), and had out of state insurance. Record review of Resident #8's care plan dated 11/01/23, revealed, PASRR positive related to intellectual/developmental disability. Administer medication as ordered, monitor for effectiveness and side effects. Invite the LIDDA representative and responsible party to the quarterly care plan meeting to discuss my function status. Level PASRR completed. Psych consult as needed. Notify Medical Doctor and Representative party. Record review of Resident #8's Administration report dated 03/01/24-03/31/24, revealed no order data found for skilled admin. During an interview on 04/17/24 at 1:01 PM, with the Administrator, he stated Resident #8 was not receiving PASRR services due to Resident #8 having insurance form another state. The Administrator stated the facility had been trying to refer her to another facility suable for Resident #8 that had an Alzheimer's unit as Resident #8's cognition was not that good. The Administrator stated he did not know much about the PASRR process and was referred to the MDS Coordinator D. During an interview on 04/17/24 at 1:37 PM, with MDS Coordinator D, she stated Resident #8 was PASRR positive for IDD and a diagnosis of seizure qualified her for PASRR services. MDS Coordinator D stated Resident #8 was not receiving PASRR services due to Resident #8 having insurance from another state. MDS Coordinator D stated she spoke to the out-of-state health and human services regarding PASRR and they did not have an answer for why the current state Resident #8 lived in now did not accept the out-state insurance. MDS Coordinator stated the out-of-state insurance did not pay for PASRR services. MDS Coordinator D stated the local mental health authority was notified of it and that they could not do anything about it. MDS Coordinator D stated the purpose of PASRR services was so resident(s) could get services that they needed to get so that the resident(s) will not have a decline in health. MDS Coordinator D stated after the meeting was held with the mental health authority there was nothing submitted to state on LTC Simple requesting PASRR services for Resident #8. MDS Coordinator D stated she was unaware if the therapy department had pick up Resident #8 for services. During an interview on 04/17/24 at 3:51 PM, Local Mental Health Authority B, she stated Resident #8 was not eligible for PASRR services due to the resident having out-of-state insurance that this state would not accept. Local Mental Health Authority B stated that was the only reason they had marked that on the PSCP. Local Mental Health Authority B stated they were not able to bill the out-of-state insurance as they would not pay for the PASRR services. Local Mental Health Authority B stated Resident #8 did need and required PASRR services as she was PASRR positive for IDD. Local Mental Health Authority B stated the risk of not getting PASRR services would be Resident #8 not getting the therapy or services she needed. Local Mental Health Authority B stated not receiving the PASRR services could led to a decline in health. During an interview on 04/18/24 at 9:10 AM, with the DON, she stated Resident #8 was receiving psychiatric treatment for a TBI Resident #8 had. The DON stated she did not know if Resident #8 was receiving PASRR services but would assume she was. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility Resident Assessment-Coordination with PASRR Program dated 01/31/24, revealed, This facility coordinates assessments with the preadmission screening and resident review (PASRR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with State's Medicaid rules for screening. The facility will only admit individuals with a mental disorder or intellectual disability who the State mental health or intellectual disability authority has determined as appropriate for admission. Recommendations, such as any specialized services, from a PASRR Level II determination and/or PASRR evaluation report will be incorporated into the resident's assessment, care planning, and transitions. Record review of facility Out of State Nursing Facility Admissions not dated, revealed, This process provides guidance to entities who refer a person living outside of Texas to a nursing facility within Texas. When a person moves from another state and was admitted to a Texas Medicaid-certified nursing facility (NF), the referring entity in the other state must complete the Texas PASRR Level 1 Screening form. Purpose: The PASRR Level 1 Screening Form was designed to identify people who are suspected of having mental illness, an intellectual disability, or a development disability diagnosis. If the documentation on the PL1 entered indicated a suspicion of MI, ID, or DD, one of the state local intellectual and development disability authorities will complete a PASRR Evaluation. The PASRR Evaluation was designed to confirm or deny the suspicion of MI, ID, or DD and ensure the person was placed in the most integrated residential setting to receive the specialized services needed to improve and maintain the person's level of function. Record review of state agency website (www.hhs.texas.gov) of PASRR reviewed on 04/17/24, revealed, Many people with mental illness and /or intellectual and developmental disabilities can safely live in a community setting while receiving the support services they need. Preadmission Screening and Resident Review was a process that helps ensure people who need these supports are only placed in a nursing facility when appropriate. PASRR was a federally mandated program that requires all states to prescreen all people, regardless of payer source or age, seeking admission to a Medicaid-certified nursing facility. PASRR has 3 goals - to identify people, including adults and children, with mental illness and or IDD. To ensure appropriate placements, whether in the community or the nursing facility. To ensure people receive the required services for mental illness and/or IDD.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on observation, interview, and record review the facility failed to provide the necessary treatment and services based on the comprehensive assessment and consistent with professional standards of practice to promote healing and prevent worsening of pressure injuries for 2 (Resident #6 and Resident #3) of 2 residents reviewed for wound care. The Wound Care Nurse grabbed a gaze without gloves and placed it into a clear cup that was soaked in betadine and then used it to provide wound care for Resident #6 who had a right lateral foot wound. The Wound Care Nurse did not date or initial Resident #3's patches after providing wound care. This deficient practice could place residents at risk for worsening pressure injuries, pain, and a decline in health. Findings include: Resident #6 Record review of Resident #6's face sheet dated 04/17/24, revealed, admission on 02/21/24 and re-admission on 03/29/24 to the facility. Record review of Resident #6's facility history and physical dated 02/21/24, revealed a [AGE] year-old male diagnosed with Diabetes Mellitus and Renal failure secondary to severe dehydration. Record review of Resident #6's order recap dated 03/14/24, revealed, right lateral foot arterial eschar (a collection of dry, dead tissue within a wound): Clean with wound cleanser, pat dry, apply betadine, leave open to air 3 times a week and as needed every 24 hours as needed and everyday shift, and every Monday, Wednesday, Friday. Record review of Resident #6's care plan dated 03/20/24, revealed, Wound Management- right lateral foot. Notify provider if no signs of improvement on current wound regimen. Provide wound care per treatment order. Observation and interview on 04/11/24 at 2:09 PM, with the Wound Care Nurse. The Wound Care Nurse stated Resident #6 had a right lateral foot wound that was cleaned and left to air dry to heal. The Wound Care Nurse grabbed a 4 inch by 4 inch gauze and cut it into smaller 2 inch by 2 inch pieces. The Wound Care Nurse placed the piece of gauze into a clear cup and soaked it with Betadine. While providing the wound care the Wound Care Nurse then put on gloves and grabbed the gauze with the Betadine-soaked solution and wiped it on Resident #6's right lateral wound. The Wound Care Nurse stated she was supposed to have used gloves when touching and cutting the gauze into pieces when she had prepped. The Wound Care Nurse stated she always used gloves but did not know what had happened. The Wound Care Nurse stated the risk could be infection. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/18/24 at 9:10 AM, with the DON, she stated nurses are trained on how to provide wound care for residents with pressure ulcers or wounds. The DON stated the Wound Care Nurse should have been using gloves because the nurses should be trying to be as clean as possible with then performing wound care on a resident. The DON stated nursing staff performing wound care would just be touching everything and the wound care items used for the treatment would not be protected which could be a risk of infection to the resident. Resident #3 Record review of Resident #3's face sheet dated 04/17/24, reveled, admission on 02/13/24 and re-admission on 04/03/24 to the facility. Record review of Resident #3's facility history and physical dated 02/19/24, revealed, a [AGE] year-old female diagnosed with Osteoporosis (a health condition that weakens bones, making them fragile and more likely to break), muscle wasting (the wasting (thinning) or loss of muscle tissue), and muscle weakness (no muscle strength), repeated falls. Record review of Resident #3's admission MDS dated [DATE], revealed, a moderate impairment to recall and make daily decisions BIMS (used to screen and identify the cognitive condition of residents upon admission into a long-term care facility) score of 7. Resident #3 was diagnosed with cancer, non-Alzheimer's Dementia, malnutrition, adult failure to thrive (syndrome of weight loss, decreased appetite and poor nutrition, and inactivity, often accompanied by dehydration, depressive symptoms, impaired immune function, and low cholesterol). Resident #3 had a pressure reducing device for chair and for bed. Record review of Resident #3's care plan dated 04/04/24, revealed, left hip surgical incisions. Notify provider if no signs of improvement on current wound regimen. Provide wound care per treatment order. Record review of Resident #3's order recap dated 04/11/24, revealed surgical incisions times 3 to left hip: Clean with wound cleanser, pat dry, apply dry protective dressing times 3 every week and as needed every 24 hours and as needed and every day shift every Monday, Wednesday, and Friday. Observation and interview on 04/11/24 at 2:52 PM, with the Wound Care Nurse. The Wound Care Nurse uncovered Resident #3 and exposed her left side hip. Resident #3 had three white patches that were not dated. The Wound Care Nurse stated she had done the wound care for Resident #3 the day before. The Wound Care Nurse stated she had lost her marker and that was why she had not placed a date or initiated the patches. The Wound Care Nurse stated it was expected to date and initial all the dressings and patches. The Wound Care Nurse stated the dressings and patches had to be dated and initialed, so the nursing staff knew when it was changed and who did it. The Wound Care Nurse stated she did not think there was a risk to Resident #3 with not dating or initialing it. During an interview on 04/18/24 at 9:10 AM, with the DON, she stated wound conducting wound care the dressing and patches had to be labeled with the date and initials of who did the wound care. The DON stated this was so everyone knew when the dressing/patches were changed. The DON stated the risk of not dating or initialing could be not knowing who conducted the wound treatment, if it was done correctly, and when it was done. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility Wound Treatment Management policy dated 06/2022, revealed, To promote wound healing of various types of wounds, it was the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Wound treatments will be provided in accordance with physician orders, including the cleaning method, type of dressing, and frequency of dressing change. Record review of the facility Clean Dressing Change policy dated 01/31/24, revealed, It was the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination. Physician's orders will specify type of dressing and frequency of changes. Multi-use wound care supplies will be dated and initiated when opened. They will be maintained as clean after initial use. Sterile items will not be used if the sterility cannot be assured at the time of initial use (i.e., open packages, broken seal). Secure dressing. [NAME] with initials and date. (Add time if dressing was more than once daily)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on the observations, interviews, and record reviews the facility failed to ensure that the residents environment remains free of accidents hazards as is possible and each resident receives adequate supervision to prevent accidents for 1 (Resident #8) of 8 residents and 1 Employee Lounge of 1 reviewed for accidents. 1.Resident #8 was placed 1:1 supervision for hitting a prior resident and Lead CNA left Resident #8 to go assist another staff and did not ensure another nursing staff member was 1:1 with Resident #8 that lead to Resident #8 hitting another Resident #9. This failure was determined to be past non-compliance on 03/22/24 and ended 03/22/24 the facility implemented action that corrected the non-compliance prior to the beginning of the investigation. 2. The facility Employee Lounge door was left open for anyone to enter the employee lounge. This failure could place residents at risk of lack of supervision, accidents, and potential for harm. Findings include: 1.Resident #8 Record review of Resident #8's face sheet dated 04/17/24, revealed, admission on 09/25/23 and re-admission on 11/13/23 to the facility. Record review of Resident #8's facility history and physical dated 10/02/23, revealed, a [AGE] year-old female diagnosed with Epilepsy (a chronic noncommunicable disease of the brain that affects people of all ages), delusional disorders (an unshakable belief in something that's untrue), history of traumatic brain injury (a sudden injury that causes damage to the brain), seizures (a sudden, uncontrolled burst of electrical activity in the brain). Record review of Resident #8's quarterly MDS dated [DATE], revealed, no BIMS score was taken due to resident not being interview able. Resident #8 diagnosed with anxiety disorder, traumatic brain injury, seizure disorder, altered mental status (a change in mental function that stems from illnesses, disorders and injuries affecting your brain), surgery on nervous system. Record review of Resident #8's order recap dated 03/19/24, revealed, 1:1 monitoring for aggressive behavior. Discontinues on 03/22/24, at 10:59 AM. Record review of Resident #8's care plan dated 11/15/23, revealed, has history of being physically aggressive towards staff/residents due to anger, history of harming others, poor impulse control. Hits staff and punches staff/residents. Administer medications as ordered. Analyze times of day, places, triggers, and what de-escalates behavior and document. Assess and address for contributing sensory deficits. Monitor and document signs and symptoms of posing danger to self and others. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #8's progress notes dated 03/22/24, revealed, Resident had an outburst this morning before breakfast, and hit another resident #9. Resident #8 was redirected and was sent back to her room. Resident #9 Record review of Resident #9's face sheet dated 03/22/24, revealed, admission on 02/29/24 to the facility. Resident #9 was a [AGE] year-old female diagnosed with Muscle weakness (no muscle strength) depressive disorder, Cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), and Diabetes Mellitus. Record review of Lead CNA's witness statement dated 03/22/24, revealed, To whom it may concern: Today in the morning, I was taking care of Resident #8 on room [ROOM NUMBER]-A, when my CNA F, asked me to help her with the transfer of another resident. It was around 7:20 AM, when I was going back to see Resident #8 and I heard Resident #9 yelling. I saw that Resident #8 hit Resident #9. I took Resident #8 back to her room and I checked her again. Everything happened in less than 10 minutes. During an interview on 04/17/24 at 1:01 PM, with the Administrator, he stated Resident #8 was one-to-one. The Administrator stated Resident #8 does not have the willingness to hit residents. The Administrator stated Resident #9 did not have any injuries as she was assessed by nursing. The Administrator stated after the incident the facility placed Resident #8 one-to-one, educated facility staff, and redirection for Resident #8. During an interview on 04/18/24 at 10:47 AM, with Lead CNA, he stated Resident #8 was placed on 1:1 supervision due to hitting another resident prior to this incident where she hit Resident #9. Lead CNA stated he was called to assist another CNA with another resident. Lead CNA stated he had told two of his CNAs who were working the floor with a resident to keep an eye out for Resident #8 who was sleeping her bed in her room and that they could keep on eye on Resident #8, while doing their duties. Lead CNA stated Resident #8 went into the dining room and saw Resident #9 and punched Resident #9 on her right arm as he heard Resident #9 yelling. Lead CNA stated the resident-to-resident altercation between Resident #8 and Resident #9 happened around 7:30AM-8AM. Lead CNA stated he did not consider telling the two CNAs on the floor to watch Resident #8 and to keep doing their duties a 1:1 . Lead CNA stated leaving Resident #8 who was on 1:1 supervision, was not considered appropriate 1:1 supervision, because he left her. Lead CNA stated he was suspended that day pending the investigation. Lead CNA stated it was confirmed on the investigation that he did leave Resident #8 unattended and was written up. Lead CNA stated he received 1:1 training from the DON. During an interview on 04/23/24 at 10:27 AM, with Resident #8 and CNA G, she did not speak to surveyor. Resident #8 when questioned would smack her lips and look down. CNA G stated Resident #8 was 1:1 due to hitting a resident. CNA G stated if she had to go to the restroom or on break that another staff member needed to replace her because Resident #8 could not be left alone as she was a 1:1. CNA G stated if one of the nursing staff left while Resident #8 was on 1:1, if left alone by 1:1 staff, that nothing would happen because there was enough staff in the facility. During an interview on 04/23/24 at 11:16 AM, LVN H, she stated if a resident was on 1:1 a staff member could only leave the resident if they were switched out. LVN H stated the current staff member could not leave the resident alone for safety, protection of self and other residents. (continued on next page)

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	676468	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Patriot Rehabilitation and Wellness Center	11490 Gateway North Blvd. El Paso, TX 79934

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/23/24 at 3:40 PM, with the Administrator, he stated Resident #8 was 1:1 and another nursing staff member was calling Lead CNA for help. The Administrator stated Resident #8 was left alone as Lead CNA left her. The Administrator stated if a facility member becomes 1:1 with a resident then that staff member needs to be relieved by another staff member. The Administrator stated the facility staff had been trained on one-to-one expected Lead CNA at that time who was not trained on how to be a 1:1. The Administrator stated Lead CNA was suspended pending the investigation which came out confirmed. The Administrator stated Lead CNA was written up and trained on one-to-one before coming back onto work. The facility completed the following corrective actions to address the non-compliance after the incident occurred but prior to the surveyor entering: Record review of Lead CNA's Employee Warning Notice of Suspension dated 03/22/24, revealed, Suspension pending investigation. Description of infraction (violations or infringements; or breach of statutes, contracts, or obligations): Resident #8 left without supervision. Plan of improvement: Educated over one to one supervision. Consequences of further infractions: Potential termination depending on severity. Record review of facility in-service training report for One-to-One dated 03/22/24, revealed, training for Lead CNA. Record review of local police incident information card dated 03/22/24, revealed, the local police was notified and a report was made. 2. Observation on 04/11/24, revealed, in 100 Hall, Housekeeper, she had come out of the employee lounge and left the door open. There was a sign in blue posted in English and Spanish that read to keep the door closed at all times. During an interview on 04/17/24 at 2:34 PM, with the Housekeeping Manager, she stated the employee lounge needed to be closed. The Housekeeping Manager stated it was closed so the residents would not go in. The Housekeeping Manager stated resident would go into the employee lounge looking for stuff to eat or drink but it was not safe for them to be eating or drinking the items that were in the employee lounge. The Housekeeping Manager stated it could be a risk if the resident was diabetic. During an interview on 04/18/24 at 9:10 AM, with the DON, she stated the employee lounge door had to be closed. The DON stated this was because there were residents who would go into the employee lounge and would look for food. The DON stated she did not know if there would be a risk of having the employee lounge door open. The DON stated if the resident was diabetic then there could be a risk if the resident entered the employee lounge. During an interview on 04/18/24 at 9:59 AM, with the Administrator, he stated the facility did not have a break room/Employee Lounge policy for keeping the door closed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility Notice poster not dated, revealed, Notice-Keep door closed at all times. Spanish: Aviso-Mantenga la [NAME] cerrade en todo momento. Record review of the facility Accidents and Supervision policy not dated, revealed, the resident environment will remain as free of accidents as was possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. Identifying hazards and risks. Evaluating and analyzing hazards and risks. Implementing interventions to reduce hazards and risks. Monitoring for effectiveness and modifying the interventions when necessary.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 46998 Based on the interview and record review the facility failed to follow guidelines for mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in uniform form format according to specifications established by CMS for 1 of 4 quarters (1st Quarter October 1, 2022 to December 31, 2022) reviewed for administration (Fiscal year 2023, for the first quarter October 1, 2022, to December 31, 2022). The facility failed to submit PBJ (Payroll Based Journal) staffing information to CMS for the 1st quarter of the fiscal year 2023. The facility's failure could place residents at risk for personal needs not being identified and met decreased quality of care, decline in health status, and decreased feelings of well-being within their living environment. Findings included: Record review of the facility CMS reports for PBJ provided by HR Coordinator dated 02/14/24, revealed, status - failed to send-quarter unavailable. Record review of the facility e-mail provided by Administrator dated 02/15/24, revealed, Corporate Administrator - Your PBJ Submission has failed because CMS was no longer accepting submissions for this reporting quarter. 2024 - 1st Quarter (10/01/23-12/31/23) Requested Submission: 02/14/24 11:08:03 PM Submitted to CMS: 02/14/24 11:08:29 PM Record review of the CMS PBJ Staffing Data Report (payroll-based staffing), CASPER Report (Certification and Survey Provider Enhanced Report) dated Fiscal Year Quarter 01/2024 (October 1 - December 31), indicated the following entry. Failed to Submit Data for the quarter . Triggered . Triggered = NO Data Submitted for the Quarter. During an interview on 04/23/24 at 3:40 PM, with the Administrator, he stated HR Coordinator was responsible for submitting the PBJ to state. The Administrator stated he was not familiar with the process of the PBJ and referred surveyor to the HR Coordinator. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/23/24 at 3:56 PM, with HR Coordinator, she stated she had submitted the PBJ to the state and had to be done quarterly. HR Coordinator stated the PBJs are used for staffing and grading/rating of the facility. HR Coordinator stated rating the facility lets families know if the facility was a good place to place their loves ones. HR Coordinator stated the process of submitting the PBJ went as follows: HR Coordinator does and completes the PBJ and then submits it to the Corporate Administrator who reviews it and then submits it to state. HR Coordinator stated she submitted it early to the Corporate Administrator and did not know what happened from there on. HR Coordinator stated she was not sure how not submitting the PBJ on time would affect the facility.

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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. 46998 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 disease and infection for 1 (Hall 100 Nurse station trash can) of 4 trash cans and 1 (Housekeeper) of 1 Housekeepers reviewed for infection control in that: The hall 100 nurse station trash can was overflowing with trash and it was on the ground. The sick Housekeeper did not follow the Covid policy by calling work to find out if she had to go into work. As stated by the DON stated, anyone feeling sick before work needs to call into work to let someone know they are not feeling well. The Housekeeper failed to follow the employee lounge warning sign of, keep door closed, when she exited the employee lounge. These deficient practices could place residents at risk for infection due to improper care practices. Finding included: Observation on 04/17/24 at 11:24 AM, revealed, 100 hall trash can at the nurse's station to be full and overflowing with trash. There were brown bags of fast food, paper towels, used clear gloves on the ground, white pieces of an unknown stick, box of masks, a white 1 inch by 1 inch pad or gauze. During an interview on 04/17/24 at 11:30 AM, with LVN J, she stated the housekeeper usually gets to her hall (100) around 1:30 PM. LVN J stated in the mean time before the housekeeper got to her hall anytime the trash was overflowing and on the ground at the nurses station it was expected for the nurse or the CNAs to throw away and pick up the trash. LVN J stated the negative impact of not picking up the trash or throwing it would be infection. During an interview on 04/17/24 at 2:34 PM, with Housekeeping Manager, she stated at 7AM-3PM she has housekeeping staff working in halls 300-400 and at 10AM-6PM, she had another housekeeper working halls 200-100. The Housekeeper stated while the housekeepers are busy in other halls the nursing staff are able to throw the trash themselves or call the housekeepers to have it thrown away. The Housekeeper stated having the trash over flowing and on the ground could be a risk of a resident picking it up and infection. During an interview on 04/18/24 at 9:10 AM, with the DON, she stated she was not sure if housekeeping would pick up the trash around and on the ground of the nurse's station. The DON stated anyone seeing the trash overflowing or on the ground was responsible for picking it up and throwing the trash out. The DON stated the risk could be infection. Observation on 04/11/24, revealed, in 100 Hall, Housekeeper, she had come out of the employee lounge wearing a blue surgical mask. (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 04/17/24 at 2:34 PM, with Housekeeping Manager, she stated she spoke with the Housekeeper, which mentioned she was not feeling well and felt sick and still came into work. The Housekeeper Manager stated the Housekeeper did not call her to tell her she felt sick and was not well. The Housekeeping Manager stated the Housekeeper was new but had been trained on Covid-19 precautions and infection prevention control. The Housekeeping Manager stated the Housekeeper did not following facility protocol when feeling sick and should have called before coming into the facility. The Housekeeping Manager stated the risk of not following facility protocol was getting everyone sick in the facility. During an interview on 04/18/24 at 9:10 AM, with the DON, she stated the facility staff have been in-serviced and trained on Covid-19 precautions and infection prevention control. The DON stated anyone feeling sick before work needs to call into work to let someone know they are not feeling well. The DON stated the facility staff not feeling well are told to stay home and not come into work. The DON stated the risk could be spreading Covid-19 or whatever the facility staff had. The DON stated the facility staff coming into work and not calling before coming into work did not follow the Covid-19 precautions and infection prevention control. Record review of the facility Infection Prevention and Control Program policy dated 01/31/24, revealed, 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. All staff are responsible for following all policies and procedures related to the program.