| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 745005 | A. Building<br>B. Wing | 07/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Center at Zaragoza, LLC | 12660 Pebble Hills Blvd.<br>El Paso, TX 79938 |

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 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the resident resided and received services in the facility with reasonable accommodation of resident needs and preferences for 3 (Resident # 3, Resident # 38, Resident # 104) of 12 residents reviewed for accommodation of needs.<br><br>The facility failed to ensure Residents 3, 38 and 104, had their call lights within reach.<br><br>These failures could place residents at risk for not having their needs/preferences met.<br><br>Findings included:<br><br>Resident #3<br><br>Record review of Resident #3's Face sheet dated 6/17/25 revealed an [AGE] year-old female with an initial admission date of 8/8/24 and a readmission date of 4/18/25.<br><br>Record review of Resident #3's health and physical dated 8/26/24 revealed an [AGE] year-old female with a diagnoses of generalized muscle weakness, lack of coordination, abnormalities of gait and mobility, unspecified gout (a painful and common form of inflammatory arthritis), and age-related physical debility.<br><br>Record review of Resident #3's admission MDS dated [DATE] revealed a BIMS score of 14 indicating the resident was cognitively intact. It indicated in the active diagnoses section I, that Resident # 3 had triggered the care area for arthritis. MDS revealed under section GG for Functional abilities that Resident # 3 had limited range of motion with impairment on both sides of upper extremities, was dependent for toileting hygiene, lower body dressing and to putting on and taking off footwear and required substantial assistance with showering and upper body dressing. The MDS revealed Resident # 3 was dependent on staff for rolling on her bed to both sides and required substantial assistance for sitting to lying and lying to siting positions, and from siting to standing.<br><br>Record review of Resident #3's care plan dated 4/18/25 called for interventions that included making sure the residents' call light was within reach and encouraging the resident to use it for assistance as needed.<br><br>Resident #38<br><br>(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 |
|---|---|---|

| 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 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #38's face sheet dated 06/19/25 revealed a [AGE] year-old male with initial admission [DATE] and readmission date 05/24/25.<br><br>Record review of Resident #38's health and physical dated 06/18/25 revealed a medical diagnoses of dysphagia (difficulty swallowing), Cerebrovascular accident (Stroke), memory and attention deficit, delirium (a specific state of acute confusion attributable to the direct physiological consequence of a medical condition, effects of a psychoactive substance, or multiple causes), malnutrition, lack of coordination, and impaired mobility.<br><br>Record review of Resident #38's significant change of status MDS dated [DATE] revealed a BIMS score of 2, indicating severe cognitive status. In Section GG-Functional Abilities revealed Resident #38 was dependent for all self-care abilities, meaning the helper does all of the effort, and the resident does none of the effort to complete the activity.<br><br>Record review of Resident #38's care plan revealed resident was to be monitored for fall risk.<br><br>In an observation and interview on 06/17/25 at 2:21 PM with Resident #38 was in his wheelchair and the call light was observed on the resident's bed frame on the opposite side where resident was. CNA G stated Resident #38 was unable to move by himself in his wheelchair and the call light was out of the resident's reach. She stated the risk of Resident #38 not having his call light within reach included injury or a fall.<br><br>In an interview on 06/19/25 at 11:30 AM with RN H, she stated the purpose of the call light was for residents to request assistance from staff. She stated the call light was to be located within the resident's reach, whether the resident was in their bed or wheelchair. RN H stated nursing staff were responsible for monitoring call light placement. RN H stated nursing staff round on residents every 2 hours and the ADON rounds on residents' multiple times throughout their shift. RN H stated the risks of a call light being out of residents' reach included a fall or not having needs met.<br><br>In an interview on 06/19/25 at 11:55 AM with CNA E revealed residents use call lights to communicate or request attention from staff. CNA E stated call lights were to be within the resident's reach and the risks of call lights not being in reach included injury or not having needs met. She stated that the nurses and CNA's were responsible for monitoring call lights. She stated the administration and supervisors also rounded on residents daily and included call light placement.<br><br>In an interview on 06/19/25 at 12:29 PM with the ADON, she stated residents use their call light to request assistance from staff. She stated the call light was to be within the residents' reach. She stated every staff member was responsible for ensuring the call light was within residents' reach. The ADON stated nursing staff round on residents every 2 hours including call light placement. She stated the risks of call lights being out of reach included injury or a fall.<br><br>Resident #104<br><br>Record review of Resident #104's Face sheet dated 6/17/25 revealed a [AGE] year-old male with an admission date of 5/23/25.<br><br>(continued on next page) |

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|---|---|
| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #104's health and physical dated 4/30/25 revealed [AGE] year-old male with a diagnoses of abnormalities of gait and mobility, muscle wasting and atrophy (refers to the decrease in size and mass of muscle tissue), lack of coordination and generalized muscle weakness.<br><br>Record review of Resident #104's admission MDS dated [DATE] revealed a BIMS score of 14 indicating the resident was cognitively intact. The MDS indicated under section GG for functional abilities that Resident # 104 had limited range of motion with impairment to both sides on lower extremities. Resident # 104 was dependent on staff for eating, oral hygiene, toileting hygiene, shower and lower body dressing. Resident # 104 depended on personnel for rolling to both sides while on bed, sit to lying and lying to sitting on side of the bed, sit to stand, transferring from bed to wheelchair and toilet transfer.<br><br>Record review of Resident #104's care plan dated 5/23/25 revealed Resident # 104 was at fall risk related to impaired mobility secondary to weakness and debility. The care plan indicated interventions by always keeping the call light within reach, to post signs on the residents' room with call don't fall to remind the resident to call for assistance.<br><br>In an observation and interview on 06/17/25 at 10:17 AM, the resident #104 was lying in bed and greeted the surveyor. The call light was on the floor to the resident's right side and about three feet away from the bed. The resident stated he had not realized the call light had fallen to the floor and attempted to look at it, and stated he could not see it. The resident said that whenever the call light fell to the floor, he needed to wait until a staff member made rounds and went into his room and then he would request assistance if needed. The resident said if there was an emergency and the call light was not within reach; he would need to wait until a staff member went to check on him or he would try to shout for help and hope someone heard him. The resident said he was not able to get on his feet.<br><br>In an observation and interview on 06/17/25 at 10:43 AM, resident #3 was sitting on her bed watching TV. The call light was observed on the floor near the back wall towards the head of the bed and out of the residents' reach. The resident stated that she needed assistance to get out of bed and to transfer to her wheelchair. The resident said she could not reach her call bell and was not able to see it. The resident stated that staff checked on her every hour and a half or up to two hours and said she would have to wait that amount of time if there was an emergency and she could not reach her call bell to ask for help.<br><br>In an observation and interview on 06/17/25 at 2:21 PM with Resident #38 was in his wheelchair and the call light was observed on the resident's bed frame on the opposite side where resident was. CNA G stated Resident #38 was unable to move by himself in his wheelchair and the call light was out of the resident's reach. She stated the risk of Resident #38 not having his call light within reach included injury or a fall.<br><br>In an interview on 06/18/25 at 01:46 PM with CNA A, stated the purpose of a call light was for the residents to call for assistance if they needed something. CNA A said the call light needed to be within a resident's reach and if it was not accessible for a resident, there was a risk of them trying to get up to look for it which could pose a fall risk in those residents who had been diagnosed for high fall risk, and for the residents not to get the help they needed on time. CNA A stated that staff made rounds every two hours to check on residents and to ensure the call lights were accessible for them.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 06/18/25 at 02:07 PM with LVN B, stated the residents needed to have access to a call light and it had to always be within reach. LVN B explained if a resident was not able to reach for their call light, it could potentially result in them not being helped in a timely manner which could result in several issues such as leaving a resident soiled or not responding to a serious emergency.<br><br>In an interview on 06/18/25 at 03:05 PM with the DON, she stated the purpose of a call light was for residents to request assistance if they needed help. The DON said a call light needed to be within reach of all residents either clipped to the bed sheets near the residents' hand or on top of the bed if it was a touch pad with the call lights. The DON explained the risk of not having a call light within reach could result in accidents such as falls if they required assistance and a resident attempted to get up on their own and they were not able to transfer themselves. The DON stated all staff were responsible for checking on the residents while in their rooms to make sure they had their call light within reach.<br><br>In an interview on 06/19/25 at 11:30 AM with RN H, she stated the purpose of the call light was for residents to request assistance from staff. She stated the call light was to be located within the resident's reach, whether the resident was in their bed or wheelchair. RN H stated nursing staff were responsible for monitoring call light placement. RN H stated nursing staff round on residents every 2 hours and the ADON rounds on residents' multiple times throughout their shift. RN H stated the risks of a call light being out of residents' reach included a fall or not having needs met.<br><br>In an interview on 06/19/25 at 11:42 AM with the Administrator, she stated call lights were used by the residents so they could call the staff if they need assistance with something. The Administrator said the call light needs to be within reach of the residents and the potential risk if a call light was not within reach, was that a resident could not ask for help if they needed assistance with something or if there was an emergency and they needed help. The Administrator explained that staff such as CNAs, LVNs and RNs had to make rounds ensuring the call lights were always within reach of the residents.<br><br>In an interview on 06/19/25 at 11:55 AM with CNA E revealed residents use call lights to communicate or request attention from staff. CNA E stated call lights were to be within the resident's reach and the risks of call lights not being in reach included injury or not having needs met. She stated that the nurses and CNA's were responsible for monitoring call lights. She stated the administration and supervisors also rounded on residents daily and included call light placement.<br><br>In an interview on 06/19/25 at 12:29 PM with the ADON, she stated residents use their call light to request assistance from staff. She stated the call light was to be within the residents' reach. She stated every staff member was responsible for ensuring the call light was within residents' reach. The ADON stated nursing staff round on residents every 2 hours including call light placement. She stated the risks of call lights being out of reach included injury or a fall.<br><br>Record review of the facility's Policy, not dated, titled: Call light policy, stated in part: When the resident is in bed or confined to a chair, be sure the call light is within easy reach to the resident. |

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|---|---|
| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide ADL care for 2 of 16 residents (Resident # 152 and #206) reviewed for ADLs.<br><br>The facility failed to ensure Resident #152 and #206's fingernails were clean and free from debris.<br><br>This failure could place residents who required assistance with ADL's at risk for unmet care needs.<br><br>Findings included:<br><br>Resident # 206<br><br>Record review of Resident #206's face sheet dated 06/19/25 revealed resident was an [AGE] year-old female with an initial admission date 05/21/25.<br><br>Record review of Resident #206's health and physical dated revealed medical diagnosesis of Diabetes Mellitus, hypertension (high blood pressure), anxiety, depression, and Alzheimer's disease (a neurodegenerative disease affecting memory and ability to perform activities of daily living).<br><br>Record review of Resident #206's admission MDS dated [DATE] revealed a BIMS score of 0 indicating severe cognitive impairment. Section GG-Functional Abilities notated Resident #206 required substantial/maximal assistance and was dependent, meaning the helper does more than half or all the effort to complete activities.<br><br>Record review of Resident #206 care plan revealed resident had an actual/potential decline in resident's ability to perform her activities of daily living and called for staff to provide assistance as needed with grooming, bathing, and personal hygiene.<br><br>In an observation 06/17/25 at 10:19 AM revealed Resident #206 had dirty fingernails, with black debri under fingernails on both hands.<br><br>In an interview on 06/19/25 at 12:32 PM with the ADON revealed nursing staff were responsible for monitoring resident's nails. She stated CNA's were to clean the residents' fingernails and nurses were to file or cut them. She stated the risks of not maintaining clean, groomed nails were injuries such as cuts on the skin, or an infection control issue.<br><br>In an interview on 06/19/25 at 01:42 PM with the DON, she stated the facility provided grooming services including fingernail cleanliness and trimming. She stated the nursing staff such as CNA's and the nurses were to cut and clean the nails. The DON stated no one monitors to ensure this service was provided. The DON stated the risks of untrimmed and dirty nails including an infection control issue.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 06/19/25 at 2:05 PM with the Administrator revealed that the facility provided fingernail trimming and cleaning services to residents. She stated that if residents were diabetic, nurses were to provide nail care and if not diabetic, then all staff could provide nail care. She stated that the nurse was responsible for monitoring residents' fingernails. She stated that she believes nail care was reviewed under ADL training upon hire and annually. She stated that the risk of residents having long dirty fingernails would be that if residents put fingers to mouth while eating something it could have led to infection.<br><br>Resident #152<br><br>Record Review of Resident # 152's admission Record dated 06/19/25 revealed a [AGE] year-old male with an original admission date of 11/29/2022 and a readmission date of 05/20/2025.<br><br>Record Review of Resident # 152's History and Physical dated 06/18/25 revealed medical diagnoses of Dementia (a neurodegenerative disease a group of symptoms affecting memory, thinking and social abilities), muscle weakness, type 2 Diabetes, depression, and anxiety.<br><br>Record Review of Resident #152's admission MDS dated [DATE] revealed a BIMS score of 04 indicating severe cognitive impairment. Section GG-Functional Abilities notated Resident #152 required substantial/maximal assistance with personal hygiene, meaning the helper does all the effort while the resident does none of the effort to complete the activity.<br><br>Record Review of Resident #152's Care Plan revealed the resident was diagnosed with depression and called for staff to monitor for signs or symptoms of depression.<br><br>In an observation and interview on 06/17/25 at 9:37 AM in residents room, it was revealed Resident #152 had long dirty fingernails for both hands. He stated that he would have liked his fingernails to be cleaned and cut.<br><br>In an interview on 06/19/25 at 2:05 PM with the Administrator revealed that the facility provided fingernail trimming and cleaning services to residents. She stated that if residents were diabetic, nurses were to provide nail care and if not diabetic, then all staff could provide nail care. She stated that the nurse was responsible for monitoring residents' fingernails. She stated that she believes nail care was reviewed under ADL training upon hire and annually. She stated that the risk of residents having long dirty fingernails would be that if residents put fingers to mouth while eating something it could have led to infection.<br><br>Review of facility policy titled ADL Services dated 02/01/16 read in part Patients shall receive assistance with activities of daily living (ADLs) every shift, as appropriate including grooming. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice for 1 (Resident #108) of 9 residents observed for oxygen management.<br><br>The facility failed to post an Oxygen sign indicating Resident # 108 received oxygen.<br><br>This failure could place residents on oxygen therapy at risk of receiving incorrect or inadequate oxygen support and decline in health and at risk of fire hazards by not posting oxygen signs outside the residents' rooms.<br><br>Findings Include:<br><br>Record review of Resident #108's Face sheet dated 6/18/25 revealed a [AGE] year-old female with an admission date of 6/3/25.<br><br>Record review of Resident #108's admission MDS dated [DATE] revealed BIMS score of 13 indicating the resident was cognitively intact. The MDS revealed the resident was dependent on staff for toileting and personal hygiene, and required maximal assistance with showering, upper and lower body dressing and putting on or taking off footwear. Section I for active diagnosis in the MDS revealed Resident # 108 had asthma, chronic obstructive pulmonary disease, or chronic lung disease. Section J for health conditions revealed the resident had shortness of breath or trouble breathing with exertion and while lying flat. Section O for special treatment, procedures and programs revealed the resident was receiving oxygen therapy.<br><br>Record review of Resident #108's care plan dated 6/18/25 revealed the resident used supplemental oxygen related to poor oxygen absorption and called for intervention to monitor for respiratory distress and to report to physician respirations, oximetry, increased heart rate, restlessness and headaches. The care plan stated Resident #108 had oxygen via nasal prongs at two liters continuously.<br><br>In an observation and interview on 06/18/25 at 10:31 AM, the resident was in her room lying on her bed. She was wearing a nasal canula and was receiving oxygen. The resident stated she was in oxygen therapy, and she used her oxygen while she was inside her room. There was no oxygen sign posted outside the residents' room.<br><br>In an interview on 06/18/25 at 01:46 PM with CNA A, she stated that when a resident was receiving oxygen in their room, an oxygen sign had to be posted by the door. This sign served to alert other staff to check oxygen levels and to warn visitors or anyone entering the facility about the potential fire hazard. She explained that failing to post a sign could lead to hazards and accidents for residents.<br><br>In an interview on 06/18/25 at 02:07 PM with LVN B, she explained one of the reasons for posting an oxygen sign outside the resident's rooms was to alert anyone who went into the facility there was oxygen in use inside the room and to avoid potential fire hazards. LVN B stated the potential negative outcome for not posting an oxygen sign could result in fire hazards of residents not being checked for oxygen levels.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 06/18/25 at 03:05 PM with the DON, she stated all rooms who had oxygen in use inside in the facility were required to have an oxygen in use sign posted outside the door. The DON explained that a potential outcome for not posting a warning sign for oxygen in use outside a residents' room was that a resident could go without oxygen, and that a fire hazard and potential explosion existed. She also noted that ADONs were responsible for checking upstairs for oxygen signs, and it was an expectation for CNAs or LVNs to report to her or the administrator if they noted a room was missing an oxygen sign.<br><br>In an interview on 06/19/25 at 11:42 AM with the Administrator, she expressed that oxygen signs were posted to notify staff and visitors of oxygen use in a room or by a resident. The administrator highlighted that there was a fire hazard if oxygen was in use without a sign posted outside the rooms and someone went in there and lit a spark. The Administrator stated there could also be a risk if a resident went unchecked for oxygen levels and they were in oxygen therapy.<br><br>In an interview with the Administrator and the DON on 6/19/25 at 3:51 PM, it was revealed that the facility did not have a policy stating oxygen signs needed to be posted outside the rooms of those residents who received oxygen. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview 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 one (Resident #213) of 10 residents reviewed for medications.<br><br>The facility failed to administer Megestrol Acetate for Resident #213 per physician's order for 2 days.<br><br>This failure could place the residents at risk of not receiving therapeutic doses of their medication.<br><br>Findings included:<br><br>Record review of Resident #216's face sheet dated 06/19/25 revealed resident was [AGE] year-old female with admission date 05/01/25 and her medical diagnoses: Nontraumatic intracerebral hemorrhage (type of stroke characterized by sudden bleeding into the brain tissue), Hemiplegia (paralysis that affects only one side of your body), Generalized Anxiety Disorder, muscle weakness, unspecified protein-calorie malnutrition, and Anorexia (treatable eating disorder in which people have a low body weight based on personal weight history).<br><br>Record review of Resident #216's admission MDS dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 14 indicating resident was cognitively intact.<br><br>Record review of Resident #216's health and physical dated 04/30/25 revealed active medication list included Megestrol Acetate, medication used to treat loss of appetite, by mouth daily.<br><br>Record review of Resident #216's Medication Administration Record dated 05/01/2025 revealed Megestrol Acetate was not administered per physician order on 05/03/25, 05/04/25 and 05/05/25 .<br><br>Record review of Resident #216's progress notes revealed no documented rationale for not administering medication per physician's order.<br><br>In an interview on 6/19/2025 at 5:00 pm with RN F revealed that medication aids are the ones who administer most medications. She stated that when residents refuse medications or medications were not administered as per doctors orders, the med aide had to let the nurse know, the nurse would then go to resident and attempt to prompt them to take medication. If that did not work, then the refusal would have to be documented in a progress note and it would be reported to the doctor and to the ADON or DON. RN F stated nurses were responsible for monitoring medications aides administered medications or that medications were administered per physician's orders.<br><br>(continued on next page) |

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| | 745005 | A. Building<br>B. Wing | 07/08/2025 |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 6/19/2025 at 5:20pm with LVN B revealed that med aides administer the majority of medications. She stated that when there was a medication refusal, the medication aide was to let nurse know and then nurse would go prompt the resident to take the medication, if that did not work, then it would have been documented in a progress note and on the Medication Administration Record. She stated that the doctor would have been notified and the DON as well. She stated that documentation was nursing judgment, and she could not recall the last time there was training provided.<br><br>In an interview on 06/19/2025 at 5:30 pm with the DON revealed that nursing staff was trained to document any medication refusals. She stated that medication aides have to let the nurse know when residents were refusing medications or not receiving medications as per physician's orders. She stated that the nurses would follow up with residents on the reasoning for their refusal of medications or review why they were not receiving medications per physician's orders and then document in a progress note. She stated that residents not receiving medications as per physician's orders could cause a decline in resident health depending on the medication and how long they were not receiving it.<br><br>In an interview on 06/19/2025 at 5:40 pm with Administrator revealed that staff (nurses and medication aides) were to document any medication refusals or residents not getting medications as per doctors' orders. She stated that this was part of on-hire training and training as needed. She stated that she was not sure how long missing medication doses would affect the residents.<br><br>Record review of facility policy titled Skilled Nursing Facility Policy: Nursing Documentation, not dated read in part Record daily nursing notes reflecting the residents' condition, responses to interventions and any changes in status. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure biologicals were stored in locked compartments and accessed by authorized personnel for 2 (Resident #3 and Resident #155) of 12 residents reviewed for medication storage , in that:<br><br>Resident #3 had a clear measuring cup at bedside with Zinc Oxide pomade (skin ointment) and a tongue depressor in it, exposed and within reach of other residents.<br><br>Resident #155 had a clear measuring cup with unknown pink ointment at bedside, exposed and within reach of other residents.<br><br>This failure could place residents at risk of access to medications not approved for administration by their physician.<br><br>Findings included:<br><br>Resident # 3<br><br>Record review of Resident #3's Face sheet dated 6/17/25 revealed an [AGE] year-old female with an original admission date of 8/8/24 and a readmission date of 4/18/25.<br><br>Record review of Resident #3's health and physical dated 8/26/24 revealed an [AGE] year-old female with a diagnosis of pressure ulcer of sacral region (the area of the lower back and pelvis that overlies the sacrum which is a large, triangular-shaped bone located at the very bottom of the spine, just above the tailbone or coccyx) and unspecified constipation.<br><br>Record review of Resident #3's admission MDS dated [DATE] revealed a BIMS (brief interview for mental status) score of 14 indicating the resident was cognitively intact. It indicated in the active diagnoses section I, that Resident # 3 had a diagnosis of pressure ulcer of the sacral region. Resident #3 triggered the care area for arthritis. MDS revealed under section GG for Functional abilities that Resident # 3 was dependent on toileting hygiene, lower body dressing and putting on and taking off footwear and required substantial assistance with showering and upper body dressing. MDS revealed Resident # 3 was dependent on rolling on her bed to both sides. MDS revealed under section M for skin conditions and treatments that Resident #3 was at risk for developing pressure ulcers and required the application of ointments and medications.<br><br>Record review of Resident #3's care plan dated 4/18/25 revealed the resident had a potential for pressure ulcers development related to scar tissue to sacral region and limited mobility. The care plan indicated Resident # 3 had moisture associated skin damage to the sacrum and gluts. The care plan called for intervention to follow the facility's protocols to prevent and treat skin breakdown by keeping the wound clean and dry by providing treatment to the site per physicians' orders until healed.<br><br>Resident #155<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record Review of Resident #155's admission record dated 6/19/2025 revealed a [AGE] year old female admitted to the facility on [DATE].<br><br>Record Review of Resident #155's history and physical dated 06/10/2025 revealed diagnosis of insulin-dependent diabetes mellitus, hypertension, hyperlipidemia(high cholesterol) and known left bundle branch block (a heart condition where the electrical signal that control the hearts rhythm is delayed or blocked).<br><br>Record Review of Resident #155's admission MDS dated [DATE] revealed no BIMS score.<br><br>Record Review of Resident # 155's care plan dated 06/11/2025 revealed resident had a potential for skin breakdown requiring barrier cream to be applied to affected area.<br><br>Record Review of Resident #155's physicians orders dated 06/11/2025 revealed Barrier cream to coccyx/buttock/peri area/ redden area for prevention every and as needed every shift.<br><br>In an observation and interview on 06/17/25 at 9:30 am revealed, a clear plastic measuring cup with an unknown pink cream like ointment was sitting on a nightstand in Resident #155's room. The resident did not know what the ointment was or what it was used for. The Residents family member stated that it had been sitting there for days, and he did not know what it was used for either.<br><br>In an observation and interview on 06/17/25 at 10:43 AM, resident #3 was observed sitting in her bed. There was a clear measuring cup containing a white substance and a tongue depressor at her bedside on her nightstand. The resident stated that the substance was a medication pomade applied by staff to her coccyx area to help a wound heal. She believed staff had applied the medication earlier that morning and forgotten to dispose of it. The resident expressed that the cup should have been discarded after use because any remaining pomade would be unusable.<br><br>In an interview on 06/18/25 at 01:38 PM with CNA A, stated that a nurse or an LVN would give the CNAs the cup with the cream for them to apply it to the resident. CNA A said if there was medication left on the cup, it needed to be disposed of, instead of leaving it on the residents' nightstand. CNA A explained that leaving the cream exposed could potentially contaminate the medication if dust or lint got into the cup. CNA A stated if the cream was to be reused and applied to the resident after being exposed and potentially contaminated, the wound on the resident could get infected, potentially making the resident sick.<br><br>In an interview on 06/18/25 at 02:07 PM with LVN B, stated the orders with cream barriers or medications were to apply the medication and then dispose of any residual cream. LVN B said the cream in the container was zinc oxide and it was to be applied with the tongue depressor in the area ordered by the wound nurse and any residual medication should be disposed of. She stated the potential outcome was for the cream to be contaminated because it was left exposed to the air and if it was applied to a resident in a wound area, it could have a negative reaction and the wound could worsen and infected. She also explained if there was a possibility for a confused resident to ingest the cream by leaving it unattended at bedside, which would make them sick.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 06/19/2025 at 11:30am with RN D, revealed that medications were not to be left at bedside unattended for any resident. She stated that leaving medication unattended could potentially expose the resident to misuse of the medication such as medication not being applied to the indicated area. She stated that it was an infection control issue because it was exposed to air. She could not recall the last training done about not leaving medications at bedside. She stated that it was the responsibility of the nurses to ensure that medications were not left at the bedside.<br><br>In an interview on 06/19/2025 at 11:55am with CNA E, revealed that medications should not be left at bedside. She stated that as a CNA, the nurse would give them the cup with ointment that needed to be applied to the resident during a brief change or after a shower. She stated that after applying the ointment, the CNA would dispose of the cup immediately. Ointments should not have been left at bedside because residents could ingest it or apply it to contraindicated areas of the body. She could not recall the last training over not leaving medications at bedside. She stated that it was all staffs' responsibility to ensure that there weren't any medications left in the reach of residents.<br><br>In an interview on 06/19/25 at 02:48PM with the Wound Care Nurse revealed that medications were not to be left unattended at bedside. She stated medication ointments were to be administered to the resident per physician's orders and disposed of per policy. She stated the risks of medications left unattended included residents misusing the medication. The Wound Care Nurse stated all nurses and medication aides were responsible for ensuring to administer all medications per physician's orders and to dispose of them properly.<br><br>In an interview on 06/18/25 at 03:05 PM with the DON, she stated that the cream left on the residents' nightstand was zinc oxide which was a barrier cream to prevent rash and to promote wound healing. DON said the cream that was leftover in the cup should have been discarded immediately once the medication had been applied to the resident for infection prevention and control. The DON said there was a risk of infection for a resident if staff were to re-use the crem and it had been contaminated by being left exposed to the air. She explained that a potential outcome could be the wound would get infected, and the residents' health could deteriorate as a result of the infected wound. The DON concluded by saying that any medication that was open and administered to a resident needed to be discarded immediately and not be left by bedside.<br><br>In an interview with the Administrator and the DON on 6/19/25 at 3:51 PM, it was revealed that the facility did not have a policy including information on procedures for supervising medications and the steps for disposing of a medication after it had been supervised. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observations, interviews, and record reviews, 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 kitchen sanitation and food storage.<br><br>-The facility failed to store foods in walk-in refrigerator and freezer in sealed containers.<br><br>-The facility failed to label and date frozen pastries stored in the freezer.<br><br>-The facility failed to keep container of tomato sauce free of dry drippings and residue around the lid.<br><br>These failures could place residents at risk of food-borne illnesses.<br><br>Findings included:<br><br>Walk-in Refrigerator:<br><br>-During an observation on 06/17/2025 at 8:10 am revealed the lids of 2 containers containing rice and rice and chicken soup to be slightly opened.<br><br>- During an observation on 06/17/2025 at 8:12 am revealed a bag of carrots was torn, exposing the carrots to air.<br><br>Walk-in Freezer:<br><br>-During an observation on 06/17/2025 at 8:18 am revealed a bag of frozen turkey patties not properly sealed and exposed to air.<br><br>-During an observation on 06/17/2025 at 8:19am revealed a container of frozen tomato sauce with dried drippings around the lid and running down the side of the container.<br><br>-During an observation on 06/17/2025 at 8:20am revealed an undated bag of churros and donuts.<br><br>In an interview with the Executive Chef on 06/19/2025 at 12:40pm revealed that all containers stored in the refrigerator and freezer should have been completely sealed to prevent any cross contamination and to preserve the freshness of the food items. He stated that all vegetables should have been kept in a sealed bag to prevent cross contamination and to seal in freshness. He stated that all containers should have been cleaned prior to being stored back in the freezer. He stated that staff were trained to ensure that all containers were cleaned after using them. He stated that dirty containers could have the potential for cross contamination and food could gather bacteria. He stated that all foods in the freezer should be in sealed bags to prevent freezer burn and prolong freshness and prevent cross contamination. He also stated that all foods should have been labeled and dated because if they were not labeled and dated, they could have expired, and the staff would not have known. He stated that all these things could lead to residents becoming sick by potentially having been exposed to bacteria or expired foods.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview with the cook on 06/19/2025 at 1:00pm revealed that all containers stored in the refrigerator were to be completely closed to prevent cross contamination and growth of bacteria. He stated that all vegetables were to be kept in sealed bags to preserve freshness and prevent bacteria growth. He stated that he was trained to ensure that all containers were cleaned upon storing them back in the refrigerator and freezer. He stated that this was to be done to prevent bacteria growth and cross contamination. He stated that all items in the freezer should have been dated so that the staff could know how long the food had been stored in the freezer. He stated not knowing how long food had been stored could have led to residents becoming sick due to eating something that was not fresh anymore.<br><br>Review of facility policy titled Food Storage Policy dated 2021 read in part All frozen food items are to be properly sealed and dated. fresh fruits and vegetables should be placed in bins, cartons or bags to promote freshness. |