STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676496	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehabilitation & Healthcare of Burleson	275 SE John Jones Drive Burleson, TX 76028

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observation and interview, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for two of eight residents (Residents #42 and #32) reviewed for resident rights. The facility failed to ensure Residents #42 and #32 were kept clean shaven. This failure could place residents at risk of a decreased sense of self-worth. Findings included: Record review of Resident #42's undated Admission Record reflected the resident was a [AGE] year-old female, who was admitted to the facility on [DATE], with diagnoses which included dementia, diabetes, communication deficit, and history of falling. Record review of Resident #42's Quarterly MDS Assessment, dated 08/06/24, reflected the resident's cognition was intact with a BIMS score of 14. The MDS reflected the resident required assistance with her personal hygiene. Record review of Resident #42's care plan, dated 05/29/24, reflected she had an ADL self-care deficit with interventions which included providing shower, shaving, oral care, hair care, and nail care. Observation and interview on 08/20/24 at 10:58 AM revealed Resident #42 had facial hair growth on her upper lip and chin. The hair on her chin was approximately an inch long. The resident stated having facial hair embarrassed her, and she preferred to have it shaved off. The resident stated the last time she was shaved was about two weeks prior. Resident #42 stated she was bathed twice a week, which was when she was usually shaved. Observation on 08/21/24 at 11:30 AM revealed Resident #42 remained unshaven. The resident stated she was bathed the previous afternoon, but they did not shave her. She stated she did not ask to be shaved. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #32's undated Admission Record reflected the resident was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses which included heart failure, dementia, sleep apnea, and diabetes. Record review of Resident #32's Annual MDS Assessment, dated 08/04/24, reflected a BIMS score was not calculated. Her Functional Status assessment indicated she required assistance with her personal hygiene. Record review of Resident #32's care plan, dated 05/06/24, reflected she had an ADL self-care deficit with interventions which included providing shower, shave, oral care, hair care and nail care. Observation and interview on 08/20/24 at 11:10 AM revealed Resident #32 had facial hair on her upper lip and chin. She stated she was embarrassed to have facial hair. The hair on Resident #32's chin was approximately 1/2 an inch long. Resident #32 stated she thought she was shaved the previous week. Interview on 08/22/24 at 1:34 PM with CNA A revealed all residents were shaved as part of their shower or bath process. She stated sometimes the male residents would ask not to be shaved, but the females always said yes when their facial hair was pointed out to them. She stated she did not know personally how long it had been since Residents #32 and #43 were shaved because she worked all over the facility. She stated she would make sure it was done as soon as possible. Record review of the facility's ADL Care policy, dated 02/11/21, reflected: Residents will receive essential services for activities of daily living to maintain good nutrition, grooming, and personal and oral hygiene Bathing includes grooming activities such as shaving and brushing teeth and hair

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental, and psychosocial needs that were identified in the comprehensive assessment for 1 of 5 residents (Resident #4) reviewed for care plans. The facility failed to develop a care plan with measurable objectives and timeframes to address Resident #4's catheter. This failure could place residents at risk of receiving inadequate interventions not individualized to their care needs. Findings included: Record review of Resident #4's MDS, dated [DATE], reflected the resident was a [AGE] year-old female readmitted to the facility on [DATE]. Her diagnoses included heart failure, hypertension (high blood pressure), and diabetes. Resident #4 had a BIMS of 12, which indicated the resident's cognition was moderately impaired. The MDS further reflected the resident had a stage 3 pressure injury and an indwelling catheter. Record review of Resident #4's care plan, initiated on 06/15/24, reflected the resident had a stage 3 pressure ulcer and was at risk for infection, pain, and a decline in functional abilities. Interventions included to provide wound care per physician's order. The care plan did not reflect Resident #4 had a catheter for wound healing. Record review of Resident #4's monthly physician orders for August 2024 reflected she had a Foley catheter 18 French for wound healing with a start date of 07/11/24. Observation and interview on 08/20/24 at 11:32 AM with Resident #4 revealed she was up in her motorized chair. The resident had a catheter and it was draining clear urine. Resident #4 stated the catheter had recently been inserted to help the wound on her bottom heal. Interview on 08/22/24 at 1:21 PM with the MDS Nurse revealed she was responsible for updating resident comprehensive care plans. She said Resident #4's catheter should have been care planned and it must have been missed. The MDS Nurse said it was important to keep care plans up to date so people would know how to care for the residents . Interview on 08/22/24 at 4:04 PM with the DON revealed the MDS nurse was responsible for updating the care plans and nursing should have followed up to make sure they were in place. The DON said risks of not having care plans updated included direct care staff not knowing how to care for the residents. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Comprehensive Care Plans policy, dated February 2021, reflected the following: Policy It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observation and interview, the facility failed to ensure residents who are unable to carry out activities of daily living received the necessary services to maintain good grooming for two of eight residents (Residents #42 and #32) reviewed for resident rights. The facility failed to ensure Residents #42 and #32 were kept clean shaven. This failure could place residents at risk of a decreased sense of self-worth. Findings included: Record review of Resident #42's undated Admission Record reflected the resident was a [AGE] year-old female, who was admitted to the facility on [DATE], with diagnoses which included dementia, diabetes, communication deficit, and history of falling. Record review of Resident #42's Quarterly MDS Assessment, dated 08/06/24, reflected the resident's cognition was intact with a BIMS score of 14. The MDS reflected the resident required assistance with her personal hygiene. Record review of Resident #42's care plan, dated 05/29/24, reflected she had an ADL self-care deficit with interventions which included providing shower, shaving, oral care, hair care, and nail care. Observation and interview on 08/20/24 at 10:58 AM revealed Resident #42 had facial hair growth on her upper lip and chin. The hair on her chin was approximately an inch long. The resident stated having facial hair embarrassed her, and she preferred to have it shaved off. The resident stated the last time she was shaved was about two weeks prior. Resident #42 stated she was bathed twice a week, which was when she was usually shaved. Observation on 08/21/24 at 11:30 AM revealed Resident #42 remained unshaven. The resident stated she was bathed the previous afternoon, but they did not shave her. She stated she did not ask to be shaved. Record review of Resident #32's undated Admission Record reflected the resident was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses which included heart failure, dementia, sleep apnea, and diabetes. Record review of Resident #32's Annual MDS Assessment, dated 08/04/24, reflected a BIMS score was not calculated. Her Functional Status assessment indicated she required assistance with her personal hygiene. Record review of Resident #32's care plan, dated 05/06/24, reflected she had an ADL self-care deficit with interventions which included providing shower, shave, oral care, hair care and nail care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 08/20/24 at 11:10 AM revealed Resident #32 had facial hair on her upper lip and chin. She stated she was embarrassed to have facial hair. The hair on Resident #32's chin was approximately 1/2 an inch long. Resident #32 stated she thought she was shaved the previous week. Interview on 08/22/24 at 1:34 PM with CNA A revealed all residents were shaved as part of their shower or bath process. She stated sometimes the male residents would ask not to be shaved, but the females always said yes when their facial hair was pointed out to them. She stated she did not know personally how long it had been since Residents #32 and #43 were shaved because she worked all over the facility. She stated she would make sure it was done as soon as possible. Record review of the facility's ADL Care policy, dated 02/11/21, reflected: Residents will receive essential services for activities of daily living to maintain good nutrition, grooming, and personal and oral hygiene Bathing includes grooming activities such as shaving and brushing teeth and hair

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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** 43791 Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one of three residents (Resident #6) reviewed for accidents and hazards. NA B failed to follow policy for transferring residents with mechanical lift devices while transferring Resident #6, resulting in him falling. This failure could place residents at risk for falls and injuries. Findings included: Record review of Resident #6's undated Admission Record reflected the resident was admitted to the facility on [DATE] with diagnoses which included emphysema, diabetes, morbid obesity, and heart failure. Record review of Resident #6's annual MDS, dated [DATE], reflected a BIMS score not calculated. His Functional Status Assessment indicated he required maximum assistance with transfers. Record review of Resident #6's care plan, dated 06/21/24, reflected the resident had cognitive impairment, and an ADL self-care deficit with interventions of maximum assistance with all of his ADLs. Record review of Resident #6's EHR reflected the resident's last weight on 08/01/24 was 402 pounds. Observation on 08/20/24 at 2:10 PM of a video on Resident #6's phone revealed a staff member, identified as NA B by the resident, lifting the resident out of his wheelchair using the Hoyer lift device without another staff member present. NA B positioned the lift device beside the bed but appeared to have problems positioning the support legs of the device under the bed. While NA B was repositioning the Hoyer lift, it tilted sideways causing Resident #6 to fall onto his bed, roll off the bed, and end up on the floor on the opposite side of the bed. NA B left the room to call for help and within one minute three additional staff members were present in the room. Resident #6 was eventually put back in bed with the assistance of five staff members and the Hoyer device. Interview on 08/20/24 at 2:01 PM with Resident #6 revealed he had recently had a fall while he was being transferred to bed. He stated NA B had tried to transfer him with the hydraulic lift, and she dropped him. He stated he fell on to the floor but did not suffer any injury. Resident #6 stated CNA B did not have any help to do the transfer, and she tried to do it on her own. Resident #6 stated he had a video of the event from his camera located at the head of his bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/22/24 at 2:12 PM with NA B revealed the nurse told her Resident #6 was ready to go back to bed, and the nurse told her she would be right there to help her. When she entered Resident #6's room, the resident told her he had soiled himself and wanted to get back in bed, so he could be changed. NA B stated she looked for the nurse, but she was busy medicating another resident. NA B stated she opted to go ahead and start the transfer. NA B stated everything was fine until she tried to position the legs of the lift device under the bed. She stated the legs would not fit under the bed and would not spread for stabilization. She stated as she was re-positioning the lift device, it tilted sideways, dumped the resident onto his bed, and then he rolled off the other side of the bed. Interview on 08/22/24 at 3:00 PM with the Administrator revealed it was the policy of the facility to have two staff members present for all mechanical lift transfers. The Administrator stated Resident #6 had shown him the video as well, and it showed NA B violating policy by performing the lift with no assistance. The Administrator suspended NA B immediately and had the DON in-service staff on transferring residents using the Hoyer lift. Record review of the facility's undated Hydraulic Lift (Hoyer Lift) policy reflected the purpose of the policy was: .to enable one individual to lift and move a resident safely, with as little effort as possible. 1. Open lift to widest point and set brakes

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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** 44140 Based on observation, interview and record review, the facility failed to ensure that a resident who needed respiratory care, including tracheostomy care and tracheal suctioning, was provided consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals and preferences for 1 of 6 residents (Resident #101) reviewed for respiratory care. The facility failed to replace Resident #101's oxygen humidifier bottle when it was empty. This deficient practice could place residents at-risk for respiratory infection, and ineffective treatment. Findings include: Record review of Resident #101's face sheet, dated 08/22/24, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #101's significant change in status MDS assessment, dated 08/06/24, reflected a BIMS score of 10, which indicated the cognition was moderately impaired. Her diagnoses included unspecified dementia (loss of cognitive functioning), essential hypertension (high blood pressure), malignant neoplasm of colon (colon cancer) and diabetes. Section O - Special Treatments, Procedures, and Programs indicated the resident received oxygen therapy. Record review of Resident #101's care plan, revised on 07/23/24, reflected: Focus: Resident uses oxygen therapy routinely or as needed and is at risk for ineffective gas exchange. This is related to heart failure. Goal: Resident will have no signs or symptoms of hypoxia (low levels of oxygen) through the next review date. Interventions: Administer oxygen therapy per physician's orders. Record review of Resident #101's physician orders, dated 07/07/24, reflected Change O2 tubing and humidifier bottle every night shift every Sun Ensure that tubing is dated when changed. Observation and interview on 08/20/24 at 10:38 AM revealed Resident #101 was lying in his bed, he stated he was doing well. Resident #101 was observed to be receiving oxygen via nasal cannula. The nasal cannula was dated 08/19/24, the oxygen concentrator was set at 2 liters, the oxygen concentrator humidifier bottle was empty. Resident #101 stated he always received oxygen. Resident #101 could not recall when the last time the water bottle was changed. Resident #101 denied any discomfort or pain. Observation and interview on 08/21/24 at 8:58 AM, revealed Resident #101 lying in bed with his oxygen nasal cannula in place. Resident #101's oxygen water bottle was empty. He denied any discomfort. Observation and interview on 08/21/24 at 2:32 PM, revealed Resident #101 lying in bed with his oxygen nasal cannula in place. Resident #101's oxygen water bottle was empty. He denied any discomfort. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/21/24 at 2:42 PM with LVN I revealed she was the assigned nurse for Resident #101. She stated Resident #101 received oxygen. She stated Resident #101's humidifier bottle should have water. She stated she checked Resident #101's oxygen level this morning (08/21/24) but did not check to see if the humidifier had water. Observed LVN I entered Resident #101 room and stated the humidifier did not have water. LVN I stated the potential risk of the humidifier bottle not having water could lead to sinuses drying out. Interview on 08/22/24 at 1:08 PM with ADON B revealed she was informed by LVN I regarding Resident #101 humidifier bottle being empty. The ADON B stated when staff checked residents' oxygen levels her expectations were for her staff to be checking humidifier bottles and refilling them. She stated it was the responsibility of the charge nurses to ensure it got done and it was her responsibility to follow up. She stated the potential risk of humidifier bottles not having water could lead to the nasal getting dried out. Interview on 08/22/24 at 3:00 PM with the DON revealed her expectations were for her nurses to follow physician orders, give the correct amount, stat checks, change tubing weekly and for humidifier bottle to be changed weekly or has needed. She stated it was the responsibility of the charge nurses, the ADON and herself to ensure it was being done. The potential risk would be dry out nasal passages . Record review of the facility's Respiratory: Oxygen Administration policy, dated 02/10/20, reflected: To describe method for delivering oxygen in order to improve tissue oxygenation, prevent hypoxia, decrease work of breathing and prevent shortness of breath with activity. Preparation of Humidification: 1. Use pre-filled humidifier bottle. Change pre-filled bottle only when empty and label bottles with date and initial.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on observation, interview and record review, the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 26 residents (Resident #92) reviewed for storage of medication. The facility failed to ensure Resident #92 did not have Dulcolax Docusate Sodium 100 mg/Stool Softener Laxative stool softener stimulant-free stored at the resident's bedside table. This failure could place residents at risk of accessing medications not prescribed to them and overdosing. Findings included: Record review of Resident #92's face sheet, dated 08/22/24, reflected the resident was a [AGE] year-old male with an admitted [DATE] and original admitted [DATE]. Resident #1 had diagnoses which included Type 2 diabetes mellitus, (an impairment in the way the body regulates and uses sugar) cerebral infarction, (stroke), hemiplegia and hemiparesis following a cerebral infarction, (one-sided muscle weakness and paralysis) and depression. Record review of Resident #92's Quarterly MDS Assessment, dated 04/12/24, reflected a BIMS score of 12, which indicated moderate cognitive impairment. Record review of Resident #92's care plan, dated 08/22/24 did not reflect anything regarding ability to self-administer medications. Record review of Resident #92's physician order, dated 08/12/23, reflected he had an order for Docusate Sodium Oral Tablet 100 mg (Docusate Sodium). Directions stated, Give one tablet by mouth two times per day. Observation and interview on 08/20/24 at 12:39 PM with Resident #92 revealed the Resident's family member brought him Dulcolax Docusate Sodium (USP) 100 mg/Stool Softener Laxative stool softener stimulant-free when he told her he was going to have a colonoscopy. He stated he had taken two tablets as well as the [NAME] that was prescribed to him the day before the colonoscopy. Resident #92 also said he was having another colonoscopy soon, and he thought he would need it then as well. Resident had the medication bedside from 07/22/24 to 08/22/24. Resident did not state that he had informed staff he had the stool softener bedside. Observation on 08/21/24 at 3:58 PM revealed the Dulcolax Docusate Sodium (USP) 100 mg/Stool Softener Laxative stool softener stimulant-free was located at the bedside in the same location as the previous day on 08/20/24. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 08/22/24 at 10:01 AM revealed the Dulcolax Docusate Sodium (USP) 100 mg/Stool Softener Laxative stool softener stimulant-free was located at the bedside in the same location as the first observed on 08/20/24. Staff was notified and questioned about the medication on 08/22/24 by surveyor. The staff removed the medication and placed it in the med room. The staff did not open the package in front of the surveyor. And the surveyor did not open the package to observe its contents. Interview on 08/22/24 at 10:14 AM revealed CNA C had not observed the Dulcolax Docusate Sodium (USP) 100 mg/Stool Softener Laxative stool softener stimulant-free stored at Resident #92's bedside table during the observation period of 08/20/24-08/22/24. CNA C stated she had not noticed it sitting beside the resident. CNA C stated prescribed medications and over the counter medications were not supposed to be at the bedside or accessible to residents per the facility policy. CNA C also stated the facility policy also reflected if CNAs observed medications at the bedside, they were supposed to notify their charge nurse. CNA C also revealed it was the nurse's responsibility to ensure medications were not at bedsides. CNA C concluded by stating residents could overdose leading to death if medications were left out unsupervised for residents to easily access. CNA C did not remember the last time she was in-serviced on the topic of self-administered medications. Records revealed the aides and nurses work 8- hour shifts Monday through Friday. And, the same staff were present during the days of the survey for Resident #92's hall. Interview on 08/22/24 at 10:24 AM with LVN F revealed she was passing medications to residents on Resident's 92's hall since 2023. LVN F stated she had not observed the over-the-counter medication at the bedside in Resident #92's room. LVN F also revealed she did not know the facility policy of prescribed medications or over the counter medication at the bedside. LVN F stated residents probably should not have any type of medication at the bedside without an order. LVN F said when the residents had items without orders, she should report it to the charge nurse. LVN F revealed it was everyone's responsibility to ensure medications were not at the bedside because there was a risk that someone could wander in and take the medication which could in harm to a resident. LVN F also revealed she would notify the charge nurse if she found any type of medication at a resident's bedside. LVN F concluded by stating she didn't remember when she was last in-serviced on medications at the bedside. Interview on 08/22/24 at 10:27 AM with LVN G revealed he was the Monday through Friday 6:00 AM-2:00 PM charge nurse. LVN G stated he had not observed the medication at the bedside. LVN G said if he had seen the medication, he would have removed the medication. LVN G said the family must have brought the medication without consent. LVN G stated if family brought medication, they were supposed to give it to the nurse. LVN G revealed if he found medication at the bedside, he would report it to the ADON and the DON. LVN G stated the procedure reflected he should document any medications found. LVN G said the risk to the resident when medication was found at the bedside depended on the medication. He stated (USP) 100 mg/Stool Softener Laxative stool softener stimulant-free could lead to diarrhea and then lead to many things depending on the resident. LVN G said he didn't remember when he was last in-serviced on medications at the bedside. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehabilitation & Healthcare of Burleson	275 SE John Jones Drive Burleson, TX 76028

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/22/24 at 10:35 AM with ADON A revealed Resident #92 had a colonoscopy recently. ADON A stated the facility's policy stated residents were not supposed to have medications at the bedside. ADON A said if medications were brought to the facility, they were supposed to be given to the charge nurse. ADON A stated if the charge nurse found medications in the resident's room, the nurse should notify the family, call the doctor, and get an order for the mediation if the resident needed the medication. ADON A said the risk to residents having access to unsecured medications was there was a risk of overmedication and the medication not being compatible with their other medications. ADON A revealed the facility had not in-serviced on medications in residents' room. ADON A also stated she was notified about a medication being found at a resident's bedside. ADON A stated Resident #92 should not have a medication at the bedside; she educated the charge nurse and physician. Interview on 08/22/24 at 10:53 AM with the DON revealed she had been the DON since April 2024. The DON stated if a resident wanted to have a medication at the bedside, the facility must perform a self-administration assessment. The DON said since this was not done on Resident #92, they would remove the medication and notify the doctor. The DON stated the facility would contact the family and explain medications must be turned into the nurses' station if they thought the family member needed additional medication. The DON stated the nurse would now complete an assessment and notify the physician and the responsible party. The charge nurse would also educate the resident if he had a medical issue to notify the nurse, so they could get an order for a needed medication. The DON revealed it was any staff member's responsibility who walked in and looked at the bedside and saw medications, to notify the charge nurse. The DON continued by stating the risk to the resident in this case was it was unknown how much was taken, so it could affect the electrolytes as well as the patient getting diarrhea which could cause a change in condition. The DON said they would count how many were in the bottle and attempt to determine how many pills were missing. The DON finished by stating she didn't remember in-servicing on this topic, but she would do one today. Record review of the facility's Medication Storage Policy, dated 01/20/21, reflected, .All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medications rooms) under proper temperature controls

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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. 48236 Based on observation, interview and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen reviewed for food and nutrition services. The facility failed to ensure the griddle was kept clean and free from build-up of grease and food crumbs. This failure could place residents at risk of food borne illnesses and cross contamination. Findings included: Observation on 08/20/24 at 9:03 AM revealed the grill had a significant grease build-up (approximately .25 inches towards the back half of it) and crumbs of food on it. Interview on 8/21/24 at 11:49 AM with the [NAME] revealed she used the griddle on Monday, 8/19/24, during the breakfast shift. The [NAME] stated she was the last person to use the grill and it had not been used since then. The [NAME] revealed the facility policy stated the grill should be cleaned then scrubbed with degreaser every time it was used. The [NAME] said she did not get a chance to clean the grill since after she used it. The [NAME] stated it was the cook's responsibility to clean the grill after it was used. The [NAME] revealed the risk to the residents was cross contamination because residents could easily become sick due to their weakened immune systems. Interview on 8/21/24 at 12:17 PM with the Dietary Manager revealed she recalled the grill last being used on Monday, 8/19/24. The Dietary Manager stated the [NAME] did not clean the griddle because there was only one packet of degreaser. The Dietary Manager stated the ideal situation was that two packets were used to thoroughly clean the griddle. The Dietary Manager stated other products could have been utilized to clean the griddle if one packet of degreaser did not finish cleaning the griddle completely. The dietary manager stated that the degreaser would be delivered on the next truck and did not state how often it is ordered. The Dietary Manager revealed the facility policy stated to clean the griddle after every shift. The Dietary Manager concluded by stating if the griddle was not cleaned, then cross contamination could occur which could lead to sickness. Record review of the Federal Drug Administration Food Code, dated 2017, section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils reflected the following: .(A) equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris A record review of the facility's Dietary Policy and Procedure Manual policy titled Equipment Cleaning Procedures revised date 05/2018 reflected, Equipment and items that are used in food preparation should be cleaned and sanitized after each use

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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** 44140 Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of three residents (Residents #43) reviewed for infection control. RN H failed to don a gown before providing bolus feeding to Resident #43, who was on Enhanced Barrier Precautions. This failure could place residents at risk of contracting an infection from residents on Enhanced Barrier Precautions and cross contamination, which could result in infections or illness. Findings include: Record review of Resident #43's face sheet, dated 08/22/24, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #43's quarterly MDS assessment, dated 07/26/24, reflected his diagnoses included Parkinsonism (brain conditions that cause slowed movements), aphasia (language disorder) following other cerebrovascular disease (brain injury), gastrostomy status and feeding difficulties. Resident #43's BIMS score was not completed due to the resident being rarely/never understood. The MDS reflected the resident had a feeding tube. Record review of Resident #43's care plan, revised on 04/04/24, reflected: Focus: The resident requires Enhanced Barrier Precautions d/t Feeding tube. Goal: The resident will remain free from active infection with MDROs through the review date. Interventions: Educate the resident and family on the reason and procedure for enhanced barrier precautions. Ensure PPE is available for use on the resident. Wear gown and gloves during high-contact resident care activities. Record review of Resident #43's physician order, dated 08/21/24 , reflected every 4 hours related to Dysphagia, Oropharyngeal Phase. Intermittent Gravity (Bolus) Enteral Feeding: Formula Jevity 1.2 Amount: 237 ml Frequency 6x/day Total ml/24 hours 1422 ml/day. Observation on 08/22/24 at 11:52 AM revealed RN H preparing to provide Resident #43's bolus feeding. Resident #43 had a sign on the door which stated EBP and had a bin of PPE hanging on the door. RN H conducted appropriate hand hygiene and then proceeded to don gloves. RN H failed to don a gown. RN H checked for residual and placement. Bolus feeding was not provided due to residual. Interview on 08/22/24 at 12:22 PM with RN H revealed she was the nurse assigned to Resident #43. RN H stated any resident who had a catheter, or wound were on Enhanced Barrier Precautions and staff were required to don PPE when providing care. She stated the reason why Resident #43 was on EBP was due to resident's g-tube. RN H stated since she had been a nurse for more than [AGE] years and was very careful, and she did not need to don a gown. RN H stated she would don PPE when she would help change the resident. RN H stated she had never had any accidents when providing Resident #43's bolus feedings. She stated the potential risk of not donning PPE would be infection control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/22/24 at 1:06 PM with ADON B revealed she was the ADON assigned to Resident #43 and was the infection preventionist. She stated residents who were on Enhanced Barrier Precautions had signs on the doors to indicate the resident was on Enhanced Barrier Precautions. ADON B stated resident who were on EBP were resident who had dialysis, Foley catheter, PICC-lines and g-tubes. She stated staff should don PPE when providing care. The ADON B stated when providing bolus feedings nurses should don PPE which includes gown and gloves. She stated the potential risk would be spread of infection. Interview on 08/22/24 at 3:03 PM with the DON revealed EBP applied to residents with skin issues, wounds, catheter, and g-tubes. The DON stated her expectations were for staff to follow facility policy on EBP regardless of the years of experience. The DON stated residents who were on EBP had signs on the doors to indicate they were on EBP. She stated the potential risk would be infection control. Record review of the facility's Infection Prevention and Control Program policy, revised on 03/26/24, reflected: .6. Enhanced Barrier Precaution EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provided opportunities for transfer of MDRO's to staff hands and clothing. EBP are indicated for residents with any of the following: a. Infection or colonization with an MDRO when Contact Precautions do not otherwise apply. b. Wounds and/or indwelling medical devices (e.g., central lines, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on interview and record review, the facility failed to establish an antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use for the facility. The facility failed to have sufficient justification for antibiotic use when Resident #57 was prescribed antibiotic treatment for UTI on 11/11/23 and it was not discontinued. This failure placed the resident at risk for unnecessary antibiotic medication and increased risk of multi-drug resistant organism (MDRO) infections. Findings included: Review of Resident #57's MDS, dated [DATE], reflected the resident was a [AGE] year-old female was admitted to the facility on [DATE]. Her diagnoses included coronary artery disease (when coronary arteries struggle to supply the heart with enough blood), hypertension, end-stage renal disease, stroke, and non-Alzheimer's dementia. Resident #57 had a BIMS of 8, which indicated her (cognition severely impaired.) Resident #57 was usually understood. The MDS further reflected the resident was taking antibiotics. Review of Resident #57's care plan, initiated on 04/20/24, reflected the resident was incontinent of bowel/bladder related to dementia and had a history of UTI. Review of Resident #57's monthly physician orders for August 2024 reflected she was on the antibiotic Cefdinir Oral Capsule 300 MG ; Give 1 capsule by mouth two times a day for UTI prevention with a start date of 11/11/23. Review of Resident #57's progress notes, dated 11/11/23, reflected the resident was started on the antibiotic Cefdinir 300 MG PO BID X 7 days due to family concern of increased confusion and strong urine odor. The antibiotic was provided by the Hospice company. Review of Resident #57's original order, created by RN A, for Cefdinir, dated 11/11/23, reflected the following: Ordered by: [Physician] Medication: Cefdinir Oral Capsule 300 MG Frequency: two times a day Schedule Type: Everyday For(Indications for Use): UTI Prevention Start Date: 11/11/23 (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	End Date: Indefinite Interview on 08/22/24 at 12:27 PM with the Hospice Nurse revealed she began working with Resident #57 March 2024, and she noticed the resident was on antibiotics, Cefdinir. The Hospice Nurse said the hospice company did not prescribe antibiotics to be taken daily as a UTI preventative and they only treated active UTI's with a round of antibiotics. She said the order would have come from Resident #1's primary care physician. The Hospice Nurse further stated she had talked to the resident's family about the ongoing use of antibiotics and educated them on the risks, and the family told her they wanted to keep Resident #57 on the antibiotics because the resident had a history of reoccurring UTI's. Interview on 08/22/24 at 3:01 PM with ADON B revealed she began working at the facility in January 2024, and Resident #57 was already on the antibiotic daily. ADON B said it was her understanding the antibiotic was prescribed by the hospice company as a prophylactic because the resident had reoccurring UTI's. ADON B further stated she was not aware Resident #57's primary physician or the hospice denied prescribing antibiotic to be taken daily as a preventative. She said there appeared to have been a lack of communication . Interview on 08/22/24 at 2:57 PM with the DON revealed she began working at the facility in March, 2024, and Resident #57 was already on the antibiotic daily. The DON said she did not question the order because she was told by ADON B the resident was on the antibiotic as a prophylactic for UTI's. The DON said risks of residents being on antibiotics long term could cause them to become resistant to the medication. Interview on 08/22/24 at 2:29 PM with Resident #57's Physician revealed Cefdinir and that amount was not normally an antibiotic that was prescribed as a prophylactic and denied prescribing that medication to be used long term. The Physician said she was under the impression the antibiotic was prescribed by the hospice company because they usually handled all resident medications when they were put on hospice services. The Physician further stated risks of being on that much antibiotics could cause the resident to become resistant to that medication . Review of the facility's Antibiotic Stewardship Program policy, revised June 2020, reflected the following: Purpose To limit antibiotic resistance in the post-acute care setting, improve treatment efficacy and resident safety, and reduce treatment-related costs. Policy The Antibiotic Stewardship Program (ASP) is designed to promote appropriate use antibiotics while optimizing the treatment of infections, and simultaneously reducing the possible adverse events associated with antibiotic use