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	07/19/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on observation, interview and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs for one (Resident #23) of 24 residents reviewed for accommodation of needs. Resident #23's call light was not within reach and was difficult for him to use. This failure could place residents at risk of not being able to call for assistance when needed. Findings included: Record review of Resident #23's face sheet dated 07/18/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Record review of Resident #23's electronic diagnosis listing dated 07/18/2024 revealed he had diagnoses including metabolic encephalopathy (chemical imbalance in the blood that impairs brain function), cerebral infarction (stroke), and vascular dementia (brain damage caused by strokes). Record review of Resident #23's Admission MDS dated [DATE] revealed he had a BIMS score of 6 (Severe Cognitive Impairment). He had functional limitation in his range of motion on his arm and leg on one side. He was dependent on staff to eat, for oral hygiene, toileting, bathing, dressing, moving around in bed, sitting up, and transferring between surfaces. His diagnoses included cerebrovascular accident (stroke) and non-Alzheimer's Dementia. His occupational therapy start date was 06/05/2024 and he had received 35 minutes of occupational therapy across two days. Record review of Resident #23's Care Plan dated 06/06/2024 revealed he needed assistance turning in bed, eating, dressing, personal hygiene and oral care, using the toilet and transferring. He was at risk for falls and his call light was to be within reach. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 07/16/24 at 03:21 PM revealed Resident #23 was in his room in his wheelchair. His call light was not visible, and he was not able to find it when asked. It was observed that his call light was wedged between the side of the wheelchair and the wheel on his left. The call light and cord did not have any type of a securing device on it such as a clip. The resident was not able to reach the call light when told where it was located. When the call light was placed on his bed at his request, he said it was not his call light. It was observed that the call light was 2.25 inches long and cylindrical in shape, with a button on the end to be pressed to call for help. He said his call light was flat and round and had a red cross on it, and it was the only type he had ever had. Resident #23 said he had the other flat round call light with the red cross on it because it was easy to use. In an interview and observation on 07/16/24 at 03:21 PM the DON revealed that Resident #23's call light should be where he could reach it. She said that determination of need for a particular type of call light depended on the resident's ability to use the call light. The DON stated she had never noticed the type of call light the resident had. She said it was important for a resident to have a call light that could be used so the resident could call staff for assistance. She said the risk to the resident of not having a call light within reach or a call light they could use was the resident would not be able to get what they needed or wanted. She said that if a resident was receiving skilled therapy their ability to use call lights would be assessed. In an interview on 07/18/24 at 04:20 PM the Therapy Director revealed that recommendations for assessments such as one for call lights could be made by either nursing or the therapy department during IDT meetings. He did not recall any recommendations regarding call lights for Resident #32 having been made. Record review of the facility policy and procedure Call lights: Accessibility and Timely Response dated 07/2022 revealed each resident would be evaluated for unique needs and preferences to determine any special accommodations that might be needed in order for the resident to utilize the call system. Special accommodations would be identified on the resident's person-centered plan of care and provided accordingly. Examples included touch pads. Staff were to ensure that that call lights were within reach of the resident and secured as needed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on interviews and record review the facility failed to electronically transmit within 14 days after the facility completed a resident's assessment, encoded MDS data including a subset of items upon a resident's transfer, reentry, discharge, and death for 5 (Residents #2, #201, #104, #92 and #74) of 6 residents reviewed for electronic transmission of MDS data to the CMS system. The facility failed to transmit discharge MDS data to the CMS system for Residents #2, #201, #104, #92 and #74 within 14 days of Resident s discharge from the facility. This failure could place residents at risk of not having specific information transmitted in a timely manner. Findings included: Record review of Resident #2's face sheet dated 07/18/2024 revealed she was [AGE] years old, was initially admitted on [DATE] and readmitted on [DATE]. Record review of Resident #2's Annual assessment MDS dated [DATE] revealed she had a BIMS score of 2 (Severe cognitive impairment). Her diagnoses included dementia, depression and psychotic disorder. Record review of Resident #2's electronic census log revealed she was discharged from the facility on 04/19/2024. Record review of Resident #2's MDS electronic log page accessed 07/18/2024 revealed her discharge ARD date was 04/19/2024, the discharge ARD was to be completed on 05/03/2024 and was 76 days overdue. In an interview on 07/18/24 at 02:14 PM MDS Nurse D revealed that Resident #2's discharge MDS was pending transmission and should have already been transmitted by MDS Nurse E. He did not know why MDS Nurse E had not transmitted the file. Record review of Resident #102's face sheet dated 07/18/2024 revealed he was [AGE] years old and was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #102's 5-day MDS dated [DATE] revealed he had a BIMS score of 13 (cognitively intact). His diagnoses included Parkinson's Disease, Chronic Obstructive Pulmonary Disease (lung condition that causes breathing difficulties), and epilepsy. Record review of Resident #102's electronic census log revealed he was discharged from the facility on 02/01/2024. Record review of Resident #102's MDS electronic log page accessed 07/18/2024 revealed his Medicare 5-Day MDS report dated 02/02/2024 was incomplete. (continued on next page)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	In an interview on 07/18/2024 at 02:14 PM MDS Nurse D revealed that since a Modification of Medicare - 5 Day MDS for Resident #102 went out on 02/01/2024, another MDS did not need to go out. Record review of Resident #104's face sheet dated 07/18/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Record review of Resident #104's Admission MDS dated [DATE] revealed he was not able to participate in the BIMS interview because he was rarely or never understood. His diagnoses included diabetes, a seizure disorder, and an unspecified disorder of the brain. Record review of Resident #104's electronic census log revealed he was discharged from the facility on 04/22/2024. Record review of Resident #104's MDS electronic log page accessed 07/18/2024 revealed his Death MDS had an ARD date of 04/22/2024, that the MDS was to be completed by 4/29/2024 and was 80 days overdue. In an interview on 07/18/2024 at 02:14 PM MDS Nurse D revealed that another MDS for Resident #104 should have gone out after a Modification of Medicare - 5 Day MDS went out on 02/01/2024. He did not know why the Death MDS did not go out. Record review of Resident #92's face sheet dated 07/18/2024 revealed she was [AGE] years old and was admitted to the facility on [DATE]. Record review of Resident #92's 5-Day MDS dated [DATE] revealed her BIMS score was 3 (Severe cognitive impairment). Her diagnoses included diabetes, and a urinary tract infection. Record review of Resident #92's electronic census log revealed she was discharged from the facility on 03/01/2024. Record review of Resident #92's MDS electronic log page accessed 07/18/2024 revealed she had a Medicare 5-day MDS dated [DATE] that was incomplete. In an interview on 07/18/2024 at 02:14 PM MDS Nurse D revealed he did not think another MDS needed to go out for Resident #92 since another 5-day MDS had been submitted. Record review of Resident #74's face sheet dated 07/18/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Record review of Resident #74's Admission MDS dated [DATE] revealed his BIMS score was 14 (cognitively intact). His diagnoses included lung cancer and deep vein thrombosis (blood clot, usually in the leg). Record review of Resident #74's electronic census log revealed he was discharged from the facility on 03/25/2024. Record review of Resident #74's MDS electronic log page accessed 07/18/2024 revealed his discharge MDS ARD 03/25/2024 was to be completed by 04/08/2024 and was 101 days overdue. (continued on next page)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	In an interview on 07/18/2024 at 02:14 PM MDS Nurse D revealed Resident #92 had insurance through an HMO and that was probably why the MDS had not been transmitted. In an interview on 07/18/24 at 02:51 PM the DON revealed that the MDS department was overseen by a corporate supervisor who was responsible for ensuring that MDS assessments were transmitted. In an interview on 07/18/24 at 02:53 PM MDS Nurse E said she had consulted with the MDS corporate supervisor who had told her that the MDSs in question did not need to be modified and had been transmitted. She provided a document CMS Submission Report dated 07/18/2024. Record review of the CMS Submission Report dated 07/18/2024 revealed that on 07/18/2024 MDS records were transmitted for Residents #2, #201, #104, #92 and #74. Record review of the facility policy MDS 3.0 Completion dated 2023 revealed that transmissions would be transmitted to the designated CMS system within 14 days of completion.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on interview and record review the facility failed to ensure that a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for 1 (Resident #111) of 7 residents reviewed for treatment and services related to range of motion. The facility failed to ensure that Resident #111 received services to increase or maintain his range of motion. This failure could put residents at risk of decreased range of motion, decreased quality of life, and increased risk of contractures and threats to skin integrity. Findings included: Record review of Resident #111's face sheet dated 07/17/2024 revealed he was [AGE] years old and was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #111's history and physical dated 06/14/2024 revealed he had diagnoses including cerebral infarction (stroke), use of a tracheostomy (opening into the windpipe to breathe through), and a feeding tube. He was unable to speak or communicate his needs. Record review of Resident #111's 5-day MDS assessment dated [DATE] revealed he was unable to speak and was rarely or never understood by others. He usually understood others. He was unable to participate in the BIMS interview. He had no symptoms of delirium, some symptoms of depression, no symptoms of psychosis and no behavioral symptoms. He had functional limitation in range of motion to his arms and legs. He was totally dependent on others for all of his activities of daily living and was totally dependent on others to move. His diagnoses included pneumonia, CVA (stroke) and respiratory failure. He had been administered antipsychotic medications during the seven days before the MDS assessment was completed. He received 30 minutes of speech therapy, 15 minutes of occupational therapy, and 30 minutes of physical therapy in the seven days prior to the assessment. His MDS assessment documented that no restorative therapy was provided during the 7-day look-back period. Record review of Resident #111's care plan dated revealed he did not have a care plan to address limited range of motion. Care plans dated 04/19/2024 addressed the resident's need for assistance with ADLs such as turning in bed, dressing, and transferring, but did not address his need for any physical, occupational or restorative therapies to maintain or increase his range of motion. Record review of Resident #111's physician's order dated 04/16/2024 revealed he was to be evaluated by Physical Therapy, Occupational Therapy and Speech Therapy and as indicated. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #111's active physician's order dated 06/16/2024 revealed that the resident's occupational therapy evaluation and treatment were complete. The resident was to be seen for skilled Occupational Therapy services including self-care, therapeutic exercise, therapeutic activity, and manual treatment, wheelchair management, neuro reeducation and group treatment 5 to 6 times a week for 100 days for generalized weakness. The order had not been discontinued. Record review of Resident #111's physician's order dated 04/21/2024 revealed that the resident's PT evaluation was completed. Recommend Skilled PT services were recommended 3 times a week for 4 weeks to include therapeutic exercise, neuromuscular reeducation (rehabilitation to restore normal muscle and nerve function), gait training (therapy to improve walking), therapeutic activities, and wheelchair management for increased level of independence with reduced risk for falls. The order was discontinued on 06/13/2024. In an interview on 07/18/24 at 09:17 AM the Director of Rehabilitation revealed that Resident #111 was not currently getting services from any therapy. He stated that Resident #111's speech, occupational and physical therapies had been discontinued on 7/8/24 because of change in payment source. He said that there were no plans to provide any additional therapy, and that the facility did not have a restorative program. He said the risk to Resident #111 of not having therapeutic interventions included contractures, increased muscle tone, and skin breakdown. In an interview on 07/18/24 at 09:20 AM Physical Therapist I revealed that Resident #111 had no contractures but had joint stiffness, and that the resident had been receiving passive range of motion exercises during the time when physical therapy was being provided. Physical Therapist I stated Resident #111 would benefit from continued physical therapy or restorative therapy. In an interview on 07/18/24 at 09:52 AM the DON revealed that the risk to Resident #111 of not receiving help maintaining his range of motion on a daily basis was contractures, atrophy of muscles and skin breakdown. She said that the facility did not have a program designed to provide these types of services, such as a restorative program. She did not know why the facility did not have this type of program. She said that staff members monitored residents for changes in functioning and changes would be reported to the therapy department so the resident could be evaluated for services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 30057 Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 2 of 12 residents (Resident #103 and Resident #15) reviewed for supervision and accidents in that: CNA A and NA B transferred Resident #103 from his wheelchair to the bed by grabbing him from the back of his pants and his under arms. The fall mat for Resident # 15 was far away from his bed. These failures could put residents at risk of accidents and serious injuries which could result in a reduced quality of life. Findings included: Record review of Resident #103's admission record dated 07/17/24 indicated he was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease and muscle weakness. He was [AGE] years of age. Record review of Resident #103's MDS dated [DATE] indicated in part: BIMS = 02 indicating resident had severe impairment. Impairment on both sides - upper and lower extremities. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair). Resident is dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. Record review of Resident #103's care plan dated 01/10/24 indicated in part: Focus: I have an ADL Self Care Performance Deficit. Goal: I will improve current level of function through the review date. Interventions/tasks: I require Extensive assistance x2 staff with transfer. During an observation on 07/16/24 at 09:12 AM CNA A and NA B transferred Resident #103 from his wheelchair to the bed. Both aides took the resident from his armpits and by the back of his pants. Resident #103 was noted to drag his feet and did not assist with the transfer as it was noted that the resident was unable to bear weight. During an interview on 07/18/24 at 10:04 AM NA B said that she had not used her gait belt during the transfer because Resident #103 was combative and the reason why they transferred the resident from his armpits and the back of his pants. NA B said that when they used the gait belt the resident would be more combative. NA B said if they transferred the resident by taking him from his underarms and from the back of his pants it could lead to an injury if his pants tore or injure his shoulders. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/18/24 at 10:57 AM CNA A said she was aware that the transfer done with Resident #103 was not necessarily correct but that it was the safer way for them due to the resident being aggressive during the transfers with a gait belt. CNA A said they had attempted to use the gait belt before but that Resident #130 had become combative and now they were transferring him by taking him from his armpits and back of pants which again was probably not safe. CNA A said at one time it had taken 3 staff members to transfer the resident due to him being combative. CNA A said she did not know what other way to safely transfer Resident #130 besides taking him from under his arms and by the back of his pants. During an interview on 07/18/24 at 11:52 AM the DON was made aware of the observation of Resident #103 being transferred to the bed by CNA A and NA B. The DON said that the staff were supposed to use a gait belt when conducting the transfer and not take the resident from underneath his armpits and the back of his pants as he could be injured. The DON said that they would look into figuring out a way to transfer the resident in a safer way. During an interview on 07/18/24 at 03:48 PM the Administrator was made aware of the observation of Resident #103 being transferred to the bed by CNA A and NA B. The Administrator said he did not think that it was a proper way to transfer a resident. The Administrator said they would be working and looking into a safer way to transfer the resident. Record review of Resident #15's admission record dated 07/18/24 indicated he was admitted to the facility on [DATE] with diagnoses of abnormalities of gait and mobility, weakness, nondisplaced (a fracture in which the bone cracks or breaks but retains its proper alignment) fracture of fourth cervical vertebra, unspecified fall and unspecified lack of coordination. He was [AGE] years old. Record review of Resident #15's MDS dated [DATE] indicated in part: BIMS = 04 indicating resident had severe impairment. Record review of Resident #15's care plan dated 04/04/24 indicated in part: Transfer; the resident requires assistance from staff to maximize independence. The resident is at risk of falling with a history of falling, follow facility all protocol. 6/12/2024 The resident has had an actual fall while attempting to ambulate without assistance, unwitnessed fall. Fall Mat in place to promote safety and prevent injury. During an observation and interview on 07/16/24 at 04:09 PM it was revealed that the fall mat for Resident #15 was away from his bed. The family member was on the other bed and stated that earlier that morning she had heard the resident trying to get up from bed and that probably that's why the mat was moved to the side. She said he tried to get up from bed without assistance frequently. During an interview on 07/16/24 at 04:11 PM with RN K revealed that the fall mat was not placed correctly. She stated the mat needed to be by the feet of Resident #15s bed and not where it was found by the surveyor. The RN stated that the potential outcome for the fall mat being away from his bed was he could fall to the floor while trying to get up from bed and potentially resulting in injuries to Resident #15. RN said Resident #15 is at fall risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/17/24 with DON it was revealed that the placement of the fall mat was not acceptable because it was away from Resident's #15 bed. The DON stated that the potential outcome was that if the resident tried to get up from his bed and he fell , he would fall to the floor, and he could potentially get injured. The DON stated that Resident #15 is at fall risk. Record review of the facility's policy titled Fall Prevention Program dated 06/22 indicated in part: High risk protocols, provide additional interventions as directed by resident's assessments, including but not limited to assistive devices, increased frequency if rounds. Record review of the facility's policy titled Use of gait belts dated 06/08/24 indicated in part: It is the policy of this facility to use gait belts with residents that cannot independently ambulate or transfer for the purpose of safety. Each nursing department employee will be given a gait belt during orientation. All employees will receive education on the proper use of gait belt during orientation and annually. It will be the responsibility of each employee to ensure they have it available for use at all times when at work. Any and all repairs needed or issues with gait belt will be reported to the supervisor immediately for replacement. Failure to use gait belt properly may result in termination. Record review of the facility's policy titled Safe resident handling/transfers dated 06/08/24 indicated in part: It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. All residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. While manual lifting techniques may be utilized dependent upon the resident's condition and mobility, the use of mechanical lifts are a safer alternative and should be used. Handling aids may include gait belts, transfer boards, and other devices (specify as applies). Policies and Procedures were requested regarding fall mats but were not provided to surveyor before exit.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on observation, interview and record review the facility failed to ensure that a resident who is fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for one (Resident #111) of 4 residents reviewed for feeding by enteral means. The facility failed to ensure that Resident #111's enteral feeding formula was properly labeled. This failure put residents at risk of not receiving adequate nutrition by way of enteral feeding. Findings included: Record review of Resident #111's face sheet dated 07/17/2024 revealed he was [AGE] years old and was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #111's history and physical dated 06/14/2024 revealed he had diagnoses including cerebral infarction (stroke), respiratory failure with hypoxia (not having enough oxygen in the blood), use of a tracheostomy (opening into the windpipe to breathe through), and a feeding tube. He was unable to speak or communicate his needs. Record review of Resident #111's 5-day MDS assessment dated [DATE] revealed he was unable to speak and was rarely or never understood by others. He was totally dependent on others for all of his activities of daily living and was totally dependent on others to move. His diagnoses included pneumonia, CVA (stroke) and respiratory failure. He had been receiving nutrition through a feeding tube before he was a resident and was continuing to receive nutrition through a feeding tube as a facility resident. Record review of Resident #111's care plan dated 04/20/2024 revealed he was receiving enteral feedings (tube feedings) Record review of Resident #111's physician's order dated 06/14/2024 revealed he was to receive Jevity 1.2 (a type of enteral feeding formula) every shift at a rate of 70 ml per hour. Observation on 07/16/24 at 2:52 PM revealed that Resident #111 was lying in bed. His eyes were open but he did not respond to questions. A plastic bottle with beige liquid was hanging from a pole next to Resident #111's bed, and a tube from the bottle led through a feeding pump and under the resident's bed clothes. Observation of all sides of the plastic bottle revealed no labels with information about who the feeding was for, the rate it was to be administered or any other information. In an interview on 07/16/24 t 02:56 PM LVN J revealed she had hung Resident #111's tube feeding at mid-day and forgot to label it. She stated the purpose of the label was to document when the feeding was started, times, rate of administration and the patient who was to receive the tube feeding. She said that the risk to the resident was that he might get the wrong feeding or it might not be know how much he should receive. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy Enteral Formula Via Feeding tube, Bolus, Gravity Pump, dated 3/3/2020 revealed the bottle should be labeled with the resident name, room number, date changed and the nurse's signature/initials. The bag or bottle should also specify the physician order for formula, rate, route, and means of administration.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871 Based on observation, interview, and record review the facility failed to ensure that a resident who needed respiratory care was provided such care consistent with the comprehensive person-centered care plan, the resident's goals and preferences for 1 of 8 (Resident #19) residents reviewed for respiratory care. The facility failed to ensure Resident #19 had her nasal cannula on per physicians' orders. The findings included: Record review of Resident #19's face sheet dated 07/17/24 revealed an [AGE] year-old female who was readmitted to the facility on [DATE] with diagnoses of altered mental status, dementia (group of symptoms affecting memory, thinking and social abilities), anxiety (a feeling of worry, nervousness, or unease), cognitive communication deficit. Record review of Resident #19's significant change in status MDS assessment dated [DATE] revealed a BIMS score 05, indicating her cognitive was severely impaired and was on oxygen therapy. Record review of Resident #19's physician orders dated 02/20/24 revealed oxygen at 2 lpm via nasal cannula, every shift for shortness of breath and to maintain pulse oximeter above 90%. Record review of Resident #19's care plan revealed focus area for risk for Respiratory infections/distress, Hypoxia (low levels of oxygen in your body tissues. It causes symptoms like confusion, restlessness, difficulty breathing, rapid heart rate, and bluish skin), SOB (shortness of breath), and cough related to DX (diagnoses) of COPD (Chronic obstructive pulmonary disease is a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Resident on 2 L of continuous oxygen via nasal cannula with goal of will not exhibit signs of respiratory distress (restlessness, wheezing, dyspnea (shortness of breath), difficulty with expectoration (coughing up and spitting out the material produced in the respiratory tract), diaphoresis (cold sweats), crackles(abnormal lung sounds), tachycardia (heart beat faster than usual, greater than 100 beats per minute), cyanosis (bluish discoloration of your skin, lips or nails due to low oxygen in your blood), decreased breath sounds) through next review date and interventions administers oxygen as ordered, monitor and report signs of respiratory distress, monitor oxygen saturation via pulse oximetry as ordered. During an observation on 07/16/24 at 10:53 am, Resident #19 was alert and oriented to person only, she was confused and could not answer questions. Resident #19 was in her room in her wheelchair with nasal cannula noted under her chin and was receiving oxygen therapy at 2 lpm. The oxygen tank was not empty. No signs of respiratory distress were noted. During an observation on 07/16/24 at 10:56 am, CNA F walked in Resident #19's room with a comb to comb her hair, she washed her hands and exited Resident #19's room at 10:58 am. CNA F did not place nasal cannula in place for Resident #19. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 07/16/24 at 10:59 am, CNA G walked in Resident #19's room with oxygen tank and replaced her oxygen tank, CNA G stated Resident #19 had probably taken off the nasal cannula and exited Resident #19's room without placing the nasal cannula back on Resident #19. During an observation and interview on 07/16/24 at 11:00 am, LVN H assessed Resident #19 and stated her oxygen saturation was at 71%, he placed the nasal cannula in place and her oxygen went up to 96%. LVN H asked Resident #19 questions, she denied shortness of breath and LVN H stated the CNAs were responsible of ensuring residents who received oxygen therapy always had their nasal cannula in place. LVN H stated the CNAs were to check the nasal cannula during their rounds and ensure it was in place before exiting the room and/or walking away from the resident. LVN H stated it was expected for CNA F and CNA G to check for Resident #19's nasal cannula placement and place back in place before they had exited the room. LVN H stated the charge nurses were responsible for ensuring the oxygen therapy was administered as prescribed by checking oxygen tanks and nasal cannula placement during the Q2 hour rounds and as needed. LVN H stated risk for not ensuring nasal cannula was in place for residents who received oxygen therapy was possible for respiratory distress. During an interview on 07/16/24 at 11:04 am, CNA G stated she had been working at the facility for 8 months and had received training in oxygen therapy upon hire. CNA G stated she was trained to check for oxygen tanks to ensure they were always full and ensure residents had their nasal cannula in place. CNA G stated CNAs were responsible for ensuring oxygen therapy was administered as prescribed by ensuring nasal cannula was in place and oxygen tanks were full during their daily rounds at least every 2 hours and as needed. CNA G stated when did not check for Resident #19's nasal cannula placement after she replaced her oxygen tank. CNAA G stated she wanted to ensure the oxygen tank was replaced before it was empty and failed to check for nasal cannula placement because she became nervous. CNA G stated the risk for not placing nasal cannula in place was the risk of respiratory distress. During an interview on 07/16/24 at 11:08 am, CNA F stated she forgot to check for Resident #19's nasal cannula after she finished combing her hair because she became nervous. CNA F said she received training on oxygen therapy upon hire and was told to ensure oxygen tanks were full and nasal cannulas were in place during her rounds. CNA F stated risk for not checking nasal cannula placement was possible respiratory distress. During an interview on 07/17/24 at 10:54 am, the DON stated CNAs and LVNs were responsible for ensuring residents who received oxygen therapy had a full oxygen tank and nasal cannula was properly placed. The DON stated the CNAs were expected to check for oxygen tank and nasal cannula during their rounds and as needed, before exiting the resident's room. The DON stated CNAs received training on oxygen treatment upon hire and annually. The DON stated risk for not ensuring nasal cannulas were properly placed was respiratory distress. Record review of Oxygen Administration policy dated 06/03/24 read in part oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals. Oxygen is administered under the orders of a physician, except in the case of an emergency. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to: the type of oxygen delivery system; when to administer, such as continuous intermittent and/or when to discontinue; equipment setting for prescribed flows rates; monitoring of oxygen saturation levels and/or vital signs, as ordered; monitoring for complications associated with the use of oxygen.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871 Based on interviews and record review the facility failed to ensure that residents who have not use psychotropic drugs were not given these drugs unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record for 2 (Resident #274, Resident #111) of 8 residents reviewed for unnecessary medications. The facility failed to ensure Resident #111 had an appropriate diagnosis for the use of Seroquel (an antipsychotic used to treat schizophrenia and bipolar disorder). The facility failed to ensure Resident #274 had an end date for Zyprexa that was ordered PRN (as needed). These failures could place residents at risk for adverse consequences such as impairment or decline in an individual's mental or physical condition of functional or psychosocial status from receiving unnecessary antipsychotic medications. Findings included: Resident #274 Record review of Resident #274's face sheet dated 07/17/24 revealed an [AGE] year-old who was admitted to the facility on [DATE] with diagnoses of altered mental status and cognitive communication and he was his own RP. Record review of Resident #274's admission MDS dated [DATE] was still in progress of completion and BIMS was not yet completed. Record review of Resident #274's physician order dated 07/13/24 revealed Seroquel oral tablet give 1 tablet by mouth two times a day for . The medication did not have any indication for use. Record review of Resident #274's physician order dated 07/13/24 revealed Zyprexa intramuscular solution reconstituted 10 mg, (olanzapine) inject 5 mg intramuscularly every 24 hours as needed for acute manic (manic episode is a period of elevated mood or euphoria, racing thoughts, pressured speech, increased risk-taking, an inflated sense of self, and decreased need for sleep. These symptoms must persist for at least one week to be considered a manic episode) episodes. The medication did not have an end date. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #274's care plan dated 07/11/24 revealed focus area for uses psychotropic medications and goals of will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date with interventions of administer psychotropic medications as ordered by physician, monitor side effects and effectiveness every shift; Consult with pharmacy, MD to consider dosage reduction when clinically appropriate at least quarterly; Discuss with MD, family re ongoing need for use of medication. Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. Record review of Resident #274's psychotropic consent dated 7/13/24 revealed Resident #274 had signed consent for Seroquel and Zyprexa. During an interview on 07/17/24 at 11:00 am, the DON stated Resident #274's Seroquel did not have indication of use and that was not correct. The DON stated Resident #274 Zyprexa medication that was as needed did not have an end date and was also not correct. The DON stated the nurse who placed the medication in the computer was responsible for putting indication of psychotropic use and end date on as needed medication. The DON stated she was the nurse who had placed Resident #274 orders in over the weekend to assist her staff from home. The DON stated ADONs, and DON were responsible for ensuring psychotropic medications had indication of use and end date for those as needed medications and this was completed during weekly psychotropic medication audits. The DON stated failure to put indication for psychotropic mediation and end date for the as needed medication was administering unnecessary medication to the residents. Resident 111 Record review of Resident #111's face sheet dated 07/17/2024 revealed he was [AGE] years old and was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #111's history and physical dated 06/14/2024 revealed he had diagnoses including cerebral infarction (stroke), respiratory failure with hypoxia (not having enough oxygen in the blood), use of a tracheostomy (opening into the windpipe to breathe through), and a feeding tube. He was unable to speak or communicate his needs. Record review of Resident #111's 5-day MDS assessment dated [DATE] revealed he was unable to speak and was rarely or never understood by others. He usually understood others. He was unable to participate in the BIMS interview. He had no symptoms of delirium, some symptoms of depression, no symptoms of psychosis and no behavioral symptoms. He had functional limitation in range of motion to his arms and legs. He was totally dependent on others for all of his activities of daily living and was totally dependent on others to move. His diagnoses included pneumonia, CVA (stroke) and respiratory failure. He had been administered antipsychotic medications during the seven days before the MDS assessment was completed. He had received 30 minutes of speech therapy, 15 minutes of occupational therapy, and 30 minutes of physical therapy in the seven days prior to the assessment. No restorative therapy was provided during the 7 day look-back period. Record review of Resident #111's care plan dated 04/19/2024 revealed he was receiving psychotropic medications (medications that affect a person's mental state). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident 111's physician's order for olanzapine (an antipsychotic medication) 5 MG tablets dated 6/14/2024 revealed he was to receive one tablet every six hours as needed for agitation. In an interview on 07/18/24 at 02:48 PM the DON revealed that an antipsychotics such Olanzapine should not be prescribed for agitation, such as was the case for Resident #111. She stated that antipsychotics should be avoided because of long term side effects, such as dependence, and extrapyramidal effects (involuntary movements). She stated that all PRN orders for psychotropic medications such as Olanzapine should have a 14 day limit. The 14 day limit was so the physician could review the medication to see if it was still appropriate for the resident, otherwise the resident might be receiving a medication that was unnecessary. Record review of use of Psychotropic Medication policy dated 06/15/24 read in part Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the meditation. Policy Explanation and Compliance Guidelines: 4. The indications for use of any psychotropic drug will be documented in the medical record. a. Pre-admission screening and other pre-admission data shall be utilized for determining indications for use of medications ordered upon admission to the facility. b. For psychotropic drugs that are initiated after admission to the facility, documentation shall include the specific condition as diagnosed by the physician. i. Psychotropic medications shall be initiated only after medical, physical, functional, psychosocial, and environmental causes have been identified and addressed. ii. Non-pharmacological interventions that have been attempted, and the target symptoms for monitoring shall be included in the documentation. 9. PRN orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration (i.e. 14 days). a. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she shall document their rationale in the resident's medical record and indicate the duration for the PRN order.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49854 Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for sanitation and food storage. The facility failed to store food in sealed containers. The facility failed to keep bottles free of dry drippings. The facility failed to store food above the floor in the walk-in freezer. These failures could affect residents by placing them at risk of food borne illness. Findings include: Interview and observation on 7/16/24 at 8:20 am with cook, revealed a bag of chips open an unsealed inside the pantry. She stated that there was a potential for the contents of the bag to be contaminated and if residents were to eat from those chips, they could get sick, and if chips were mushy, there was a risk of chocking for those who have issues with consistency if they need to be chewing on them. During an observation inside the walk-in freezer revealed a box of frozen vegetables on the floor. The cook stated that the box should not be on the floor because there was a risk of contamination and that the residents could get sick. The surveyor showed to dietary manager the picture of the open bag containing chips that was found inside the pantry and she stated it was unacceptable because every item needed to be inside a sealed bag or container and the risk of having food unsealed was the potential of things such as dust getting inside the unsealed bag creating bacteria in the food which could potentially make the residents sick. In an interview on 07/16/24 at 08:29 AM with the dietary manager revealed there was a risk of bacteria growing on the vegetables if they were to be in contact with the floor. A box of mini muffins was observed on the top of a metal rack inside the walk-in freezer. They were soaked with water dripping from the condensation on the ceiling of the freezer and the dietary manager said that no boxes should be stored there. She said that there was a risk of mold and bacteria growing on the bread caused by the accumulation of water inside the box from the ice condensation from the freezer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During Observation and Interview on 07/16/24 09:16 AM with Dietary Manager revealed a container with jelly not properly closed. A chocolate dessert topping bottle had dry chocolate drippings. Interview with cook revealed that if the jelly container was not properly closed, there was a risk of the contents spilling inside the refrigerator and that could potentially contaminate the rest of the food stored inside. She also said that there was a risk of bacteria growing inside the container, contaminating the jelly and there was a risk if the food was served to the residents, they could get sick if they ate it. She said the same could happen with the chocolate drippings on the bottle. Upon showing the pictures of the container with the jelly and the dry chocolate drippings to the dietary manager, she stated that it was not acceptable to have unsealed containers inside the refrigerator because they can spill its contents inside potentially contaminating the rest of the food stored as well as potentially growing bacteria which could make the resident sick if they ingested the contaminated food. She said that dry drippings can also grow bacteria which could contaminate the food inside the refrigerator and that they could make the resident sick. The dietary manager said the expectation was for kitchen staff to clean the containers or bottles each time they finish using them to avoid the risk of contamination . In an interview on 07/17/24 04:00 PM with the DON, the surveyor showed the pictures of the box with vegetables on the floor of the walk-in freezer, the wet box of muffins on the top the metal rack below the ice condensation inside the freezer, the open bag of chips inside the pantry, and the dried drippings on the chocolate bottle. The DON said it was not acceptable because all those food items could get contaminated; she said if the box of vegetables found on the floor of the freezer were to be contaminated and they were to be used, the risk was the residents could get sick. DON said that the possible outcome would be the same for the box with the mini muffins, the open bag of chips and the dry drippings of chocolate on the bottle and said that there was a potential risk of all those items growing bacteria which could get the residents sick if they were served that food. In an interview on 07/18/24 at 09:36 AM with the administrator, revealed a box of vegetables found on the floor of the walk-in freezer, he said that it was not acceptable because there was a risk of cross contamination. For the wet box containing mini muffins with the ice condensation on top, he stated that there was risk that the condensation could leak into the box creating bacteria on the muffins. He stated that same outcome could happen with the open bag of chips from the pantry and the dry drippings from the bottle with chocolate. He stated that the risk of the residents ingesting food prepared with any of these items could result in them getting sick from their stomach if bacteria had grown on the food. Record Review of the policy titled Food Safety Requirements dated 07/2022 states in part: Policy Explanation and Compliance Guidelines. Storage of food in a manner that helps prevent deterioration or contamination of the food, including growth of microorganisms. B. Dry food storage - keep foods/beverages in a clean, dry area off the floor and clear of ceiling sprinklers, sewer/waste disposal pipes, and vents. C. Refrigerated storage - foods that require refrigeration shall be refrigerated immediately upon receipt or placed in freezer, whichever is applicable. Practices to maintain safer refrigerated storage include keeping foods covered or in tight containers. 8. Additional strategies to prevent foodborne illness include preventing cross-contamination of food.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 49854 Based on observations and interviews, the facility failed to dispose of garbage and refuse properly for 1 barrel of used cooking oil outside of the facility. One barrel used to dispose of used cooking oil was open without a lid and it had trash inside. This failure could place residents at risk of decreased quality of life due to an exterior environment which could attract pests, rodents, and other animals. Findings included: Observation and interview on 07/17/24 at 11:21 AM with the DM revealed that the oil dump barrel was not covered . I was almost full to the brim of the barrel, and it had trash and debris inside floating on the used oil. The DM said that by having the barrel uncovered, there was a risk of it spilling and attracting pests such as flies and bugs. The DM said that the potential outcome could be that it affects the residents and staff from the facility and by attracting pests the residents could get sick if food from the kitchen is contaminated. In an interview on 07/17/24 at 12:00 PM with the maintenance director revealed that when the equipment in the kitchen was cleaned such as the deep fryer, the cooking oil that had been used was dumped in the container located outside at the back of the facility to dispose of it. He said that there's a company that disposes of that oil, but he was not sure when that oil was picked up. He said the container must be closed and it should have a lid on top. The maintenance director said that if the container is not closed and if it rains, the oils and grease might overflow. He stated that people can get into the facility premises because there's a skate park at the back and it was possible they could do something to it like tipping it over. Upon looking at the picture of the container not covered, he said that it was not acceptable. The maintenance director said there was also a risk of attracting pests such as roaches and flies by not covering the container which could impact the safety and quality of life of the residents. In an interview on 07/17/24 at 04:00 PM with the DON she stated that by the oil barrel not being sealed there was a potential risk for it to be spilled and that it could attract pests such as roaches and flies that could potentially harm the living situation of her residents. DON said there was a risk of harming the health and wellbeing of the residents of the facility. In an interview on 07/18/24 09:36 AM with the administrator he stated that the risk of having the container exposed and without a lid is that it can attract insects such as flies and roaches and that can create a problem for the residents and staff at the facility. The administrator said that if it was to rain, the contents of the barrel could spill over, and it would create a potential hazard for the residents and staff in the facility. Policies and Procedures for proper storage and disposal of garbage and refuse, was requested on 7/18/2024 but were not provided to the surveyor by the time of exit.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 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 to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #25) of 12 residents reviewed for infection control in that: NA B failed to wash her hands and change her gloves after they became contaminated during incontinent care while assisting Resident #25. These failures could place resident's risk for cross contamination and the spread of infection. Findings included: Record review of Resident #25's admission record dated 07/17/2024 indicated he was admitted to the facility on [DATE] with diagnoses of dementia, muscle wasting and atrophy (muscle weakness). He was [AGE] years of age. Record review of Resident #25's MDS dated [DATE] indicated in part: BIMS = 00 indicating resident had severe impairment. Bladder and bowel: Urinary/bowel continence = Always incontinent. Record review of Resident #25's care plan initiated on 03/22/2024 indicated in part: Focus: I have bowel incontinence. Goal: I will remain free from skin breakdown due to incontinence and brief use through the review date. Interventions/Tasks: I use disposable briefs to enhance dignity. Change every 2 hours and prn. INCONTINENT: Check me every 2hrs and as required for incontinence. administer Pericare PRN. Change clothing PRN after incontinence episodes. During an observation on 07/16/24 at 09:35 AM CNA A and NA B performed incontinent care for Resident #25. Upon entering the resident's room CNA, A washed her hands and NA B did not and proceeded to put on a gown and some gloves. Both aides undid the resident's brief, and he was noted to have a bowel movement. NA B took some wet wipes and wiped the bowel movement from the resident's rectal area. While still wearing the same gloves NA B turned the resident on his side as she placed her hands on the resident's back and arms. While still wearing the same gloves NA B took the soiled brief and placed it in the trash can then took a new brief and fastened it to Resident #25. During an interview on 07/18/24 at 09:56 AM NA B said that she normally washed her hands or sanitized them before putting gloves on, but she was so nervous that she forgot to do that. NA B said that during the incontinent care of Resident #25 after her gloves became contaminated, she should have changed them to prevent any cross contamination. NA B said they received training regarding infection control and that she knew about washing her hands and changing her gloves but that she had gotten nervous due to the surveyor observing her and forgotten the steps. NA B said if she did not change her gloves after they became contaminated it could lead to cross contamination and the spread of infections. (continued on next page)

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	676468	A. Building B. Wing	07/19/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/18/24 at 10:12 AM ADON C was made aware of the observation of incontinent care performed by NA B. The ADON said she was in charge of doing the infection control training for staff such as handwashing but had not had a chance to do the training just yet as she had just started working at the facility on 06/24/2024. ADON C said it was expected for staff to wash or sanitize their hands before putting gloves on to perform resident care. The ADON said the staff were supposed to change their gloves after they became contaminated to prevent the spread of infections. ADON C said she felt the failure occurred because the staff member got nervous. During an interview on 07/18/24 at 11:46 AM the DON was made aware of the observation of incontinent care performed by NA B. The DON said that staff were expected to wash their hands before putting gloves on and that they were supposed to change their gloves after they became contaminated. The DON said if the staff did not wash their hands or change their gloves that could lead to possible spread of infections. The DON said the ADONs were in charge of training and overseeing the CNAs regarding incontinent care and infection control. During an interview on 07/18/24 at 03:48 PM the Administrator was made aware of the observation of incontinent care performed by NA B. The Administrator said the staff member was expected to wash her hands before putting gloves on and to change her gloves after they became contaminated. The Administrator said if the staff did not wash their hands or changed their gloves at the appropriate time that could lead to cross contamination. The Administrator said he would be meeting with the DON and discussing what they needed to do next regarding the training of staff. Record review of the facility's policy titled Incontinence dated 02/2023 indicated in part: Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible. Record review of the facility's policy titled Personal Protective Equipment dated 06/2024 indicated in part: This facility promotes appropriate use of personal protective equipment to prevent the transmission of pathogens to residents, visitors, and other staff. Personal protective equipment, or PPE, refers to a variety of barriers used alone or in combination to protect mucous membranes, skin, and clothing from contact with infectious agents. It includes gloves, gowns, face protection (facemasks, goggles, and face shields), and respiratory protection (respirators). All staff who have contact with residents and/or their environments must wear personal protective equipment as appropriate during resident care activities and at other times in which exposure to blood, body fluids, or potentially infectious materials is likely. PPE will be utilized as part of standard precautions regardless of a resident's suspected or confirmed infection status. Indications/considerations for PPE use: Gloves: Wear gloves when direct contact with blood, body fluids, mucous membranes, non-intact skin, or potentially contaminated surfaces or equipment is anticipated. Perform hand hygiene before donning gloves and after removal. Gloves are not a substitute for hand hygiene. Change gloves and perform hand hygiene between clean and dirty tasks, when moving from one body part to another, when heavily contaminated, or when torn. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled infection prevention and control program dated 05/27/24 indicated in part: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Standard precautions: all staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. Direct care staff shall demonstrate competence in resident care procedures established by our facility.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49854 Based on observation, interview 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 safe operating equipment in safe operating condition. The facility failed to maintain the stove in operational condition. This failure could place residents at risk of foodborne illnesses; and potential for injury to residents and staff by not maintaining essential equipment in safe operating condition. Findings include: Observation and interview on 7/16/24 at 9:20 am with DM revealed that the oven on the right side of the stove was not working. She said it was reported to maintenance and documented in the work order log in the nurse's station. The DM showed the surveyor that she had logged in a request to repair the oven on 3/24/2024. The DM said she did not know what happened and why the oven was not fixed. The DM stated the risk of not having an oven in good condition could impact the residents at the facility who eat the food prepared in the kitchen by delaying services. The DM said another potential risk could be that if the oven did not show the correct temperature, it could result in the food not being cooked properly and that could potentially make the residents sick. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 07/17/24 at 11:38 AM with the maintenance director revealed that staff were trained in how to report if something needed to be repaired. He explained staff needed to go to the rotunda or nursing station and make a note in the work order binder for whatever needed to be repaired. He said he reviewed the maintenance work order binder every morning to follow up. The maintenance director said he worked Monday to Friday and on-call on the weekends. He stated once he reviewed the binder, he checked on the equipment that needed to be repaired. The maintenance director said he reviewed the work order for the oven, and he determined he could not fix it himself. He contacted the vendor they had for the oven, they inspected the oven, and they sent him a quote explaining what was broken, what needed to be fixed and the cost of parts and labor. He said the work order was approved; it took about 3 weeks for them to repair the equipment, however it broke down again about 2 days after it was fixed. He called them back, told them they were under warranty for the repairs, the vendor went back about a week after, repaired the oven again and informed him a valve was blocked which was creating the issue. The maintenance director said the oven broke down again towards the end of April. He called them again, but he did not make a work order for it. They came back about a week after, inspected the oven and they disarmed the entire oven. The technicians found out that a solenoid (a solenoid gas valve is designed to control the gas flow in cooking appliances) relay was burned out and that made the oven short. They told him that the part was in back order and that's why they had not gone back to repair the oven. He said the facility had been waiting for about 3 months for the part. He said he called them back to follow up and they told him they would send an email letting him know what had happened. The maintenance director had not checked his email up until 07/17/24 11:53 AM. He stated that the oven was part of the essential equipment for the facility because that is how they prepared the food for the residents. The potential outcome was if the other oven from the stove broke down, the kitchen would not be able to prepare food for the residents and that could impact on how the residents are fed. He also stated if the temperature from the oven is not regulated, it could potentially get the residents sick if food was not prepared properly. During an interview with the DON on 07/17/24 at 04:00 PM she stated that the oven is considered essential equipment because it is used to cook meals for most of the residents in the facility. The DON said the potential outcome of having an oven that is not working properly could result of the food not being cooked properly and get the residents sick. During an interview on 07/18/24 at 09:36 AM with the administrator revealed that staff reported to the maintenance department about any broken appliances that must be fixed through the maintenance log which was in the rotunda or nursing station and the binder was blue in color so that way it was easy to identify; then the maintenance department director inspected the binder to see what needed to be addressed. The administrator said the binder was reviewed every morning when the maintenance director gets to his shift. He said he was aware that the oven was repaired around April and that they found out that the part was not the correct one and they were told by them that the part was in back order. When asked by the surveyor if the facility could use a different vendor to repair the oven or other appliances, the administrator said that it was possible to use a different vendor other than the current one. He said that there were no other efforts to find a different vendor because they were happy with their services. He said that the oven was not essential equipment. The surveyor requested from the administrator a policy stating what is considered essential equipment for the facility. He said that he did not think there was a risk for the residents if the oven was not functioning. He said there would be a risk if the oven was not functioning correctly and if food was not being cooked well because of it, but the oven not working did not present a risk for the residents. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a work order placed on 3/24/24 in the work order binder revealed that the oven was inspected by the maintenance director and it stated oven in kitchen keeps tripping the breaker after being plugged in. Record review of a quote dated 4/30/2024 provided to the facility by [NAME] Heating, Cooling and Plumbing stated that the parts and labor included replacing the pilot safety valve, replacing the variable speed motor and that technicians would perform all repairs to manufacturers specifications and would test for a proper operation. Record review of a policy titled work order request dated 07/2022, stated in part: When orders are completed, maintenance personnel will complete the assignment on the work order log in the maintenance book. Records of the work order for repairing the oven were not given to the surveyor by exit. Policies and Procedures for what is considered essential equipment for the facility was requested on 7/18/2024 but were not provided to the surveyor by the time of exit.