STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676495	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Starr County Nursing and Transitional Care	5260 Brand St Rio Grande City, TX 78582

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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** 50487 Based on observations, interview and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preference for one (Resident #9) of three residents reviewed for call lights. The facility failed to ensure Resident #9 had the call light within reach while in bed in his room. This failure could place residents at risk of being unable to obtain assistance or help when needed and in the event of an emergency. Findings were: Record review of Resident #9's Admission record dated 02/13/24 reflected an [AGE] year-old female with diagnoses of Unspecified Dementia (decline in thinking, learning and reasoning), Unspecified Severity without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety, Heart failure unspecified, Muscle Wasting And Atrophy Unspecified Site, Anxiety (persistent and uncontrollable feelings of fear that disrupt daily living), Need for assistance with personal care, Unspecified convulsions (type of unknown seizures). Record review of Resident #9's Annual MDS dated [DATE] reflected a BIMS score of 0 indicating severe cognitive impairment. Section GG - Functional Abilities and Goals indicated Resident requires substantial /maximal assistance with upper and lower body dressing, sitting to lying on bed, rolling left and right side on bed, and toileting hygiene. Observation on 10/14/24 at 11:25 a.m., revealed Resident #9's call light device was in top of the bedside table, Resident #9 was not able to reach it. During an interview on 10/14/24 at 11:38 AM, CNA B observed Resident #9's call light device was in top of the bedside table, Resident #9 was not able to reach it. CNA B said Resident #9 was supposed to have her call light near her so she can call for help should she need to. CNA B said she usually used her call light on and off. CNA B said she checks all residents to make sure their call lights are within reach, and they are not in need of any other assistance. She said she does this at the beginning when she first begins working and throughout her shift. CNA B said a negative outcome of not having the call light within reach was that a resident could fall and the resident could not be able to call for help. (continued on next page)

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	During an interview on 10/14/24 at 12:00 PM, CNA C said that Resident #9 used the call light. CNA C said that Resident #9 was able to grab the call light but sometimes had difficulty pressing the call light button. CNA C said that she went to the residents room frequently, every 2 hours to check if resident needed anything. CNA C stated that a negative outcome was that Resident #9 could fall and not able to call for assistance. During an interview on 10/14/24 at 12:45 PM, LVN A said that Resident #9 did not use the call light, her cognitive status was bad. LVN A said that was important to have the call light within reach so the resident could call me, and it could take longer to check what the resident needed. LVN A said that a negative outcome was that a resident could get skin irritations, pressure ulcers and even falling. During an interview on 10/15/24 at 11:55 AM, LVN J said that Resident #9 used her call light when she needs something. She said she always makes sure she has it within reach and reminds her to use it. LVN E said that if a resident cannot reach the call light, then they cannot get help, they may have a fall and be at risk of getting hurt. During an interview on 10/15/24 at 12:00 PM, ADON D said that if call lights are not within reach, Resident #9 could have fallen when trying to get the call light. Record review of facility's policy titled Call Lights: Accessibility and Timely Response date implemented: 10/13/22 states. Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Policy Explanation and Compliance Guidelines: 1. All staff will be educated on proper use of the resident call system, including how the system works and ensuring resident access to the call light. 2. All residents will be educated on how to call for help by using the resident call system. 5. Staff will ensure the call light is within reach of resident and secured. As needed.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50487 Based on record review and interview the facility failed to perform preadmission screening for individuals with a mental disorder and individuals with intellectual disability prior to admission for 1 of 3 residents (Resident #67) reviewed for preadmission screening. The facility failed to perform a PASRR for Resident #67 after she was admitted on [DATE] with readmission on 12/20/23. This failure could place residents at risk of receiving inadequate care. Findings included: Record review of Resident #67's admission record revealed an [AGE] year-old female with an original admitted on 10/20/23 and a readmission on 12/20/23. Diagnoses included Bipolar Disorder Unspecified (a mental health condition characterized by extreme shifts in mood, energy, and activity levels), Unspecified Dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (a mental disorder that causes a person to lose the ability to think, remember, learn, make decisions, and solve problems, but without behavioral disturbances) Record review of Resident #67's care plan dated 10/23/23 revealed pg. 5 identified a problem dated 11/6/23 of behavior problem with diagnosis of bipolar disorder, with a goal that the resident will have fewer episodes, with interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated on 11/06/2023. Anticipate and meet the resident's needs. Date initiated on 11/6/23. Record review of Resident #67's L1 dated 10/20/23 was negative for Mental Illness or Intellectual or Developmental Disability. In an interview with MDS LVN L on 10/15/24 at 2:45 PM, she stated she did not know how she missed Resident #67's PASRR L1 that was negative on 10/20/23 and she should have sent a 1012 form used for further evaluation of mental illness. She said she overlooked the PASRR L1. She said a level 2 should be done with those diagnoses, regardless of a diagnosis of dementia. MDS LVN L said she did not have or send a 1012 for Resident #67. She stated, Because the Resident was not evaluated, resident had not received the proper care. In an interview with ADON I on 10/16/24 at 10:50 AM, she stated that if all residents with Mental Illness or intellectual or developmental disability needed to be screened when admitted . She said a form was supposed to be filled out for the evaluation for the diagnosis of bipolar disease. ADON I stated that Resident #67 was not getting the services that was appropriate for her diagnosis. During an interview on 10/16/24 at 11:00 AM, the DON stated that if a PASRR positive was received then a form was filled out for evaluation for residents to get approved for services. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the ADMIN on 10/16/24 at 11:10 AM, stated that she was not familiar with the process of the PASRR, but she thought that failing to do this process could affect the services provided to the residents. Reference: CFR S483.20(k)(2), and the resident remains in the facility longer than 30 days, the facility must screen the individual using the State's Level I screening process and refer any resident who has or may have MD, ID or a related condition to the appropriate state-designated authority for Level II PASARR evaluation and determination.

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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** 50487 Based on observation, interview, and record review the facility failed to ensure a resident, who was fed by enteral means, received the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers for 1 of 6 residents (Resident #21) reviewed for enteral feeding. The facility failed to ensure Resident #21's head of bed was maintained at 30 degrees elevated while receiving continuous feeding. The failure could place residents at risk of aspiration (when food or liquid goes into the lungs or airway). Findings included: Record review of Resident #21's face sheet dated 10/14/24 revealed an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (a brain disorder that gradually destroys memory and thinking skills, and eventually the ability to perform everyday tasks), Dysphagia Unspecified (difficulty swallowing), Gastrostomy complication unspecified (wound infection, Cerebrovascular Disease (a group of conditions that affect blood flow and the blood vessels in the brain). Record review of Resident #21's quarterly MDS assessment dated [DATE] revealed he was severely cognitive impaired (a condition where a person has trouble with memory, learning, concentration, and decision-making to the point that it limits their ability to function socially or occupationally), had enteral feeding while a Resident (intake of food via the gastrointestinal tract). Record review of Resident #21's care plan dated 03/2/21 revealed a focus area for requires tube feeding related to Dysphagia (difficulty swallowing) with a goal of will remain free of side effects or complications related to tube feeding through review date and interventions that included Elevate HOB (head of bed) i.e. 30-45 degrees during and i.e. 30-40 minutes after tube feeding is stopped. During an observation on 10/14/24 at 11:45AM, revealed Resident #21 was in bed with the continuous enteral feeding running at 40 milliliters per hour. Resident #21's bed was elevated at approximately 30 degrees while Resident #21's head and torso were not elevated at 30 degrees, and she was lying flat on her back. No signs of distress were noted. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/14/24 at 11:48 AM, revealed LVN A was called into Resident #21's room. LVN A called for help to reposition resident, LVN A stated his head of bed was elevated at 30 degrees but Resident #21 was not as she was lying on her back. LVN A stated CNAs and nurses were responsible of ensuring residents who received continuous enteral feeding like Resident #21 were repositioned with the head of bed elevated at least 30 degrees. LVN A stated CNAs and nurses conducted rounds at least every 2 hours to ensure proper positioning for residents on continuous enteral feeding. LVN A stated failure to position Resident #21 head of bed at 30 degrees placed her at risk of aspiration (occurs when contents such as food, drink, saliva, or vomit enters the lungs). During an interview on 10/16/24 at 08:00 AM, LVN J stated that residents with enteral feedings had to be with the head elevated at 30 degrees. LVN J stated that if head of bed was not elevated the residents with enteral feedings are at risk of aspiration pneumonia. During an interview on 10/16/24 at 10:00 AM. the DON stated all CNAs and nurses were responsible for ensuring residents who received continuous feedings were positioned with the head of bed elevated at least 30 degrees. The DON stated the charge nurses were responsible for ensuring proper position during their continuous rounds. The DON stated risk included aspiration pneumonia and lung congestion. Record review of Tube (enteral) Feeding General Information policy on Lippincott Manual of Nursing 11th edition reflected in part Suggested protocol for enteral tube feeding orders: elevated head of bed 30-45 degrees at all times during continuous feedings.

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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** 48278 Based on observation, interview and record review, the facility failed to ensure that residents who needed respiratory care were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 5 (Resident #301) residents reviewed for respiratory care. The facility failed to ensure Resident #301's oxygen was administered at the correct setting of 2 liters per minute on 10/14/24 at 11:57 a.m. This failure places residents who receive respiratory care at an increased risk of developing respiratory complications and a decreased quality of care. The findings included: Record review of Resident #301's face sheet dated 10/14/2024 reflected a [AGE] year-old male with an admitted [DATE]. Pertinent diagnoses included Chronic Obstructive Pulmonary Disease (chronic inflammatory lung disease that makes it difficult to breathe), Congestive Heart Failure (heart doesn't pump enough blood for your body's needs), Type 2 Diabetes, and Hypokalemia (lower than normal potassium level in the bloodstream). Record review of Resident #301's comprehensive care plan dated 10/14/2024 revealed Resident #301 has oxygen therapy related to Chronic Obstructive Pulmonary Disease with interventions to provide reassurance and allay anxiety; Have an agreed-on method for the resident to call for assistance. Stay with the resident during episodes of respiratory distress, and change residents position every 2 hours to facilitate lung secretion movement and drainage. Record review of Resident #301's physician's order summary revealed oxygen at 2LPM via Nasal cannula every shift continuously for hypoxia related to COPD, order start date 10/14/2024. During an observation of Resident #301 on 10/14/2024 at 11:57 a.m., his oxygen concentrator setting was set at 1.5 LPM via nasal cannula. Observed Resident #301 in bed, asleep. No signs of respiratory distress noted. In an interview on 10/14/2024 at 12:04 p.m. with LVN H stated, she was the nurse for Resident #301. She stated her shift started at 6 a.m. LVN H verified that the O2 setting was set at 1.5 LPM. She stated it was supposed to be at 2 LPM. She stated the O2 setting was to be checked at every shift. LVN H stated that she has not checked it for today. That she normally checks it before lunch or at the end of her shift, depends how her day was going. LVN H stated that the negative outcome of keeping Resident #301 at a lower oxygen rate than ordered would be that his oxygen level can go down and it can affect his brain or organs. She stated they had a respiratory care in-service/training about 2-3 months ago. In an interview on 10/14/2024 at 12:13 p.m. with Resident #301 stated, he was doing well. He denied any chest pain, shortness of breath or headache. He had no concerns with his oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/14/2024 at 12:50 p.m. with ADON I stated, she was the ADON for 300 & 400 halls. ADON I stated the nurse was responsible for checking the O2 settings once every shift and throughout their shift. She stated the managers also check in the morning and in the afternoon before they leave. ADON I stated the admissions coordinator had checked it this morning and it was at 2 LPM. She stated she checked the O2 settings at around 7:30 a.m. and did a second round when the surveyors got here. ADON I stated Resident #301 can get hypoxic (low levels of oxygen in the body) if he continued at a low O2 setting than prescribed since Resident #301 had COPD. She stated they had respiratory care in-service/training not too long ago, maybe around July 2024, they do it yearly. In an interview on 10/14/2024 at 4:28 p.m. the DON stated the nurse was responsible for checking the O2 settings every shift. She stated the ADON and herself also check it, as needed. The DON stated the if Resident #301 was not getting the full oxygen as prescribed it can cause a decrease in his oxygen saturation. She stated that respiratory care in service/training was done around July 2024, it was done yearly and as needed. Record review of the Respiratory Skills Checklist dated 06/25/24 revealed the LVN H was checked off on Respiratory Skill: Oxygen Administration, Tracheal Suctioning and Tracheostomy Trained and Returned Demonstration Performed/Passed on 6/25/24. Record review of the copy the facility provided of the Lippincott Nursing Procedures 11th edition 2016 for Administering Oxygen Therapy revealed: Nursing Assessment and Intervention 3. Administer oxygen in the appropriate concentration and device. 5. Increase or decrease the inspired oxygen concentration, as appropriate. c. Determine oxygen prescription . and . follow these flow rates.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50487 Based on interviews, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 2 of 4 residents (Residents #26 and #304), reviewed for pharmaceutical services. The facility failed to ensure: LVN M performed a safety check and compare physician orders against single dose bister pack prior to administering Resident #26's medication. LVN N perform a safety check and compare physician orders against single dose bister pack prior to administering Resident #304's medication . These deficient practices placed residents at risk for not receiving the therapeutic effects of their prescribed medications. The findings included: 1. A record review of Resident #26's admission record, dated 10/16/2024 revealed an admitted [DATE] with diagnoses which included type 2 diabetes (a chronic condition that affects how your body regulates blood sugar (glucose) levels), unspecified dementia (a clinical syndrome that describes dementia without a specific diagnosis), muscle wasting and atrophy (the loss of skeletal muscle mass). A record review of Resident #26's physician's orders dated 10/16/2024 revealed an order for Nuedexta oral capsule 20-10 milligrams, one capsule to be administered via Gastrostomy tube one time per day. A record review of Resident #26's care plan dated 12/07/22 revealed, Resident #26 a behavior problem. Resident #26 will at times will have fits of crying with no apparent trigger to cause the crying. With interventions which included, Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 06/19/2023. During an observation and interview on 10/16/2024 at 08:10 AM, LVN M prepared Resident #26's medications, she removed * capsules from the single-dose blister pack containing Nuedexta 20 milligram capsules. The blister pack indicated to give one capsule via Gastrostomy tube every 12 hours. LVN M was noted to not perform a safety check to the order prior to pouring the medication. LVN M said she was unaware the dose had changed and stated when a physician order changes a change of directions sticker should have been placed in the single-dose blister pack . During an interview on 10/16/24 at 10:35 AM, LVN A stated that nurses and med aids needed to do a safety check of the physician orders against the single-dose blister pack. LVN A stated that when physician orders change, a change of directions sticker should have been placed on the blister pack or discard that blister pack because this could cause a medication error . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/24 at 10:45 AM, the DON stated that the nurse should have placed a change of direction sticker to prevent a medication error or give the wrong dose to the resident . 2. A record review of Resident #304's admission record, dated 10/16/24 revealed an admitted [DATE] with diagnoses which include type 2 diabetes (a chronic condition that affects how your body regulates blood sugar (glucose) levels), overactive bladder (a condition characterized by involuntary bladder contractions that cause a sudden, intense urge to urinate, often with little or no warning), morbid obesity (a condition characterized by an excessive amount of body fat that significantly increases the risk of serious health problems), Hypertension (a chronic condition where the force of blood against the artery walls is persistently elevated). A record review of Resident #304's physician's orders dated 10/16/2024 revealed the physician prescribed Resident #304 was prescribed Losartan Potassium oral tablet 50 milligrams administer 1 tablet by mouth one time per day. A record review of Resident #304's care plan dated 09/30/2024 revealed, Resident #304 has hypertension HTN, see MAR for medication orders. With interventions which included, Give anti-hypertensive medications as ordered. Monitor for side effects such orthostatic hypotension and increased heart rate (Tachycardia) and effectiveness. Date Initiated: 10/01/2024 During an observation and interview on 10/16/2024 at 09:25 AM, LVN N prepared Resident #304's medication. LVN N poured * pills from a single-dose blister pack that indicated Losartan 50 milligrams give one tablet via gastrostomy tube every 12 hours. LVN N poured the medication without first performing a safety check. LVN N stated she was unaware of the order had changed and stated when a physician order changes a change of directions sticker should have been placed on the single-dose blister pack. During an interview on 10/16/24 at 10:35 AM, LVN A stated that nurses and med aids needed to do a safety check the physician orders against the single-dose blister pack. LVN A stated that when physician orders change, a change of directions sticker should have been placed on the blister pack or discard that blister pack because this could cause a medication error. During an interview on 10/16/24 at 10:45 AM, the DON stated that the nurse should have placed a change of direction sticker to prevent a medication error or give the wrong dose to the resident. A record review of the policy named Medication Administration date implemented on 10/24/22 revealed: Compare medication source (blister pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time.

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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** 26141 Based on observation, record review, and interview, the facility failed to establish and maintain an infection prevention and control program, designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, for four (R#48, R#52, R#26 and R#53) of 24 residents that were reviewed for infection control and transmission-based precautions policies and practices, in that: 1. The facility failed to ensure Resident #48's indwelling catheter drainage bag was not touching the floor when placed behind his wheelchair. 2. The facility failed to ensure LVN M performed hand hygiene for at least 20 seconds before medication administration for Resident #52. 3. LVN M failed to properly clean a multi-use medical device between each resident during medication administration for Resident #26 and Resident #53. These failures could place residents that require assistance with personal care at risk for healthcare associated cross-contamination and infections. The findings were: 1. Record review of Resident #48's Admission Record dated 10/16/24 revealed Resident #48 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a group of symptoms affecting memory, thinking and social skills), obstructive and reflux uropathy (is when your urine can't flow through your ureter, bladder, or urethra due to some type of obstruction), age-related physical debility, muscle weakness, unsteadiness on feet, and muscle wasting and atrophy. Record review of Resident #48's quarterly MDS assessment dated [DATE] revealed: -was sometimes able to make himself understood (ability is limited to making concrete requests) -was sometimes able to understand others (responds adequately to simple, direct communication), - resident required maximum assistance for his ADLs, - did not have indwelling catheter, external catheter, ostomy or intermittent catheterization. Record review of Resident #48's comprehensive care plan initiated on 10/07/24 revealed Resident #48 had 16 Fr with 30ml bulb foley catheter r/t Obstructive Uropathy, with intervention to monitor for s/sx of discomfort on urination and frequency, monitor/document for pain/discomfort due to catheter and monitor/record/report to MD for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. (continued on next page)

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Starr County Nursing and Transitional Care	5260 Brand St Rio Grande City, TX 78582

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #48's physician's order summary dated 10/05/24 revealed monitor for privacy bag placement every shift related to obstructive and reflux uropathy, unspecified. Monitor that collection bag is off the floor and hung below bladder level every shift related to obstructive and reflux uropathy, unspecified. During an observation on 10/16/24 at 9:16 a.m. in the 200 hall, Resident #48 was self-propelling himself up the hall. Surveyor heard a swishing noise and looked down at the back of Resident #48's wheelchair. Resident #48 had the indwelling catheter drainage bag in a black privacy bag. The privacy bag was hung so low on the back of his wheelchair that it was dragging on the floor. Surveyor asked Resident #48 his name and Resident #48 did not respond and just looked at Surveyor and began rocking his wheelchair back and forth. In an interview on 10/16/24 at 9:17 a.m. ADON/LVN D said she was the ADON for the 200 hall. ADON/LVN said it was fine if the privacy bag was dragging on the floor because the catheter bag was in the privacy bag. The ADON/LVN D then bent down and took off the privacy bag, shortened the straps and then rehung the bag so that it was not touching the floor, stood up and then walked away. In an interview on 10/16/24 at 9:23 a.m. CNA E said the foley privacy bag should not be dragging on the floor. CNA E said the reason the foley bag should not be dragging on the floor was because of contamination to the foley. CNA E said they got in-services often on infection control and preventing contamination frequently. CNA E said they had an in-service on foley care last month. In an interview on 10/16/24 at 9:41 a.m. N.A. F said she did transfer Resident #48 to the wheelchair. The N. A. said she put the foley bag on the wheelchair. The N.A. said she did know the bag was not supposed to be dragging on the floor but did not know the reason why it was not supposed to be dragging on the floor. The Nurse Aide said she was still in training. In an interview on 10/16/24 at 4:09 p.m. the DON said the foley privacy bag can touch the floor, but it cannot drag. The CNAs are responsible to place the foley in the privacy bag and to place it on the W/C. The DON said the CNAs get instruction on how to hang the foley bag. The purpose of privacy bag is to give the resident privacy and to protect the foley bag from touching the floor. The foley bag can't touch the floor due to infection control. In an interview on 10/17/24 at 1:50 P.M. LVN G said a foley must not touch the floor. The foley touching the floor would be infection control. Record review of the copy the facility provided of the Lippincott Nursing Procedures 8th edition for Indwelling Urinary Catheter Care and Removal revealed: Implementation Inspect the catheter system for disconnections and leakage, because a sterile, continuously closed system is required to reduce the risk of CAUTI. Don't place the drainage bag on the floor, to reduce the risk of contamination and subsequent CAUTI. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #52's Face Sheet dated 10/15/24 reflected an [AGE] year-old female with an original admitted [DATE]. Her diagnoses included unspecified dementia (decline in cognitive abilities that affects a person's ability to perform everyday activities), Diabetes Mellitus (high levels of glucose in the blood). During an observation of medication administration for Resident #52 on 10/15/24 at 7:30AM, LVN M washed her hands for 16 seconds prior to beginning medication administration and 16 seconds after medication administration was completed. During an interview on 10/16/25 at 08:00AM, CNA K stated that handwashing should be done for at least 20 seconds. CNA K stated that was important to properly wash the hands to prevent contaminate the next Resident. During an interview on 10/16/24 at 09:00AM, LVN M stated handwashing should be done for at least 20 seconds to prevent the spread of germs and infections. LVN A stated by not washing hands for 20 seconds or greater, it could lead to Resident #52's wound becoming infected. LVN M stated staff were in-serviced frequently on hand hygiene and infection control but could not remember when the last in-service was. During an interview on 10/16/24 at 10:20AM, LVN J stated handwashing should be done for at least 20 seconds to prevent the spread of infection. LVN J stated a negative outcome could be a cross contamination from one resident to another resident. During an interview on 10/16/24 at 10:35 AM, LVN A stated that handwashing should be done for at least 20 seconds with soap and water. LVN A stated if handwashing was not done correctly there was a risk of cross contamination. In an interview on 10/16/24 at 11:00AM, the DON stated handwashing should be at least 20 seconds or greater when lathering hands. The DON stated by not washing hands for 20 seconds are greater could increase the chances of spreading germs. The DON stated that a good handwashing needed to be done to prevent contamination from one Resident to another one. Record review of facility's Hand Hygiene policy revised on October 14, 2022, reflected: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Hand Hygiene technique when using soap and water: a. Wet hand with water. Avoid using hot water to prevent drying of skin. b. Apply to hands the amount soap recommended by the manufacturer. c. Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers. d. Rinse hands with water. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Dry thoroughly with a single-use towel. f. Use clean towel to turn off the faucet 3. During a medication administration observation on 10/15/24 at 07:35 AM, LVN M picked up the wrist blood pressure device from the top of the medication cart and took it to the room of Resident #53 and took her blood pressure on the left wrist. She then took the wrist blood pressure device and placed it on top of the medication cart. LVN M did not sanitize the wrist blood pressure device before or after use and then went and used the blood pressure device with Resident #26. During an interview on 10/16/24 at 10:35 AM, LVN A stated she should have disinfected the blood pressure device before and after each use. LVN A stated that the staff used Micro Kill Bleach and that should let it sit for three minutes. She stated a potential negative outcome for failure to sanitize multi-use devices between residents would be the transfer of diseases and infection. During an interview on 10/16/24 at 10:45 AM, LVN J stated that multiple use blood pressure devices should be disinfected before and after each use in between residents. LVN J stated that failure to disinfect the blood pressure device was that all residents are at risk for cross contamination. During an interview on 10/16/24 at 11:11 AM, the DON stated a potential negative outcome for failure to sanitize multi-use devices between residents would be increased risk of infection to residents. Record review of the facility-provided policy titled Infection Prevention and control Program, date implemented 5/13/23, revealed: Equipment protocol: All reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment. 50487