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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>745038 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                      | (X3) DATE SURVEY COMPLETED<br><br>08/02/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Tierra Este Nursing and Rehabilitation Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>14300 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49854</b></p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure that the resident had the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility for 1 of 12 residents (Resident # 298) reviewed for resident rights, in that:</p> <p>Resident #298's indwelling urinary catheter bag was not covered.</p> <p>The deficient practice could affect residents by contributing to poor self-esteem, and dignity issues.</p> <p>The findings included:</p> <p>Record review of Resident #298 ' s face sheet dated 08/01/2024 documented he was [AGE] years old and was admitted to the facility on [DATE].</p> <p>Record review of Resident #298 ' s MDS dated [DATE] revealed he had a BIMS score of 11 (Moderate Cognitive impairment). He had a diagnosis of neuromuscular dysfunction of bladder (the nerves and muscles do not work together well and as a result the bladder may not fill or empty correctly), urinary tract infection and benign prostatic hyperplasia without lower urinary tract symptoms (needing to urinate frequently during the day and night, with a weak urine stream and leaking or dribbling of urine).</p> <p>Record review of Resident # 298 ' s care plan initiated on 07/22/2024 revealed that he had an indwelling suprapubic catheter (a type of catheter that is left in place), and the position of the catheter bag and tubing needed to be below the level of bladder and away from the entrance door. He required extensive assistance from a care member.</p> <p>During an observation on 07/29/2024 at 11:23 AM it was revealed that Resident #298 ' s foley bag was hanging by the side of his bed facing the door of the bedroom and it was not covered with a privacy bag.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>In an interview on 7/30/2024 at 2:29 pm, RN A said the foley bag should not be exposed because it violates the resident ' s privacy. She said the potential outcome of having his foley bag exposed could be that he felt ashamed if someone saw the bag and its contents. RN A said all staff were responsible for checking that foley bags are covered by a privacy bag and they were supposed to monitor throughout their shift.</p> <p>In an interview on 7/30/2024 at 2:44 pm, the DON said the foley bag being covered by a privacy bag relates to quality of care and that it should not be exposed because it violated the resident ' s privacy. She said the potential outcome could be that the resident felt bad for having his foley bag exposed and it could have made him feel ashamed. DON stated that staff responsible for checking for privacy bags included the CNAs, LVNs, RNs and herself.</p> <p>Record review of the facility policy titled Catheter Care dated 07/2022 reads in part: Privacy bags will be available and catheter drainage bags will be covered at all times while in use.</p> |

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| <p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486</b></p> <p>Based on observation, interviews and record review, the facility failed to ensure residents the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for one (Resident #15) of 15 residents reviewed for accommodation of needs.</p> <p>The facility failed to ensure that Resident #15's electronic monitoring camera was not obstructed when care was being provided as requested by the family.</p> <p>This failure could put residents at increased risk of not having their rights/preferences honored.</p> <p>Findings included:</p> <p>Record review of Resident #15's face sheet dated 08/02/2024 revealed she was [AGE] years old and was admitted to the facility on [DATE]. The face sheet identified Family Member Z as the resident's responsible party and Power of Attorney.</p> <p>Record review of Resident #15's quarterly MDS dated [DATE] revealed she had a BIMS score of 5 (severe cognitive impairment). She required substantial to moderate assistance to use the toilet, shower or bathe, dress her upper or lower body, and with personal hygiene. She was frequently incontinent of bowel and bladder. Her diagnoses included a hip fracture and other fractures, non-Alzheimer's dementia, anxiety disorder, and repeated falls.</p> <p>Record review of Resident #15's care plan last revised on 08/18/2023 revealed she had a self-care deficit. She required assistance moving around in bed, bathing, with her personal hygiene, transferring, dressing, eating and using the toilet.</p> <p>In an interview and observation on 07/29/24 at 02:50 PM Resident #15's Family Member Z revealed that the family member had placed a camera in the resident's room so the family member could monitor the care that was being provided to the resident. Family Member Z said that facility staff regularly placed items in front of the camera, purposely blocking the view of the care being provided to the resident. Family Member Z stated s/he had spoken to some of the staff members about this practice and was told that staff were instructed by the Director of Nurses to block the camera to protect the resident's privacy. The family member stated s/he had spoken to both the nursing facility Administrator and the Director of Nurses and was told that staff were to block the camera during incontinent care to protect the resident's privacy. Family Member Z showed where the camera was and how staff placed items in front of it to block the view of the resident in bed.</p> <p>In an interview on 08/01/24 at 03:07 PM the DON revealed that the family member of Resident #15 had expressed concern because staff members were blocking the camera view of resident care during incontinent care. She stated that she had instructed staff to cover the camera during incontinent care to protect the resident's dignity. The DON said Family Member Z wanted the camera uncovered to always watch the resident but that the family member could not identify a specific concern or reason s/he wanted to observe care provided. A policy regarding electronic monitoring was requested.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>In an interview on 08/01/2024 at 5:05 PM the Administrator revealed that it was facility practice to cover cameras in resident's rooms during incontinent care to preserve resident's dignity, and that was why the family member's request was not honored. The Administrator stated that some family members wanted to see every last detail. She stated that Resident #15's family member wanted to observe resident care although the family member was not able to voice any particular concern about the care being provided.</p> <p>Record review of the undated facility policy Texas Department of Human Services (DHS) Information Regarding Authorized Electronic Monitoring revealed in part that a person who intentionally hampers or obstructs an electronic monitoring device installed in a resident's room in accordance with state regulations commits a misdemeanor.</p> <p>Record review of Resident #15's Spanish language document Informacion sobre el monitoreo electronico autorizado para centros para convalecientes (Information about authorized electronic monitoring for centers for convalescents) signed 09/08/2023 by Resident # 15's family member revealed a Spanish translation of the facility policy Texas Department of Human Services (DHS) Information Regarding Authorized Electronic Monitoring including that a person who intentionally hampers or obstructs an electronic monitoring device installed in a resident's room in accordance with state regulations commits a misdemeanor.</p> |   |  |

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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026</b></p> <p>Based on observation, interview, and record review the facility failed to consult with the resident's physician when there was a significant change in the resident's physical status for 2 (Resident #295 and Resident #6) of 6 residents reviewed for physician notification.</p> <p>-The facility failed to consult with physician and/or Nurse Practitioner when the facility did not have Famotidine 20 mg, Amiodarone HCL 200 mg, Budesonide Inhalation Solution, and Cholestyramine Oral Pkt to administer as ordered on 07/29/24 during the morning medication pass.</p> <p>-The facility failed to consult with physician and/or Nurse Practitioner when the facility did not have a dosage for the Voltaren Gel for Resident #6 ordered 02/24/24.</p> <p>This failure could place residents at risk of delayed medical treatment.</p> <p>Findings include:</p> <p>Resident #295</p> <p>Record review of Resident #295's Admission Record dated 08/01/24 revealed she was [AGE] years old and was admitted to the facility on [DATE].</p> <p>Record review of Resident #295's Hospital History &amp; Physical dated 07/30/24 revealed she a diagnosis of gastrointestinal bleed, atrial fibrillation (An irregular heartbeat that occurs when the electrical signals in the two upper chambers of the heart fire rapidly at the same time), pneumonia (is an infection of the lungs that may be caused by bacteria), hypertension, shortness of breath, and asthma.</p> <p>Record review of Resident #295's Entry MDS dated [DATE] revealed entry date 07/28/24.</p> <p>Record review of Resident #295's Care Plan revised 07/29/24 revealed she was at risk for increased abdominal distress, weight loss and GI Bleed r/t GERD (gastroesophageal reflux disease), administer medications per order, monitor for effectiveness and report to MD if resident c/o of increased abdominal discomfort and discomfort. She had asthma, give medication as ordered, monitor and document side effects and effectiveness.</p> <p>Record review of Resident #295's active physician's orders initiated 07/28/24 revealed Budesonide Inhalation suspension (helps prevent the symptoms of asthma) 0.5 mg/2 ml 1 IUD[sic] Inhale orally every 12 hours for asthma, Famotidine (used to treat stomach Ulcers) 20 mg give 0.5 tablet by mouth one time a day for GERD (a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth in the stomach, called the esophagus), Cholestyramine Oral Packet (used to lower cholesterol levels in the blood) 4 GM give 1 packet by mouth two times a day for hyperlipidemia. Amiodarone HCL (helps keep heart rhythm normal) 200 mg give daily was not listed on physician's orders.</p> <p>(continued on next page)</p> |

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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Record review of Resident #295's Hospital Patient Discharge Instructions dated 07/28/24, revealed Medication Instructions: Amiodarone HCL 200 mg 0.5 tablet oral daily, Famotidine 20 mg 0.5 tablet oral daily, Budesonide 0.5 mg/2 ml suspension via nebulized inhalation, and Cholestyramine 4 GM/5 GM oral twice daily.</p> <p>Record review Resident #295's Physician's Orders dated 07/28/24 with DON revealed there was not an order for Amiodarone 200 mg give 0.5 mg by mouth daily.</p> <p>Record review of Resident #295's Medication Administration Record date July 2024 revealed, Amiodarone HCL 200 mg give 0.5 tablet by mouth one time a day for atrial fibrillation, Famotidine 20 mg give 0.5 tablet my mouth one time a day for GERD, Cholestyramine Oral Packet 4 GM give 1 packet by mouth two times a day for hyperlipidemia, and Budesonide Inhalation suspension 0.5 mg/2 ml 1 IUD [sic] inhale orally every 12 hours for asthma.</p> <p>Record review of an email written by DON to the vendor pharmacy dated 08/02/24 at 11:38 AM, revealed medication removal from automated medication dispensing system for Resident #295 on 7/29/24 Metoprolol Tartrate 25 mg one tablet, Amox/Clav (Augmentin antibiotic used to treat bacterial infections) 500/125 one tablet and Hydralazine 25 mg one tablet. The DON stated, the other prescribed medications was not stocked in the automated medication dispensing system to administer the scheduled doses in the morning.</p> <p>In an interview and observation on 07/29/24 at 9:12 AM, during medication pass observation with RN A, revealed Resident #295 was admitted to the facility on [DATE] on the 2-10 shift. RN A said licensed staff had been trained to fax physician's orders to the vendor pharmacy after hours, so medications were sent to the facility on the next business day. RN A said they did not have the Amiodarone HCL, Famotidine 20 mg, Cholestyramine Oral Packet, Budesonide Inhalation suspension in the automated medication dispensing system to administer the scheduled doses in the morning.</p> <p>In an interview and observation and interview on 07/29/24 at 10:00 AM, during medication pass observation with Med Aide E revealed RN A obtained Metoprolol Tartrate 25 mg one tablet and Hydralazine 25 mg one tablet from the automated medication dispensing system. Med Aide E said the Famotidine 20 mg, Amiodarone HCL 200 mg, Budesonide Inhaler, and Cholestyramine Oral Pkt were not stocked in the automated medication dispensing system to administer the scheduled doses in the morning . Med Aide E said they had been trained to immediately notify the nurse when medications are not available to administer according to physician's orders.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>In an interview on 08/02/24 at 1:00 PM, with DON said NP was at the facility on 07/29/24 and did not know if the nurses had informed him Resident #295's medications were not available on that day to administer the scheduled doses in the morning. She said the resident was admitted [DATE] late on the evening shift. She said when the nurses enter the physician orders in the electronic record, the orders are automatically transmitted to the vendor pharmacy. She said she called the vendor pharmacy today and was informed physician orders received after 5:00 PM, would not be filled until the next business day. She said the nurses needed to call the local contracted pharmacy after 5:00 PM, and fax them a copy of the physician's orders, so the prescribed medications were delivered on the day physician's orders were received. She said, We were not aware of this process. That is why we were not getting the medications delivered on the same day that the orders were given by the physician and/or NP. The vendor pharmacy was closed, and they were not aware that new orders had been faxed after business hours. This resulted in not having the necessary medications on hand to administer as ordered. DON stated she was going to provide training to the licensed staff as soon as possible to prevent this from reoccurring.</p> <p>In a telephone Interview on 08/02/24 at 12:17 PM, with FNP F revealed licensed staff notified him most of the time when medications were not available to administer as ordered. He said he expected the nurses to continue to administer medications according to hospital discharge orders until resident was assessed by the physician and/or FNP after admission to determine if they would continue with the same medications or make changes as needed. FNP said We would not want to make changes to the medications if the resident has been stabled with the current medication regime from the hospital. Failure to administer prescribed medication could affect the resident depending on the number of missed doses and the type of medication. FNP said he was not notified, on 07/29/24 that the Famotidine 20 mg, Cholestyramine, Budesonide and Amiodarone HCL on 07/29/28 had not been administered as ordered. FNP said he expected the nurses notify him right away when medications were not on hand to administer as ordered.</p> <p>Resident #6</p> <p>Record review of Resident #6's Admission Record dated 08/01/24 revealed she was [AGE] years old and was admitted on [DATE].</p> <p>Review of Resident #6's Hospital History &amp; Physical dated 02/13/24 revealed she had a diagnosis of Diabetes Mellitus, Pulmonary embolism, Hypertension, and Dementia.</p> <p>Record review of Resident #6's Quarterly MDS dated [DATE] revealed she had a diagnosis of Diabetes Mellitus, and non-Alzheimer's dementia. She received PRN pain medication in the last five days.</p> <p>Record review of Resident #6's Care Plan revised 07/29/24 revealed, her care Plan did not address pain to right shoulder.</p> <p>Record review of Resident #6's physician's order initiated 02/29/24 revealed Order Start Date 02/29/24 Voltaren Eternal Gel 1% did not have a dosage.</p> <p>Record review of Resident #6's Medication Administration Record date July 2024 revealed Start Date: 02/29/24 Voltaren Eternal Gel 1% did not have a dosage to apply to right shoulder topically two times a day for pain for shoulder pain at 7:30 AM and 7:30 PM. Fluticasone Proplonate Nasal Suspension 50 mcg/ACT two applications in both nostrils in the morning for allergies at 7:00 AM.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Record review of the manufacturer's User Guide revealed, before using Fluticasone Propionate nasal spray blow your nose to clear nostril. Close one nostril. Tilt your head forward slightly. And, Keeping the bottle upright, carefully insert the nasal applicator into the other nostril. Start to breathe in through your nose, and while breathing in, press firmly and quick down one time on the applicator to release the spray period to get the full dose, use your fourth finger and middle finger to spray while supporting the base. For the bottle with your thumb. Avoid spraying in your arm in your eyes. If a second spray is required in that nostril, repeat the same steps for the other nostril. Wipe the nasal applicator with a clean tissue and replace the dust cover.</p> <p>In an observation on 07/29/24 at 9:47 AM, during medication pass observation with Med Aide G, revealed the physician's order for Voltaren Gel 1% did not specify a dosage. Med Aide G said he was going to apply Voltaren Gel for Arthritis Pain 2.25 inches, using the dosing card to measure the amount according to the directions on the medication box. Med Aide G applied Voltaren Gel to the tip of the shoulder joint and rubbed most of the medication to the deltoid area (upper arm). Med Aide G stated, The Voltaren Gel is ordered for the shoulder, but I also apply the Voltaren Gel to the upper arm to help with the pain. Med Aide administered Fluticasone Propionate nasal spray one spray to each nostril without asking the resident to blow her nose prior to use and did not close one of the nostrils while administering the medication.</p> <p>In an interview on 08/01/24 at 2:36 PM, with Med Aide G revealed, she had not been trained in school and was not familiar with the instructions on how to administer Fluticasone Propionate nasal spray.</p> <p>In a telephone interview on 08/02/24 at 2:44 PM with Nurse Practitioner (NP) H, revealed the nurses had not reported to him Voltaren External Gel did not have a dosage. Nurse practitioner said, he expected the nurses to call him to get a dosage to ensure that the medication was effective in treating the resident's pain. Nurse Practitioner said the negative effect of not having a dosage for use of Voltaren External Gel was minimal but could affect the resident if the correct dose of medication was not applied to the affected area to relieve pain.</p> <p>In an interview and record review on 08/02/24 at 3:00 PM, with DON, revealed that she was not aware that the order for Voltaren External Gel did not have a dosage. DON said that all physician's orders must specify the dosage for all prescribed medications. She said the Med Aides had been trained to immediately report to the nurses if medication orders did not have a dosage. The nurses had been trained to immediately notify the physician when medication orders did document the prescribed dosage of the medication. Failure to have a dosage on medications orders could result in the resident getting too much or too little medication to address the medical needs of the resident.</p> <p>Review of facility's policy &amp; procedure on Notification of Changes dated 07/22/24, revealed Policy: The purpose of this policy is to ensure the facility promptly consults the resident's physician; and notifies, consistent with his or her authority when there is a change requiring notification. Compliance Guide: Circumstances that require a need to alter treatment. This may include discontinuation of current treatment due to: Adverse consequences.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of facility's policy &amp; procedure on Unavailable Medications dated 07/2022 revealed, Policy: This facility shall use uniform guidelines for unavailable medications. Policy Explanation and Compliance Guide: Medications may be unavailable for a number of reasons. Staff shall take immediate action when it is known that the medication is unavailable: Determine reason for unavailability, length of time medication is unavailable, and what efforts have been attempted by the facility or pharmacy provider to obtain the medication. Notify physician of inability to obtain medication upon notification or awareness that medication is not available. Obtain alternative treatment orders and/or specific orders for monitoring the resident while the medication is held. If a resident misses a scheduled dose of the medication, staff shall follow procedures for medication errors, including physician/family notification, completion of a medication error report, and monitoring the resident for adverse reactions to omission of the medication.</p> |

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| <p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Keep residents' personal and medical records private and confidential.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486</b></p> <p>Resident #15</p> <p>Privacy</p> <p>07/29/24 03:19 PM camera [NAME], [NAME], Santa - putting the pillow over the camera - they says it for her privacy- went on administrator . Aracelli DON is telling [NAME] to cover block the cameras. Leave TV and light on during the night - does not know if this is her or the other resident's TV or liResident ght.</p> <p>7/30/24 - 1:40 PM - CONsurla [NAME] DTEs [NAME] - Moved camera from head of bed to sid [NAME] now cover it Cant give instructions. over the camera.</p> <p>08/01/24 03:07 PM DON - policies related to cameras - has had concerns about this Homes - reason that they cover if for dignity - want to see Mom - Says to keep an eye on her - Daughters says she is is not sure of the care. Says dignity and privacy concern. question of balance between resident and family rights. [NAME] moves the camera around - hatdit by the lght fixutre but a fire dncern. Mr [NAME] has not said anything . He does have a camera - no concerns expressed. will ask for set up help. Plocy - provied regulation - regulation is her policy.</p> |

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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026</b></p> <p>FACILITY</p> <p>Environment</p> <p>Observation on 07/29/24 at 6:30 AM, revealed tile floors by the entrance of the facility and resident halls were full of dust, dried black stains, and paper particles. There was a white tablet on the floor by the decentralized nurse's station in the 300 Hall.</p> <p>Observation on 07/29/24 at 7:34 AM, revealed there was a white sheet on the floor soaked with water and caution sign directly in front of Janitor's Closet.</p> <p>Observation on 07/29/24 at 8:05 AM, revealed water was leaking from the condensation pipe in the Mechanical Room, the drain was full of water and water was leaking into the hallway and Janitor Room next to the Mechanical Room.</p> <p>Observation on 07/29/24 at 8:05 AM, revealed water was leaking through the floor base into the Janitor room from the Mechanical Room. It was observed the the floor was full of dust and a piece of paper and plastic were on the floor.</p> <p>Observation and interview on 07/29/24 at 8:10 AM, revealed with Maintenance Supervisor, revealed the flapper rusted, and the edges were cracked and edges were missing on half of the flapper seal, round tube connected to the flapper was cracked. The maintenance Director stated, If no water is dripping from the condensation pipe, the flapper dries and will get stuck on the drain and will not allow the water to drain into the drain. That why the water was over flowing to the floor and was leaking into the wall of the Janitor's room and to the hallway. Maintenance Supervisor reported that on had called him to report that water was leaking to the hallway from the Mechanical Room. Maintenance Supervisor reported that he checked the drain once a week.</p> <p>Observation at 8:39 AM, revealed that housekeeper had mopped 3/4 of one side of the hallway and placed caution signs. Housekeeper stated, that is how she had been trained to mop 3/4 of one side of the hallway and placed caution signs.</p> <p>Observation and interview on 07/29/24 at 8:43 AM, revealed revealed that housekeeper had mopped 3/4 of the floor on the 200 Hall. It was observed that the Social Social Worker disregarded the Caution Sign, and was observed walking on the wet floor towards the resident rooms. The Social Worker stated, she was going to get residents from their rooms to take them to the dining room.</p> <p>(continued on next page)</p> |

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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Observation on 07/29/24 at 8:58 revealed that [NAME] housekeeper was mopping the floor on the side of the nurses station by the director of nurses office and only had one caution sign, alerting others that the floor was wet. The housekeeper reported they had been trained to mop a small area of the floor and to place two caution signs Until the floor was dry. The housekeeper stated that since she only had one caution sign in her housekeeping card she had placed her housekeeping card on the other end to block the area and keep people from walking on the floor because she did not have another caution sign to place.</p> <p>Observation on 07/29/24 at 7:58 AM, in the 200 Hall revealed a dead cricket was on the floor in the hallway.</p> <p>Observation on 07/29/24 at 9:05 AM revealed that in the 400 hall there was a white tablet on the floor. The surveyor confirmed the findings with [NAME] LVN assigned to work on the 400 Hall.</p> |

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| <p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34486</p> <p>Based on interview and record review the facility failed to coordinate assessments with the pre-admission screening and resident review program for one (Resident #50) of 2 residents reviewed for compliance with PASARR regulations.</p> <p>The facility failed to screen Resident #50 for PASARR when she received a new diagnosis of Schizophrenia.</p> <p>This failure could put residents eligible for PASSR services at risk of not receiving PASSR-recommended specialized services.</p> <p>Findings included:</p> <p>Record review of Resident #50's face sheet dated [DATE] revealed she was [AGE] years old and was admitted to the facility on [DATE]. Her principal diagnosis was Encounter for attention to gastrostomy (attention to a feeding tube).</p> <p>Record review of Resident #50's physician's progress note dated 07/28/2013 revealed she had diagnoses including dementia, delusional disorders and recurrent major depressive disorder. She had attention seeking behaviors and was prescribed Sertraline (a medication for depression, panic disorder, obsessive-compulsive disorder, social anxiety disorder).</p> <p>Record review of Resident #50's PASRR Level 1 Screening dated 06/16/2023 revealed dementia was her primary diagnosis and there was no evidence that she had a mental illness.</p> <p>Record review of Resident #50's electronic diagnoses listing accessed 7/31/2024 revealed she had a diagnosis of schizophrenia, added to her diagnoses on 07/05/2023.</p> <p>Record review of Resident #50's annual MDS assessment dated [DATE] revealed she had a BIMS of 0 (severe cognitive impairment). She had no signs or symptoms of delirium, mild symptoms of depression, no symptoms of psychosis and no behavioral symptoms. Her diagnoses included non-Alzheimer's dementia, anxiety disorder, depression, psychotic disorder and Schizophrenia. During the seven days before the MDS assessment, she was given antipsychotics, antianxiety medications and antidepressants.</p> <p>Record review of Resident #50's care plan last revised 08/17/2023 revealed she used psychotropic medication related to diagnoses including schizophrenia. Her care plans revised 07/29/2024 stated she used an antidepressant and anti-anxiety medication related to her diagnosis of Schizophrenia.</p> <p>Record review of Resident #50's Psychiatric Subsequent assessment dated [DATE] revealed she had diagnoses including Schizophrenia and per nursing staff met the criteria for Schizophrenia because she had visual hallucinations, delusions, and other symptoms over the previous 6 months.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>In an interview on 08/01/24 at 01:58 PM MDS Nurse B revealed that Resident #50's new diagnosis of schizophrenia should have triggered a new Level 1 Screening. She said she had no evidence that a new Level 1 Screening was triggered or performed for Resident #50 when the new diagnosis was discovered. She said new diagnoses were discussed in morning meeting and should appear daily on the resident's dashboard. She said rescreening for Resident #50 should have been done even if it turned out she did not meet criteria for PASSR services. She said rescreening residents with new diagnoses was important to ensure that residents with qualifying conditions would get the services to which they were entitled. For residents with diagnoses of mental illness these included receiving case management services from the local mental health services provider.</p> <p>In an interview on 08/01/24 at 02:29 PM the DON revealed that when Resident #50 received the new diagnosis of schizophrenia she should have been rescreened for PASSR eligibility. She said that MDS nurses were responsible for monitoring residents for changes in PASSR status. She said that when there was a new diagnosis the resident's change in the status would be discussed and referred to the physician to request a reassessment for PASSR eligibility.</p> <p>Record review of the facility titled PASSR dated 06/2022 revealed it was the facility's policy to meet federal requirements and State of Texas guidelines to complete a PASSR evaluation of residents to determine if a PASSR level II evaluation was required. If a resident was assessed as positive for Mental Illness this would indicate the need for further assessment by the state designated authority. Serious mental illness included schizophrenia. The policy did not address what should be done if a resident received a new diagnosis indicating mental illness.</p> |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 20026</p> <p>Based on observation, interview and record review the facility failed to ensure that must ensure that residents received treatment and care in accordance with professional standards of practice for one (Resident #39) of 20 residents reviewed for quality of care.</p> <p>The facility failed to ensure that Resident #39's dressing to her external cardiac pacemaker was dated when changed and was not draining onto her gown and skin.</p> <p>This failure put the resident at increased risk of infection and not receiving the necessary care and services.</p> <p>Findings included:</p> <p>Record review of Resident #39's dated 08/01/2024 revealed she was [AGE] years old, initially admitted to the facility on [DATE] and readmitted on [DATE].</p> <p>Record review of Resident #39's history and physical dated 07/25/2024 revealed she had a diagnosis of combined systolic and diastolic heart failure (when the chambers of the heart do not pump or relax enough to send enough blood to the body) with LVAD implantation (a mechanical pump implanted in the chest to help the heart pump blood to the rest of the body).</p> <p>Record review of Resident #39's quarterly MDS assessment dated [DATE] revealed she had a BIMS score of 9 (moderate cognitive impairment). She had no symptoms of delirium, depression, psychosis and no symptomatic behaviors. She required substantial assistance for oral hygiene, toileting, upper body dressing, moving in bed and for transfers. She was dependent on staff for bathing, lower body dressing and personal hygiene. Her diagnoses included heart failure, cardiomyopathy (disease of the heart muscle), kidney failure, multi-drug-resistant organism (a type of infection resistant to antibiotics), diabetes, stroke, hemiplegia or hemiparesis (paralysis on half of the body), and depression.</p> <p>Record review of Resident #39's care plan revised 08/21/2023 revealed she had a LVAD and was at risk for complications.</p> <p>Record review of Resident #39's physician's order initiated 06/12/2024 and discontinued 07/31/2024 revealed that the resident's dressing for the LVAD driveline exit (where the wires for the LVAD exit the chest and go to the power source) was to be changed on Tuesdays during the day shift.</p> <p>Record review of Resident #39's physician's order initiated 07/29/2024 and discontinued 08/01/2024 revealed that she would receive Bactrim DS 800-160 MG (an antibiotic) twice a day for 7 days for LVAD driveline exit drainage.</p> <p>Record review of Resident #39's active physician's order initiated 08/01/2024 revealed that wound care to her LVAD drive line exit side was to be done during the morning shift on Tuesdays and as needed.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Record review of Resident #39's active physician's order initiated 08/01/2024 revealed she was to receive Amoxicillin-Pot Clavulanate Oral Tablet 875-125 MG (an antibiotic) twice a day for 7 days for an LVAD infection.</p> <p>In an interview and observation on 07/29/24 at 09:47 AM Resident #39 was lying in bed. A white machine sat on her bedside table with several electrical cords running from the machine and under her blanket. Resident #39 said the white machine [LVAD] was like a pacemaker for her heart and the cords went into her body. As she pulled back her blanket to show where the cords entered her body [the LVAD driveline insertion site] it was observed that there was a dried reddish-brown spot measuring 2 by 3 inches on the gown she was wearing. She said staff changed the dressing on her LVAD insertion site once a week.</p> <p>In an interview and observation on 07/29/24 09:53 AM LVN C uncovered Resident #39's LVAD driveline insertion site. The LVN stated that the resident's gown should not have dried drainage on it. The LVAD driveline insertion site was covered with a transparent wound dressing through which could be seen brownish-red drainage. It was noted that there was no date on the dressing. The LVN said the wound dressing was not dated but should be. She said the dressing was dated so staff knew when it was last changed. She said she should have noticed the condition of the dressing when she did her morning rounds. She said there was an increased risk of infection if the dressing was not changed as ordered. She said that the dressing should not be draining, that she would change the dressing and that it would be a PRN dressing change.</p> <p>In an interview on 08/01/24 at 02:20 PM the DON revealed that when a wound dressing was changed it should be dated. She said the dressing should be dated so staff would know when wound care was provided and this would help prevent infections. She said wound care for Resident #39's LVAD driveline was done by the wound care nurse, and the dressing would be changed by the charge nurse if needed when the wound care nurse was not in the facility. She said she had been informed by LVN C that Resident #39's LVAD dressing had been found soiled and not intact. She said the condition of the dressing should have been identified and addressed by the nurse during morning rounds, and the dressing should have been changed at that point.</p> <p>34486</p> <p>Resident #39</p> <p>General</p> <p>07/29/24 09:53 AM [NAME], LVN - - wound draining - sent out culture - dressing is not dated - states for hygiene and should be changed - this would be PRN change. - no date.</p> <p>Care Plan -</p> <p>Resident has and LVAD. At risk for complications.</p> <p>Date Initiated: 07/28/2023</p> <p>Revision on: 08/21/2023</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>08/01/24 02:20 PM DON - wound care is [NAME] and if she is not avavile and needs to be changes will be done by nursing. Whena wound dressing in schanged it should be dated. shoud be dated so nikno w wound change date and prevent infections. LVAC [NAME] infoemed her - it was soiled. Nurses monitor it as they do their rounds. 3xQ24 hours - condition of dressing should have been caught during rounds. Trigger woudl be how soiled it is - dressing not intact. Risk for infection from the draininge. tested postive - Was tested in APril, June, negative, last one Monday collected cam positve. started on amoxicilliin and infections disease and drew labs this AM to see changes.</p> |   |  |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 20026</p> <p>Based on observation, interview, and record review the facility failed to ensure that a resident who needed respiratory care was provided such care consistent with the comprehensive person-centered care plan, the resident's goals and preferences for one (Resident #192) of seven residents reviewed for respiratory care and 1 of 1 oxygen storage room observed for oxygen management.</p> <p>-The facility failed to ensure Resident #192 had her nasal cannula on per physicians' orders and that the nasal cannula was covered when not in use.</p> <p>-The facility failed to ensure 4 oxygen metal cylinders were stored in the oxygen storage room.</p> <p>-The facility failed to ensure an oxygen sign was posted outside of the scale room where oxygen was stored.</p> <p>This failure could put the resident at increased risk of receiving insufficient oxygen and of infection. These failures could place residents on oxygen therapy at risk of not receiving oxygen support due to improper storage.</p> <p>The findings included:</p> <p>Record review of Resident #192's face sheet dated 07/31/2024 revealed she was [AGE] years old and was admitted to the facility on [DATE].</p> <p>Record review of Resident #192's history and physical dated 12/31/2023 revealed she had diagnoses including dementia and pneumonia. She was receiving supplemental oxygen.</p> <p>Record review of Resident #192's physician's orders dated 07/27/2024 revealed she was to receive oxygen continuously at 2 liters per minute by way of a nasal canula to keep her pulse oximetry reading (amount of oxygen in the blood) at greater than 90 percent.</p> <p>Record review of Resident #192's electronic diagnoses listing accessed on 07/31/2024 revealed she had diagnoses including acute respiratory failure with hypoxia (a condition where there is not enough oxygen getting into the body).</p> <p>Resident #192 was too new to require a completed MDS.</p> <p>Record review of Resident #192's baseline care plan dated 07/30/2024 revealed she needed set-up assistance for eating and oral hygiene. She needed substantial assistance with bathing and toileting. She was dependent on staff for personal hygiene. She was receiving oxygen therapy.</p> <p>In observation and interview on 07/29/24 at 07:23 AM Resident #192 was lying in bed awake. She did not have oxygen tubing on. She said she was supposed to wear it all the time but that staff members had forgotten to put it back on her after her bath. It was observed that a nasal canula attached to the concentrator next to Resident #192's bed was laying uncovered on top of the small chest beside her bed.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>In an interview on 07/29/24 at 07:27 AM LVN D revealed that if Resident #192 had an order for continuous oxygen she should have the nasal cannula on at all times. He said not always having the oxygen cannula could put the resident at risk of decreased oxygen. He said the cannula should not be uncovered because the cannula might get dirty, and the resident might breathe in dust or germs, and it was an infection control issue. He said he needed to get Resident #192 a new cannula and detached the tubing from the oxygen concentrator.</p> <p>In an interview on 08/01/24 at 02:14 PM the DON revealed that if a CNA took a resident's oxygen cannula off the CNA should put it back if the resident had an order for continuous oxygen. She said the oxygen cannula should be put in a zip-lock baggie when not in use and that if it was discovered uncovered, the nurse should be notified to replace the cannula. She said the uncovered oxygen cannula was an infection risk.</p> <p>Record review of the facility policy Oxygen Administration dated 03/2012 revealed that oxygen was administered to the resident consistent with professional standards of practice. Oxygen was administered under orders from a physician. Staff would keep delivery devices covered in a plastic bag when not in use.</p> <p>Oxygen Storage:</p> <p>In an observation on 08/02/24 at 8:36 AM, with central supply clerk K revealed there were 4 metal oxygen cylinders stored in the scale room. There was no oxygen sign posted on the door. The central supply clerk stated oxygen cylinders should only be stored in the oxygen storage room. He said he and the nursing staff were responsible for posting the oxygen signs on the door.</p> <p>In an interview on 08/02/24 at 8:40 AM, with DON revealed oxygen metal cylinders should not be stored in the scale room. She said staff had been trained on only storing oxygen cylinders in the oxygen storage room.</p> <p>The Surveyor asked for policy and procedure on oxygen administration and was not provided prior to exit.</p> <p>34486</p> <p>Resident #192</p> <p>Respiratory Care</p> <p>302 - 07/29/24 07:23 AM [NAME], [NAME] - oxygen forgot to put it back on her - and cannula is not covered. [NAME] - 07/29/24 07:27 AM he is not sure if continuous - oxygen is 91 - Cannula should no be uncovered because of infection control. She states does not normally use oxygen -but has been continuous here.</p> <p>Baseline care plan states thresident usus oxygen</p> <p>Dx of ACUTE RESPIRATORY FAILURE WITHHYPOXIA</p> <p>Resident too new to require completed MDS.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>08/01/24 02:14 PM DON - CNA takes cannula off CNA should put it back on if continuous - Does not think this is a competency but have reviewed with during all staff but probably no documentation. Oxygen cannula should be put in a ziplock bag. Put in a zip lock bag because of infection risk, - nurses should be notified because then will noted [NAME] replace. - [NAME] reported to her and cannula and it was changed. Requested policy on oxygen cannula management.</p> |   |  |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026</b></p> <p>Based on observation, 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 3 (Resident #6, #296 and Resident #80) of 6 reviewed for pharmacy services.</p> <p>-The facility failed ensure physician order dated 02/24/24 for Resident #6 had a dosage for the Voltaren Gel ordered for shoulder pain.</p> <p>-The facility failed to ensure Med Aide I notified the nurse when Resident #296 refused to take Lactulose on 07/29/24 according to physician's orders.</p> <p>-The facility failed to administer Resident #80 Zinc Sulfate 220 mg on 07/29/24 according to physician's orders.</p> <p>-The facility failed to ensure Licensed Staff (LVN J, and LVN D) did not sign off on the Controlled Drugs-Audit Record form prior to counting and verifying that all controlled substances in the medication cart had been accounted for with the on-coming nurse at the change of shift.</p> <p>-The facility failed to ensure Licensed Staff (RN A and LVN C) signed the Controlled Drugs-Audit Record form after counting and verifying that all controlled substances in the medication cart had been accounted for with the on-coming nurse at the change of shift.</p> <p>These failures could place residents at risk of delayed medical treatment.</p> <p>Findings include:</p> <p>Resident #6</p> <p>Record review of Resident #6's Admission Record dated 08/01/24 revealed she was [AGE] years old and was admitted on [DATE].</p> <p>Review of Resident #6's Hospital History &amp; Physical dated 02/13/24 revealed she had a diagnosis of Diabetes Mellitus, Pulmonary embolism (is a life-threatening medical emergency that occurs when a blood clot blocks an artery in the lung), Hypertension, and Dementia.</p> <p>Record review of Resident #6's Quarterly MDS dated [DATE] revealed she had a diagnosis of Diabetes Mellitus, and non-Alzheimer's dementia. She received PRN pain medication in the last five days.</p> <p>Record review of Resident #6's Care Plan revised 07/29/24 revealed, her care Plan did not address pain to right shoulder.</p> <p>Record review of Resident #6's physician's order initiated 02/29/24 revealed Voltaren Eternal Gel 1% did not have a dosage.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Review of the Medication Administration Record date July 2024 for Resident #6 revealed, Voltaren Eternal Gel 1% did not have a dosage apply to the right shoulder topically two times a day for pain for shoulder pain at 7:30 AM and 7:30 PM.</p> <p>Review of the manufacturer's User Guide revealed, use the dosing card to measure the correct dose. Gently rub into the skin using your hand to the affected area.</p> <p>Observation on 07/29/24 at 9:29 AM, during medication pass observation with Med Aide G revealed that she was going to apply Voltaren Gel for Arthritis Pain 1%, 2.25 inches using the dosing card to measure the amount to apply to the right shoulder according to the directions on the dosing card and instructions on the medication box. It was observed at 9:46 AM, that Med Aide applied the Voltaren Gel to the tip of the shoulder joint and applied most of the medication to the deltoid area (upper arm). Med Aide G stated, I also apply on the arm to help with the pain</p> <p>In an interview on 07/31/24 at 11:41 AM, with DON, revealed the nurses should immediately notify the physician and/or NP if a physician's order is missing a dosage.</p> <p>In a telephone interview on 08/02/24 at 2:44 PM with Nurse Practitioner H, revealed the nurses had not reported to him the order for the Voltaren External Gel did not have a dosage. Nurse practitioner H said, he expected the nurses to call him to get a dosage. Nurse Practitioner H said that the negative effect of not having a dosage for use of Voltaren External Gel was minimal unless they applied the whole tube of medication it could have a negative effect on the resident.</p> <p>In an interview 08/02/24 at 3:00 PM, with DON, revealed that she was not aware that the order for Voltaren External Gel for Resident #6 did not have a dosage. DON said that all physician's orders must specify the dosage for all prescribed medications. She said the Med Aides had been trained to immediately report to the nurses if medication orders did not have a dosage. The nurses had been trained to immediately notify the physician when medication orders did document the prescribed dosage of the medication. Failure to have a dosage on medications orders could result in the resident getting too much or too little medication to address the medical needs of the resident.</p> <p>Resident #296</p> <p>Record review of Resident #296's Admission Record dated 08/01/24 revealed she was [AGE] years old and was admitted to the facility on [DATE].</p> <p>Record review of Resident #296's Hospital History &amp; Physical dated 07/30/24 revealed she a diagnosis of chronic pain, and hypothyroidism.</p> <p>Record review of Resident #296's Admission MDS dated [DATE] revealed she had a diagnosis of arthritis, and hypothyroidism.</p> <p>Record review of Resident #296's Care Plan revised 07/29/24 revealed she had a diagnosis of hypothyroidism. Administer medications as ordered.</p> <p>Record review of Resident #296's active physician's orders initiated 07/18/24 revealed Lactulose give 10 GM/15 ml give 30 ml by mouth every 8 hours for constipation.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Record review of Resident #296's Medication Administration Record date July 2024 revealed Lactulose give 10 GM/15 ml give 30 ml by mouth every 8 hours for constipation was refused by the resident.</p> <p>Observation on 07/30/24 at 7:29 AM, during medication pass observation with Med Aide I, revealed Resident #296 refused to take Lactulose 10 GM/15 ml. Resident said she did not want to take the Lactulose because she would have diarrhea and did not want to soil herself.</p> <p>In an interview and record review on 08/01/24 at 10:31 AM, LVN J said she did not remember if Med Aide I had reported to her that Resident #296 had refused the Lactulose on 07/29/24 at 7:30 AM. Review of the MAR revealed Lactulose was not administered as ordered on 07/29/24 due to resident refusing to take medication as ordered. LVN J said Med Aides had been trained to report to the nurses when medications were held or refused.</p> <p>In an interview on 08/01/24 at 10:33 AM, with Med Aide I said that she did not remember if she had reported to LVN J when Resident #296 had refused to take the Lactulose on 07/29/24 at 7:30 AM. Med Aide I said Med Aides had been trained to report to the nurses when medications were held or refused.</p> <p>Resident #80</p> <p>Record review of Resident #80's Admission Record dated 07/31/24 revealed he was [AGE] years old and was admitted to the facility on [DATE].</p> <p>Record review of Resident #80's Hospital History &amp; Physical dated 05/14/24 revealed he a diagnosis of Atrial Fibrillation (is an irregular heartbeat that causes a heart to beat faster and more irregularly than normal), Hypertension, Cerebral Vascular Accident (a medical emergency that occurs when blood flow to the brain is suddenly cut off), Dysphagia (difficulty swallowing), Stage 4 Decubitus Ulcer (is a type of pressure injury that occurs when skin is damaged by constant pressure for a long time).</p> <p>Record review of Resident #80's Admission MDS dated [DATE] revealed he had a diagnosis of Vitamin Deficiency.</p> <p>Record review of Resident #80's Care Plan revised 07/29/24 revealed he had the potential for nutritional problem r/t diet restrictions. Administer medications as ordered. Monitor/document for side effects and effectiveness.</p> <p>Record review of physician's orders, revealed LVN D had not administered the Zinc Sulfate Oral tablet 220 mg one tablet during the medication pass observation on 07/29/24.</p> <p>In an interview and record review on 07/31/24 at 9:36 AM LVN D revealed he had not administered the Zinc Sulfate 220 mg on 07/29/24 during the med pass observation, due to not having the medication to administer as ordered.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>In an Observation and interview on 07/31/24 at 9:41 AM, Central Supply Clerk said he ordered over the Counter Medications (OTC) on a weekly basis. He said that he was responsible for checking the back-up supply of OTC medications stored in the Medication Prep room, on a weekly basis to ensure OTC medications were reordered before they ran out of medications. Central Supply Clerk said, let's go check to see if we have a backup supply of Zinc Sulfate 220 mg in the Medication Prep Room. He said they had run out of Zinc Sulfate 220 mg and was going to place an order today.</p> <p>Review of facility's policy &amp; procedure on Medication Administration dated 07/22/22 revealed, Policy: Medications are administered by licensed nurse, or other staff who are legally authorized to do so in this state, as ordered by the physician in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy explanation and compliance guidelines: Administer medications as ordered in accordance with manufacturer specifications. Crush medications as ordered.</p> <p>Review of facility's policy &amp; procedure on Medication Ordering and Receiving from Pharmacy Provider dated 01/23, revealed, Policy: Penetrations and related products are received. From the provider on a timely basis. The Nursing Care Center maintains accurate records of medication order and receipt. Procedures: All new medication orders are transmitted to the pharmacy. New medications, Except for emergency or stat medications, are ordered as follows: If the first dose of medication is scheduled to be given before the next regularly scheduled pharmacy delivery. If the first dose of medication is scheduled to be given before the next regularly scheduled pharmacy delivery, please telephone or transmit the medication orders to the pharmacy immediately upon receipt. Inform the pharmacy of the need for the prompt delivery. Timely delivery of new orders is required so that medication administration is not delayed. If available, the emergency kit is used when the resident needs non-controlled medication prior to pharmacy delivery. A medication order form is also used to notify the provider of changes in dosage, directions for use this continuation, etc. of current medications.</p> <p>Review of facility's policy &amp; procedure on Medications Orders dated 07/2022 revealed, Policy: This facility will use uniform guidelines for the ordering of medications. Policy Explanation and Compliance Guide: Elements of the Medication Order: Dosage-strength of medication is included.</p> <p>Review of facility's policy &amp; procedure on Unavailable Medications dated 07/2022 revealed, Policy: This facility shall use uniform guidelines for unavailable medications. Policy Explanation and Compliance Guide: Medications may be unavailable for a number of reasons. Staff shall take immediate action when it is known that the medication is unavailable: Determine reason for unavailability, length of time medication is unavailable, and what efforts have been attempted by the facility or pharmacy provider to obtain the medication. Notify physician of inability to obtain medication upon notification or awareness that medication is not available. Obtain alternative treatment orders and/or specific orders for monitoring the resident while the medication is held. If a resident misses a scheduled dose of the medication, staff shall follow procedures for medication errors, including physician/family notification, completion of a medication error report, and monitoring the resident for adverse reactions to omission of the medication.</p> <p>Controlled Drugs:</p> <p>100 Hall:</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Record review on 07/29/24 of the Controlled Drugs - Audit Record in Hall 100 revealed LVN had signed off on the Controlled Drugs - Audit Record prior to counting narcotics with on-coming nurse.</p> <p>Interview on 07/29/24 at 3:13 PM, with LVN said she had signed the Controlled Drugs - Audit Record before counting Controlled Substances with the on-coming nurse.</p> <p>Record review on 07/30/24 of the Controlled Drugs - Audit Record in Hall 100 revealed LVN J had signed off on the Controlled Drugs - Audit Record prior to counting narcotics with on-coming nurse.</p> <p>In an interview on 08/02/24 at 8:39 with LVN revealed licensed staff had been trained to count controlled substances at change of shift with the on-coming nurse and sign the Controlled Drugs - Audit Record after the count had been completed.</p> <p>200 Hall:</p> <p>Interview and record review on 07/29/24 at 9:12 AM, RN A said she had counted controlled substances at the change of shift and had forgot to sign the Controlled Drugs - Audit Record after the count had been completed. RN A licensed staff had been trained to count controlled substances at change of shift with the on-coming nurse and sign the Controlled Drugs - Audit Record after the count had been completed.</p> <p>300 Hall:</p> <p>Interview and record review on 07/29/24 at 3:10 PM, with LVN D revealed, he had signed off on the Controlled Drugs - Audit Record prior to counting narcotics with on-coming nurse. LVN D said licensed staff had been trained to count controlled substances at change of shift with the on-coming nurse and sign the Controlled Drugs - Audit Record after the count had been completed.</p> <p>Interview and record review on 07/29/24 at 3:21 PM, with RN L revealed licensed staff had been trained to count controlled substances at change of shift with the on-coming nurse and sign the Controlled Drugs - Audit Record after the count had been completed.</p> <p>400 Hall:</p> <p>Interview and record review on 07/29/24 at 9:43 AM, with LVN C said, she had counted controlled substances at the change of shift and had forgot to sign the Controlled Drugs - Audit Record after the count had been completed. LVN C licensed staff had been trained to count controlled substances at change of shift with the on-coming nurse and sign the Controlled Drugs - Audit Record after the count had been completed.</p> <p>Review of facility's policy &amp; procedure dated 07/2022 on Controlled Substance Administration &amp; Accountability revealed, Policy: It is a policy of this Facility to promote safe, high quality patient care, Compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion, or accidental exposure. Policy Explanation and Compliance Guidelines: The charge nurse or other designee conducts daily visual audit of the required documentation of controlled substances.</p> |   |  |

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| <p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 20026</p> <p>Based on interviews and record review, the facility failed to ensure drug regimen irregularities reported by the Pharmacist Consultant were acted upon by the physician for 1 (Resident #21) of 6 residents reviewed for physician response to medication regimen review.</p> <p>The facility failed to ensure that the physician responded timely to Pharmacist Consultant recommendations for Resident #21 to evaluate the continued need for iron sulfate beyond 8 weeks of therapy as per CMS Guidelines.</p> <p>These failures could place residents at risk for unnecessary medications.</p> <p>Findings included:</p> <p>Record review of Resident #21's Admission Record dated 07/30/24 revealed she [AGE] years old and was initially admitted on [DATE] and readmitted on [DATE].</p> <p>Record review of Resident #21's Hospital History &amp; Physical dated 02/01/24 for revealed had a diagnosis of anxiety, depression, hyperlipidemia (in condition where there are high levels of fats, or lipids in the blood), hypertension (a condition where the pressure in your blood vessels is consistently too high), hypothyroidism (a condition that occurs when the thyroid gland doesn't produce enough thyroid hormones), vitamin D deficiency, cough, seasonal allergies, overactive bladder, and GERD (Gastroesophageal Reflux Disease is a digestive disorder that occurs when stomach acid flows back up into the esophagus, the tube that connects the mouth to the stomach).</p> <p>Record review of Resident #21's Quarterly MDS dated [DATE] revealed she had diagnosis of vitamin D deficiency, and gastroesophageal reflux disease.</p> <p>Record review of Resident #21's Care Plan revised 07/31/24 revealed, she at risk for increased abdominal distress, weight loss, and GI bleed r/t GERD. Administer medications as ordered.</p> <p>Record review of Resident #21's Physician's Order dated July 2024 revealed, Ferrous sulfate (FeroSul) 325 mg give one tablet by mouth one time a day for supplement.</p> <p>Record review of Resident #21's the Medication Administration Record dated 07/29/24 Ferrous sulfate (FeroSul) 325 mg give one tablet by mouth one time a day for supplement.</p> <p>Record review of Pharmacy Consultant recommendation dated 06/30/24 for Resident #21 revealed Please evaluate the continued need for iron sulfate 325 mg QD beyond eight weeks of therapy as per CMS guidelines. Physician/Prescriber Response revealed medication was discontinued on 08/01/24.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>In an interview on 08/01/24 3:00 PM, the DON said she did not know why the pharmacy consultant recommendation had not been acted on since 06/30/24. She said there was not a system in place for ensuring the recommendations were promptly acted upon by the physician and that recommendation changes were completed in the medical record. She stated by not having a system in place for medication regimen reviews and recommendations a negative outcome could occur. She stated going forward she would be responsible for following up that all recommendations were completed timely and followed through.</p> <p>In an interview on 08/02/24 at 12:37 PM, administrator stated she was not aware that the pharmacy recommendations were not completed timely. She stated the physician should act upon the recommendation with 3 days but not later than the next review date. She stated pharmacy recommendations should be acted upon before the next monthly pharmacy review to prevent use of unnecessary drugs.</p> <p>Review of Medication Regime Review policy &amp; procedure dated 07/2022 revealed, Policy: The drug regimen of each resident is reviewed at least once a month by licensed pharmacist and includes a review of the resident's medical chart. Procedure Explanation and Compliance Guidelines: Medication Regime Review (MRR), is a thorough evaluation of the medication regiment of a resident, With the goal of promoting positive outcomes and minimizing adverse consequences. And potential risks associated with medications. The MRR includes: Review of the medical record in order to prevent, identify, report, and resolve medication related problems, medication errors or other irregularities. The pharmacist shall document, either manually or electronically, that each medication regiment review has been completed. The pharmacist shall document, either that no irregularity was identified or the nature of any identified irregularities. The pharmacist shall communicate any irregularities to the facility by written communication to the attending physician, the facility's Medical Director, and the Director of Nursing. Timelines and responsibilities for Medication Regime Review: Consultant pharmacist show schedule at least one monthly visit to the facility and shall allow sufficient time to complete all required activities. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities.</p> <p>49854</p> <p>Resident #18</p> <p>Unnecessary Meds, Psychotropic Meds, and Med Regimen Review</p> <p>07/31/24 02:49 PM</p> <p>Antipsychotic: Order Summary: Aripiprazole Oral Tablet 10 MG (Aripiprazole)</p> <p>Give 1 tablet by mouth at bedtime related to DEPRESSION, UNSPECIFIED (F32.A)</p> <p>Opioid: tramadol HCl Oral Tablet 50 MG (Tramadol HCl) *Controlled Drug* Give 1 tablet by mouth every 4 hours as needed for Pain - Moderate.</p> <p>Antidepressant: trazodone HCl Oral Tablet 50 MG (Trazodone HCl). Give 1 tablet by mouth at bedtime related to INSOMNIA, UNSPECIFIED (G47.00). Wellbutrin XL Oral Tablet Extended Release 24 Hour 150 MG (Bupropion HCl). Give 1 tablet by mouth one time a day for SMOKING CESSATION AID.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Diuretics: acetazolamide Oral Tablet 250 MG (Acetazolamide). Give 1 tablet by mouth two times a day related to EDEMA, UNSPECIFIED (R60.9)</p> |

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| <p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34486</p> <p>Based on interviews and record review the facility failed to ensure that residents who have not use psychotropic drugs were not given these drugs unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record for 5 (Resident #6, Resident #18, Resident #32, Resident #44, and Resident #45) of 6 residents reviewed for unnecessary medications.</p> <ul style="list-style-type: none"> <li>- The facility failed to ensure that Resident #6 did not receive the anti-psychotic Risperidone for agitation.</li> <li>- The facility failed to ensure that Resident #18 did not receive the anti-psychotic Aripiprazole for depression.</li> <li>- The facility failed to ensure that Resident #32 did not receive the anti-psychotic Olanzapine for dementia with behavioral disturbances.</li> <li>- The facility failed to ensure that Resident #44 had a 14-day stop date on his prescription for Quetiapine.</li> <li>- The facility failed to ensure that Resident #45 had a 14-day stop date on his prescription for Alprazolam.</li> </ul> <p>These failures could place residents at risk of being administered medications that were not medically necessary.</p> <p>Findings included:</p> <p>Resident #6</p> <p>Record review of Resident #6's face sheet dated 08/01/2024 revealed she was [AGE] years old and admitted to the facility on [DATE].</p> <p>Record review of Resident #6's quarterly MDS dated [DATE] revealed she had a BIMS score of 8 (Moderate cognitive impairment). She had no symptoms of delirium, depression, or psychosis and no behavioral symptoms. Her diagnoses included Non-Alzheimer's Dementia and Depression. She was being administered an antipsychotic medication on a routine basis, no GDR had been attempted and the physician had not documented GDR as clinically contraindicated.</p> <p>Record review of Resident #6's care plan dated 05/26/2024 revealed she was receiving risperidone [an antipsychotic] for behavior management of agitation.</p> <p>Record review of Resident #6's physician's order dated 02/13/2024 and discontinued 07/29/2024 revealed she was to be administered 0.25 MG of risperidone at bedtime for agitation.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Record review of Resident #6's pharmacist recommendation to the attending physician dated 05/01/2024 revealed the resident was receiving the antipsychotic risperidone which should only be used for specific conditions/diagnoses. The undated prescriber response indicated that the resident's diagnosis for risperidone should be changed to a mood disorder.</p> <p>Record review of Resident #6's physician's order dated 07/29/2024 revealed she was to be administered 0.25 MG of risperidone at bedtime for major depressive disorder.</p> <p>In an interview on 08/01/24 03:04 PM the DON revealed that Risperidone for agitation was not an appropriate diagnosis.</p> <p>Resident #18</p> <p>Record review of Resident #18's face sheet dated 08/01/2024, reflected a [AGE] year-old resident initially admitted on [DATE] with diagnosis including schizoaffective disorder (a combination of symptoms including mood disorders such as depression or bipolar disorders), and major depressive disorder.</p> <p>Record review of Resident #18's quarterly MDS Assessment, dated 05/14/2024, reflected Resident #18 was taking antidepressants.</p> <p>Record review of Resident #18's Care Plan, dated 02/20/2024, reflected that Resident #18 was on antidepressant medication due to a diagnosis of depression.</p> <p>Record review of Resident #18 's Orders, dated 02/05/2024, reflected that Resident # 18 was on Aripiprazole oral table 10 MG (Aripiprazole) and ordered to administer 1 tablet by mouth at bedtime related to depression, unspecified.</p> <p>Record review of Resident #18 's Medical Administration Record, ranging from dates 07/01/2024 to 07/31/2024 reflected that Resident # 18 was on Aripiprazole oral table 10 MG for the 31 days of the month.</p> <p>Record review of Drugs.com on 08/15/2024 revealed that Aripiprazole is an antipsychotic used to treat schizophrenia. Aripiprazole is not approved for use in older adults with dementia-related psychosis.</p> <p>Resident #32</p> <p>Record review of Resident #32's face sheet dated 07/31/2024 revealed she was [AGE] years old and was admitted to the facility on [DATE].</p> <p>Record review of Resident #32's Admission MDS assessment dated [DATE] revealed she had a BIMS score of 1 (Severe cognitive impairment). She had no symptoms of delirium or depression. She had signs of psychosis including delusions (misconceptions or beliefs that are firmly held, contrary to reality). She had no symptomatic behavior. Her diagnoses included cerebrovascular accident (stroke), non-Alzheimer's dementia, depression and psychotic disorder. She was receiving antidepressants and antipsychotic medications.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Record review of Resident #32's care plan dated 06/25/2024 revealed she had a history of delusional disorder and was to receive medications as ordered. Her care plan dated 07/29/2024 revealed she used psychotropic medication for delirium and was to receive medications as ordered.</p> <p>Record review of Resident #32's physicians order dated 06/22/2024 and discontinued 07/29/2024 revealed she was to receive 2.5 MG of olanzapine (an antipsychotic) at bedtime for dementia with psychosis.</p> <p>Record review of Resident #32's physicians order dated 07/29/2024 revealed she was to receive 2.5 MG of olanzapine (an antipsychotic) at bedtime for delusional disorder.</p> <p>Record review of Resident #32's MAR for June of 2024 revealed she received 2.5 MG of olanzapine daily beginning on 06/23/2024 through the end of the month for a diagnosis of dementia with psychosis.</p> <p>Record review on 07/30/2024 of Resident #32's MAR for July of 2024 revealed she received 2.5 MG of olanzapine daily beginning on 07/01/2024 through 07/29/2024 for a diagnosis of dementia with psychosis.</p> <p>In an interview on 08/01/24 at 02:57 PM the DON revealed Resident #32's diagnosis of dementia with psychosis was not an appropriate diagnosis for olanzapine, an antipsychotic medication. She stated that the diagnosis had been changed to delusional disorder and she was trying to find out from the physician if this was a tenable diagnosis for use of olanzapine.</p> <p>Resident #44</p> <p>Record review of Resident #44's face sheet dated 08/01/2024, reflected a [AGE] year-old resident initially admitted on [DATE] with diagnosis including bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and post-traumatic stress disorder.</p> <p>Record review of Resident #44's quarterly MDS Assessment, dated 06/06/2024, reflected Resident #44 was taking antidepressants and antipsychotics.</p> <p>Record review of Resident #44's Care Plan, dated 06/02/2024, reflected that Resident #44 was on antidepressant medication due to a diagnosis of depression and anxiety.</p> <p>Record review of Resident #44 ' s Orders, dated 06/02/2024, reflected that Resident #44 was on hydroxyzine oral tablet 25 MG (an antianxiety medication) and ordered to administer 25 mg by mouth every 8 hours as needed for anxiety. No stop date or number of days the order was to be in effect were included in the order.</p> <p>Record review of Resident #44 ' s Medical Administration Record, ranging from dates 07/01/2024 to 07/31/2024 reflected that Resident #44 was administered one hydroxyzine 25 MG daily 13 times, and two hydroxyzine 25 MG daily 14 times.</p> <p>(continued on next page)</p> |

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| <p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>During an interview on 7/31/2024 at 3:30 pm the DON revealed that there should be a 14-day stop date on any psychotropic medication. She said the nurses had not been trained on the 14-day stop of medication, and that she discovered issued with psychotropic and antipsychotic medication early July 2024 and had been working to resolve them. The DON said the risk of not stopping psychotropic medications after 14 days could result in side effects to the residents such as Tardive Dyskinesia (a condition affecting the nervous system, often caused by long-term use of some psychiatric drug) for taking medications they are not supposed to be taking. The DON revealed the receiving nurse was responsible for talking to the doctor for clarifications on medication administration. The DON said that progress notes should be entered of the receiving nurse communicating with the doctor if there are discrepancies with a resident ' s medications. The DON said that if after talking with the doctor and the doctor determines there are no changes in medication, there should be a progress note saying there are no changes being made.</p> <p>Resident #45</p> <p>Record review of Resident #45's face sheet dated 07/31/2024 revealed he was [AGE] years old, was initially admitted to the facility on [DATE] and readmitted on [DATE].</p> <p>Record review of Resident #45's quarterly MDS assessment dated [DATE] revealed he had a BIMS score of 11 (Moderate cognitive impairment). He had no symptoms of delirium, depression, psychosis and no symptomatic behaviors. He had diagnoses including anxiety disorder. He had received antianxiety medications.</p> <p>Record review of Resident #45's Care Plan dated 05/16/2024 revealed he used anti-anxiety medications related to his diagnosis of anxiety disorder.</p> <p>Record review of Resident #45's physician's order dated 05/07/2024 revealed he was to receive 0.25 MG of alprazolam (an antianxiety medication) every six hours as needed for anxiety. No stop date or number of days the order was to be in effect were included in the order.</p> <p>Record review of Resident #45's MAR for May 2024 revealed he was administered Alprazolam 0.25 on 05/08, 05/20, 05/22, 05/27 and 05/30/2024.</p> <p>Record review of Resident #45's MAR for June 2024 revealed he was administered Alprazolam 0.25 on 06/26/2024.</p> <p>Record review of Resident #45's MAR for July 2024 revealed he was administered Alprazolam 0.25 on 07/12/2024.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>During an interview with on 7/31/2024 at 3:30 pm the DON revealed she was the one responsible for talking to the doctor for clarifications on medication administration was the receiving nurse. The DON said that progress notes should be entered of the receiving nurse communicating with the doctor if there are discrepancies with a resident's medications. The DON said that if after talking with the doctor and the doctor determines there are no changes in medication, there should be a progress note saying there are no changes being made. The DON said for psychotropics they had to document it. The DON said the nurses had not been trained on the 14-day stop of medication. The DON said she discovered this issue in early July 2024. The DON said the risk of not stopping psychotropic medications after 14 days could result in side effects to the residents such as Tardive Dyskinesia (a condition affecting the nervous system, often caused by long-term use of some psychiatric drug) for taking medications they are not supposed to be taking.</p> <p>Record review of the facility policy Use of Psychotropic Medication dated 7/2022 revealed residents were not given psychotropic drugs unless they were necessary to treat a specific condition as diagnosed and documented in the resident's clinical record. PRN orders for all psychotropic drugs shall be used for a limited duration of 14 days.</p> <p>49854</p> <p>Resident #18</p> <p>Unnecessary Meds, Psychotropic Meds, and Med Regimen Review</p> <p>07/31/24 02:49 PM</p> <p>Antipsychotic: Order Summary: Aripiprazole Oral Tablet 10 MG (Aripiprazole)</p> <p>Give 1 tablet by mouth at bedtime related to DEPRESSION, UNSPECIFIED (F32.A)</p> <p>Opioid: tramadol HCl Oral Tablet 50 MG (Tramadol HCl) *Controlled Drug* Give 1 tablet by mouth every 4 hours as needed for Pain - Moderate.</p> <p>Antidepressant: trazodone HCl Oral Tablet 50 MG (Trazodone HCl). Give 1 tablet by mouth at bedtime related to INSOMNIA, UNSPECIFIED (G47.00). Wellbutrin XL Oral Tablet Extended Release 24 Hour 150 MG (Bupropion HCl). Give 1 tablet by mouth one time a day for SMOKING CESSATION AID.</p> <p>Diuretics: acetazolamide Oral Tablet 250 MG (Acetazolamide). Give 1 tablet by mouth two times a day related to EDEMA, UNSPECIFIED (R60.9)</p> <p>Resident #44</p> <p>Unnecessary Meds, Psychotropic Meds, and Med Regimen Review</p> <p>07/31/24 02:23 PM</p> <p>Hydroxyzine was supervised to the resident with a starting date of 6/18/24 and was supervised</p> |   |  |

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| <p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 20026</p> <p>Based on observation, interview, and record review, the facility failed to ensure the medication error rate was not five percent or greater. The facility had a medication error rate of 22% based on 12 errors out of 53 opportunities, for two residents (Resident #21, Resident #295) of six residents observed for medication administration, by one (Med Aide E) of four staff reviewed for medication errors.</p> <p>-The facility failed to ensure Med Aide E administered eight morning medications to Resident #21 on 07/29/24.</p> <p>- The facility Med Aide E failed to administer Resident #295 Famotidine 20 mg, Amiodarone HCL 200 mg, Budesonide Inhalation Solution, and Cholestyramine Oral Pkt on 07/29/24 according to physician's orders for the scheduled morning medication pass.</p> <p>These failures had the potential to affect facility residents by placing them at risk of not achieving the therapeutic effects of ordered medications to manage their medical conditions and decline in health.</p> <p>Findings include:</p> <p>Resident #21</p> <p>Record review of Resident #21's Admission Record dated 07/30/24 revealed she [AGE] years old and was initially admitted on [DATE] and readmitted on [DATE].</p> <p>Record review of Resident #21's Hospital History &amp; Physical dated 02/01/24 for revealed had a diagnosis of anxiety, depression, hyperlipidemia (in condition where there are high levels of fats, or lipids in the blood), hypertension (a condition where the pressure in your blood vessels is consistently too high), hypothyroidism (a condition that occurs when the thyroid gland doesn't produce enough thyroid hormones), vitamin D deficiency, cough, seasonal allergies, overactive bladder, and GERD (Gastroesophageal Reflux Disease is a digestive disorder that occurs when stomach acid flows back up into the esophagus, the tube that connects the mouth to the stomach).</p> <p>Review of History and physical date 02/01/24 written by NP F for Resident #21, revealed past medical history of anxiety, depression, hypertension, hyperlipidemia, hypothyroidism. She was initially transferred to the hospital for evaluation of nausea and vomiting. Had been transferred to the hospital for nausea and vomiting. She was found to have a small amount obstruction. Resident has a history of right knee replacement, several years ago and is requesting pain management.</p> <p>Review of Resident #21's Quarterly MDS dated [DATE] revealed she had diagnosis of hypertension, renal insufficiency, multi-drug resistant organisms, hyperlipidemia, anxiety disorder, hypothyroidism, vitamin D deficiency, and gastroesophageal reflux disease.</p> <p>(continued on next page)</p> |

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| <p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Review of Resident #21's Care Plan revised 07/31/24 revealed, she was at Risk for coughing, sneezing, watery, dry, red eyes, runny nose, related to diagnosis of Allergic. Rhinitis. Administer medications is ordered. Resident had depression and was at risk of fluctuation in moods, little interest, or pleasure in doing things, and decrease socialization. Administer medications as ordered. Resident was at risk for increased abdominal distress, weight loss, and GI bleed r/t GERD. Administer medications as ordered. The Care Plan did not have any information related to crushed meds.</p> <p>Review of Resident #21's Physician's Order dated July 2024 revealed,</p> <p>Acidophilus (Probiotic) one capsule by mouth once a day for digestive support.</p> <p>Fish Oil 1000 mg 1 soft gel my mouth for Dyslipidemia.</p> <p>Lidocaine patch 5% apply to right knee two times a day for pain.</p> <p>Ferrous sulfate (FeroSul) 325 mg give one tablet by mouth one time a day for supplement. Docusate Sodium. 100 mg give one tablet by mouth two times a day for constipation.</p> <p>Myrbetriq ER give one tablet by mouth one time a day for overactive bladder.</p> <p>Loratadine give one tablet by mouth one time a day for allergic rhinitis.</p> <p>Pantoprazole Sodium (Protonix) give one tablet by mouth one time a day for GERD. Escitalopram Oxalate 20 mg Give one tablet by mouth one time a day for depression.</p> <p>She did not have an order to crush medication.</p> <p>Observation 07/29/24 at 8:07 AM, revealed Med Aide E entered room to administer medications to Resident #21 and handed the medication cup to the resident. The Resident placed the Fish Oil Softgel capsule, it in her mouth, took a sip of water and started coughing. Resident told Med Aide E the capsule was stuck in her throat and could not spit out or swallow the capsule. The resident's face was red, was coughing and was anxious. Resident kept saying she was not able to spit out the capsule and was stuck in her throat. Surveyor immediately went to get the nurse. The nurse immediately went to resident's room. The Resident kept saying the capsule was stuck in her throat and could not swallow the capsule and kept coughing. The Nurse gave the resident 4 hard pats on the back and was able to spit out the capsule. The nurse left the room. The Resident continued to clear her throat and spitting phlegm. Med Aide did not ask the resident if she wanted to take the rest of her medications and did not apply the Lidocaine Patch to the right knee as ordered. The Med Aide disposed the rest of the tablets in the red sharp container.</p> <p>In an Interview and record review on 07/29/24 at 8:17 AM Med Aide E revealed she only worked PRN and did not know the residents very well. She said she had made a list in the morning prior to starting the medication pass of those resident that needed to have crushed medications and demonstrated to the surveyor Resident #21 was on her list. Med Aide E said, It was my fault, because I did not crush her medications as noted on my list and on the Special Instructions in the electronic medication record. Med Aide demonstrated to surveyor the Special Instructions written on the MAR documented CRUSHED MEDICATIONS</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Interview on 07/29/24 at 8:12 AM, revealed Resident #21 was oriented to person, place, and situation. Resident reported that she had been having problems with swallowing for approximately two weeks. Resident reported that the Med Aides always crush all her medication except for the one that was working today.</p> <p>Review of Resident #21's the Medication Administration Record dated 07/29/24 documented Chart Codes of 8 (not administered due to nauseated/vomiting), for the</p> <p>Escitalopram Oxalate 20 mg Give one tablet by mouth one time a day for depression,</p> <p>Ferrous sulfate (FeroSul) 325 mg give one tablet by mouth one time a day for supplement,</p> <p>Loratadine give one tablet by mouth one time a day for allergic rhinitis,</p> <p>Myrbetriq ER give one tablet by mouth one time a day for overactive bladder,</p> <p>Acidophilus (probiotic) one capsule by mouth once a day for digestive support,</p> <p>Pantoprazole Sodium (Protonix) give one tablet by mouth one time a day for GERD,</p> <p>Docusate Sodium. 100 mg give one tablet by mouth two times a day for constipation, and</p> <p>Lidocaine patch 4% apply to right knee two times a day for pain.</p> <p>Interview on 07/31/24 at 10:50 AM, with LVN J revealed, Med Aide E had not reported to her she had not administered the morning medications Resident #21 on 07/29/24. LVN J said Med Aides had been trained to report to the nurses when medications were held or refused.</p> <p>Observation and interview on 07/31/24 at 11:20 AM, with RN A and Med Aide I, revealed they did not have Lidocaine Patches for Resident #21, in the nurse's and Med Aide Carts.</p> <p>Observation on 07/31/24 at 11:24 AM, with RN A, revealed they did not have Lidocaine Patches for Resident #21 in the Medication Prep Room.</p> <p>Interview and record review on 07/31/24 at 11:41 AM, with DON revealed, that training was in progress since April 2024, when she was hired to address medications not re-ordered timely resulting in missed doses of prescribed medications. DON said medications should be re-ordered 7 days before they run out of medications. DON said, Lidocaine 4% was an over-the counter medication, and Med Aide E had not reported to her that the last patch had been used on 07/30/24. DON said she would have the central supply clerk buy the Lidocaine 4% patches at the local store as soon as possible.</p> <p>In a telephone interview with Med Aide E on 07/31/24 at 1:14 PM, confirmed she had not reported to LVN J when she had not administered the medications on 07/29/24 to Resident #21 during the morning med pass and had not applied the Lidocaine patch to the right knee as ordered. Med Aide E said they had been trained to report to the nurses when medications were refused or when medications are not available to administer as ordered. Med Aide reported she had not reported to LVN J on 07/29/24, that Escitalopram Oxalate 20 mg was not on hand to administer the dose scheduled at 7:30 AM.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Interview and record review on 07/31/24 at 2:00 PM, with DON confirmed physician's orders for Resident #21, did not document a physician's order to discontinue the Lidocaine patch 5%.</p> <p>Resident #295</p> <p>Record review of Resident #295's Admission Record dated 08/01/24 revealed she was [AGE] years old and was admitted to the facility on [DATE].</p> <p>Record review of Resident #295's Hospital History &amp; Physical dated 07/30/24 revealed she a diagnosis of gastrointestinal bleed, atrial fibrillation (An irregular heartbeat that occurs when the electrical signals in the two upper chambers of the heart fire rapidly at the same time), pneumonia (is an infection of the lungs that may be caused by bacteria), hypertension, shortness of breath, and asthma.</p> <p>Record review of Resident #295's Entry MDS dated [DATE] revealed entry date 07/28/24.</p> <p>In a telephone Interview on 08/02/24 at 12:17 PM, with FNP F revealed licensed staff notified him most of the time when medications were not available to administer as ordered. He said he expected the nurses to continue to administer medications according to hospital discharge orders until resident was assessed by the physician and/or FNP after admission to determine if they would continue with the same medications or make changes as needed. FNP said We would not want to make changes to the medications if the resident has been stabled with the current medication regime from the hospital. Failure to administer prescribed medication could affect the resident depending on the number of missed doses and the type of medication. FNP said he was not notified, on 07/29/24 that the Famotidine 20 mg, Cholestyramine, Budesonide and Amiodarone HCL on 07/29/28 had not been administered as ordered. FNP said he expected the nurses notify him right away when medications were not on hand to administer as ordered.</p> <p>Record review of Resident #295's Care Plan revised 07/29/24 revealed she was at risk for increased abdominal distress, weight loss and GI Bleed r/t GERD (gastroesophageal reflux disease), administer medications per order, monitor for effectiveness and report to MD if resident c/o of increased abdominal discomfort and discomfort. She had asthma, give medication as ordered, monitor and document side effects and effectiveness.</p> <p>Record review of Resident #295's active physician's orders initiated 07/28/24 revealed Budesonide Inhalation suspension (helps prevent the symptoms of asthma) 0.5 mg/2 ml 1 IUD[sic] Inhale orally every 12 hours for asthma, Famotidine (used to treat stomach Ulcers) 20 mg give 0.5 tablet by mouth one time a day for GERD (a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth in the stomach, called the esophagus), Cholestyramine Oral Packet (used to lower cholesterol levels in the blood) 4 GM give 1 packet by mouth two times a day for hyperlipidemia. Amiodarone HCL (helps keep heart rhythm normal) 200 mg give daily was not listed on physician's orders.</p> <p>Record review of Resident #295's Hospital Patient Discharge Instructions dated 07/28/24, revealed Medication Instructions: Amiodarone HCL 200 mg 0.5 tablet oral daily, Famotidine 20 mg 0.5 tablet oral daily, Budesonide 0.5 mg/2 ml suspension via nebulized inhalation, and Cholestyramine 4 GM/5 GM oral twice daily.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Record review of Resident #295's Medication Administration Record date July 2024 revealed, Amiodarone HCL 200 mg give 0.5 tablet by mouth one time a day for atrial fibrillation, Famotidine 20 mg give 0.5 tablet my mouth one time a day for GERD, Cholestyramine Oral Packet 4 GM give 1 packet by mouth two times a day for hyperlipidemia, and Budesonide Inhalation suspension 0.5 mg/2 ml 1 IUD [sic] inhale orally every 12 hours for asthma were not administered on 07/29/24 (Chart Code 9 See Progress Notes).</p> <p>In an interview and record review on Resident #295's Physician's Orders dated 07/28/24 with DON revealed there was not an order for Amiodarone 200 mg give 0.5 mg by mouth daily.</p> <p>In an interview on 08/02/24 at 12:37 PM, with the Administrator revealed, Central Supply Clerk must notify the DON, if OTC are not on hand to administer. The Administrator said, I will give him money to go and buy the OTC that are needed at one of the local stores. Administer said she was aware of issues with timely delivery of medications from the vendor pharmacy. The nurses should call the pharmacy local on call pharmacy after hours, not just fax the orders to the pharmacy vendor pharmacy because the local on call pharmacy is not connected to the portal. So they do not received the faxes that are sent to the vendor pharmacy after hours. She said Med Aides had been trained to immediately report to the nurse assigned to the resident if medications were held or refused. The nurse should assess the resident and follow up to determine why the medication was held or refused. The nurse have been trained to documented the assessment in the resident's electronic nurses progress notes.</p> <p>Record review of an email written by DON to the vendor pharmacy dated 08/02/24 at 11:38 AM, revealed medication removal from automated medication dispensing system for Resident #295 on 7/29/24 Metoprolol Tartrate 25 mg one tablet, Amox/Clav (Augmentin antibiotic used to treat bacterial infections) 500/125 one tablet and Hydralazine 25 mg one tablet. The DON stated, the other prescribed medications (Amiodarone HCL, Budesonide, Famotidine, Cholestyramine) was not stocked in the automated medication dispensing system to administer the scheduled doses in the morning.</p> <p>In an interview and observation and interview on 07/29/24 at 9:12 AM, during medication pass observation with RN A, revealed Resident #295 was admitted to the facility on [DATE] on the 2-10 shift. RN A said licensed staff had been trained to fax physician's orders to the vendor pharmacy after hours, so medications were sent to the facility on the next business day. RN A said they did not have the Amiodarone HCL, Famotidine 20 mg, Cholestyramine Oral Packet, Budesonide Inhalation suspension in the automated medication dispensing system to administer the scheduled doses in the morning.</p> <p>In an interview and observation and interview on 07/29/24 at 10:00 AM, during medication pass observation with Med Aide E revealed RN A obtained Metoprolol Tartrate 25 mg one tablet and Hydralazine 25 mg one tablet from the automated medication dispensing system. Med Aide E said the Famotidine 20 mg, Amiodarone HCL 200 mg, Budesonide Inhaler, and Cholestyramine Oral Pkt were not stocked in the automated medication dispensing system to administer the scheduled doses in the morning.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>In an interview on 08/02/24 at 1:00 PM, with DON said NP was at the facility on 07/29/24 and did not know if the nurses had informed him Resident #295's medications were not available on that day to administer the scheduled doses in the morning. She said resident was admitted [DATE] late on the evening shift. She said when the nurses enter the physician orders in the electronic record, the orders are automatically transmitted to the vendor pharmacy. She said she called the vendor pharmacy today and was informed physician orders received after 5:00 PM, would not be filled until the next business day. She said the nurses needed to call the local contracted pharmacy after 5:00 PM, and fax them a copy of the physician's orders, so the prescribed medications were delivered on the day physician's orders were received. She said, We were not aware of this process. So, I will be providing training to the licensed staff as soon as possible.</p> <p>Review of facility's policy &amp; procedure on Medication Administration dated 07/22/22 revealed, Policy: Medications are administered by licensed nurse, or other staff who are legally authorized to do so in this state, as ordered by the physician in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy explanation and compliance guidelines: Keep medication cart clean, organized, and stocked with adequate supplies. Administer medications as ordered in accordance with manufacturer specifications. Crush medications as ordered. Report and document any adverse side effects or refusals. Correct any discrepancies and report to nurse manager.</p> <p>Review of facility's policy &amp; procedure on Unavailable Medications dated 07/2022 revealed, Policy: This facility shall use uniform guidelines for unavailable medications. Policy Explanation and Compliance Guide: Medications may be unavailable for a number of reasons. Staff shall take immediate action when it is known that the medication is unavailable: Determine reason for unavailability, length of time medication is unavailable, and what efforts have been attempted by the facility or pharmacy provider to obtain the medication. Notify physician of inability to obtain medication upon notification or awareness that medication is not available. Obtain alternative treatment orders and/or specific orders for monitoring the resident while the medication is held. If a resident misses a scheduled dose of the medication, staff shall follow procedures for medication errors, including physician/family notification, completion of a medication error report, and monitoring the resident for adverse reactions to omission of the medication.</p> |   |  |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>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.</p> <p>20026</p> <p>Based on observation, interview, and record review, the facility failed to provide pharmaceutical services that assured the accurate acquiring, receiving, dispensing, safe and secure storage of medications for 4 of 4 nurse carts checked for controlled substances; 2 of 2 Med Aide carts checked for storage of medications.</p> <p>-The facility failed to ensure liquid medication stored in medication carts on three halls (200, 300 and 400) did not have dried drippings on the sides of the bottles.</p> <p>-The facility failed to ensure medications were stored according to routes of administration.</p> <p>-The facility failed to ensure 1 of 7 medication carts was locked when not in use.</p> <p>The facility failed to ensure bottle of Betadine stored in the treatment cart was free of dried drippings.</p> <p>-The facility failed to ensure opened bottles of Acidophilus Probiotic Dietary Supplement were refrigerated after opening in 7 of 7 medication carts.</p> <p>This failure could result in drug diversion of controlled substances. These failures could affect residents that received medications at the facility by placing them at risk of not having prescribed medications and cross contamination.</p> <p>Medication Cart:</p> <p>In an observation and interview on 07/29/24 at 7:27 AM, with Med Aide E revealed Medication Cart for Hall 100 and Hall 200 Hall revealed oral medications were stored with nasal medications. MED E said staff had been trained to stored medications separately in medication cart according to routes of administration.</p> <p>In an observation on July 29, 2024, at 7:30 AM reveal nurse's medication cart the 100 Hall 100 was unlocked and unattended.</p> <p>In an interview on 08/02/24 at 8:39 with LVN J revealed licensed staff had been trained to keep medications carts locked when not in use.</p> <p>In an observation and interview at 07/29/24 at 8:46 AM, with Treatment Nurse revealed bottle of Povidone iodine (Betadine) had dried drippings around the cap and the sides of bottle.</p> <p>Hall 100:</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>In an observation and interview on 08/02/24 at 9:52 with DON, revealed bottle of Acidophilus Probiotic Dietary Supplement was dated as opened on 07/30/24. DON confirmed the manufacture's label on the bottle said to Refrigerate after opening. DON immediately removed the medication bottle from the medication cart.</p> <p>Hall 400:</p> <p>In an observation and interview on 08/02/24 at 9:49 AM with Med Aide G, revealed bottle of Acidophilus Probiotic Dietary Supplement was dated as opened on 07/30/24. Med Aide G confirmed the manufacture's label on the bottle said to Refrigerate after opening. Med Aide G said she was not aware medication needed to be refrigerated after opening.</p> <p>Hall 300:</p> <p>In an Observation and interview on 08/02/24 at 10:03 with LVN D, revealed bottle of Acidophilus Probiotic Dietary Supplement was dated as opened on 07/16/24. LVN D confirmed the manufacture's label on the bottle revealed said to Refrigerate after opening. LVN D said I know Acidophilus Probiotic Dietary Supplement needs to be refrigerated after opening. I don't know why it's in the medication cart.</p> <p>Review of facility's policy &amp; procedure dated 07/2022 on Medication Storage revealed, Policy: It is a policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy or medication rooms according to manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy Explanation and Compliance Guidelines: All right from biologicals will be stored in locked compartments. Such as medication cards. Under proper temperature controls. Only authorized personnel will have access to the key to lock the compartments. During the medication, past medications must be under the direct observation of the person. Administering medications are locked in the medication storage area/cart. Medications should be stored so that various routes of administrations are separated. Medications requiring refrigeration are kept in the refrigerator.</p> |   |  |

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| <p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>20026</p> <p>Based on observations, interviews, and record reviews the facility failed to prepare food by methods that conserve nutritive value in 1 of 1 kitchen reviewed for food preparation.</p> <p>The facility [NAME] N failed to prepare instant mashed potatoes according to manufacturer's serving chart.</p> <p>These failures could could impact the nutritional value of the meal.</p> <p>Findings included:</p> <p>In an observation and interview on 07/29/24 with [NAME] N revealed they had 16 residents on Pureed Food and was going to prepare 20 servings for the lunch meal. He said he was going to prepare Mashed Potatoes and was going to 2 lbs. of potato flakes to 4 quarts of water. He said I just eyeball the amount of water and potato flakes to get the correct consistency and amount of potato flakes to get 20 servings. I don't go by the serving chart on the container.</p> <p>In an interview and record review on 08/01/24 at 1:58 PM, with Dietary Manager revealed, Recipe for Mashed Potatoes documented Instructions: Follow manufacturer directions for exact amounts. The Dietary Supervisor stated, I don't understand why you are concerned about the [NAME] not following the manufacturer directions if the consistency of the potato was adequate.</p> |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026</b></p> <p>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.</p> <ul style="list-style-type: none"> <li>-The facility failed to ensure the shelf in the food preparation area used to store spices was free of food particles.</li> <li>-The facility failed to keep food preparation tables and equipment free of white stains, and food particles.</li> <li>-The facility failed to keep the tiles floors free of black grease build-up.</li> <li>- The facility failed to keep food coloring bottle free of dried drippings.</li> </ul> <p>The facility failed to keep trash can covered in the food preparation area.</p> <ul style="list-style-type: none"> <li>-The facility failed to store foods in the refrigerators and freezers in sealed containers.</li> <li>- The facility failed to keep food containers free of grease build up, and dried stains in the dry storage room.</li> <li>-The facility failed to store foods stored on metal racks in the dry storage room in sealed containers.</li> <li>-The facility failed to store foods in the refrigerators and freezers in sealed containers.</li> <li>-The facility failed to label food containers stored in the refrigerators.</li> <li>-The facility failed to store boxes of food and frozen foods promptly after delivery.</li> <li>-The facility failed to discard perishable foods stored, in the dry storage area and refrigerator. [NAME] onions were soft to touch, mushy, and a had black mold. Large bag of cold slaw mixed had liquid substance in the bag and cabbage was mushy. Large packet of lettuce stored in the refrigerator was mushy and had black substance.</li> <li>-The facility failed maintain drain covers free of black stains and cracks.</li> <li>-The facility failed to wash dishes in the three-compartment sink according to poster that specified procedure to sanitize pots and pans.</li> </ul> <p>These failures could affect residents by placing them at risk of food borne illnesses.</p> <p>Findings included:</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Observation on [DATE] at 6:38 AM during the initial tour in the kitchen revealed:</p> <p>Food Preparation Area:</p> <ul style="list-style-type: none"> <li>-The shelf directly above the food preparation table by the stove where spice bottles were stored was full of food particles.</li> <li>-Stainless steel tables had dried white stains under the steamer and sides of the table.</li> <li>-Steamer had white calcium build-up on the sides.</li> <li>-Deep Fryer was full of crumbs and pieces of chicken were in the oil pan.</li> <li>-Tile floor between the deep fryer and steamer had dried black stains and there was a piece of chicken on the floor.</li> <li>-The sides of the stove had dried brown stains and grease build-up.</li> <li>-Broken toaster was full of dust and food particles.</li> <li>-Storage shelves under stainless steel table had dried white stains and food particles.</li> <li>-Tile floor throughout the kitchen had black grease build-up and food particles.</li> <li>-Multiple Spice bottles were opened, grease build-up on lids and sides of bottles.</li> <li>-Small bottle of food color stored with spice bottles had dried drippings on the cap and sides of bottle.</li> <li>-Stainless steel shelf in the dish washing room had food particles and dried white stains.</li> <li>-Large Trash can in food preparation area was uncovered.</li> <li>-Hand Sink had dried white stains.</li> <li>-Mobile Dish [NAME] had dust and food particles on the bottom of storage columns.</li> <li>-Stainless steel table directly below spice rack was dusty, had dried food stains, and pieces of paper on top of table.</li> <li>-Stainless steel table where blender was stored had dried red liquid stains, and grease build up.</li> <li>-Ice Scoop was stored in a zip-lock bag that was not sealed on top of ice machine. The top of the ice machine was full of dust.</li> <li>-3 cardboard boxes labeled keep frozen that contained Super-crisp Regular Fries and Mighty Shakes were on the floor by the Dietary Manager's office.</li> </ul> <p>(continued on next page)</p> |   |  |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>-6 boxes of 2% Reduced Fat Milk and two other boxes of frozen foods were on the floor in the dry storage room by the refrigerator; The [NAME] stated food delivery had come early this morning and they had not had time to put the food away because they busy were preparing the breakfast meal.</p> <p>Interview and review of photos taken during initial tour of the kitchen on [DATE] at 2:04 PM, with the Dietary Manager revealed, he did not have written assignments to clean the kitchen, due to each worker being responsible for cleaning their own works areas. He said the kitchen was cleaned after each meal. He said the Deep Fryer should be cleaned after each use. He said the commercial toaster was not in use because it was broken.</p> <p>Dry Storage Area:</p> <ul style="list-style-type: none"> <li>- Large plastic container with a white lid was stored on the metal rack in the Dry Storage Room, had grease built up and food particles around the top of the lid.</li> <li>-Large white plastic container that contained onions had several onions that had black mold and mushy.</li> <li>-Three Mobile Ingredient Bins had dried white stains and food residual on the lids.</li> </ul> <p>-6 boxes of 2% Reduced Fat Milk were on the floor next to the refrigerator.</p> <p>Foods Stored in Refrigerators:</p> <ul style="list-style-type: none"> <li>- A bowl of cornflakes covered with Saran wrap was stored in the refrigerator and was not dated.</li> <li>-A red opened container of Whipped Light Cream was uncovered.</li> <li>-Large stainless steel food pan that contained cooked broccoli was covered with Saran wrap and was not dated.</li> <li>-Large stainless steel food pan contained Chile with meat dated [DATE] was partially covered with Saran wrap and was not sealed.</li> <li>-Small disposable plate that contained a peanut butter and Jelly sandwich was covered with Saran wrap and was not dated.</li> <li>-Large plastic container with a red covered that contained a red liquid was not labeled or dated. The lid had a white powdery substance and small food particles on the lid.</li> <li>-Large stainless steel food pan dated [DATE] that contained Picadillo (stewed meat) was partially covered with Saran Wrap was not completely sealed.</li> <li>-Large zip lock bag stored that contained chicken strips was not dated.</li> <li>-Sliced cheese wrapped in Saran wrap was not dated.</li> <li>-Large meal tray that had glasses of milk were not dated.</li> </ul> <p>(continued on next page)</p> |   |  |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <ul style="list-style-type: none"> <li>-Large plastic bag that contained coleslaw dice mix had a lot of liquid in the bag and contents was mushy.</li> <li>-Large opened cardboard box stored on the bottom shelf of the refrigerator had dried light red liquid stains on the front and side of the box.</li> <li>-Bottom shelf of Refrigerator # 2 had a large piece of dried lettuce and food particles on the bottom shelf.</li> <li>-Packet of lettuce wrapped in Saran wrap dated [DATE] had black mold and was mushy.</li> <li>-Refrigerator #1 had dried white stains and food particles on the edges of the refrigerator.</li> <li>-Large opened cardboard box that contained beef patties was opened on [DATE] was not sealed.</li> <li>-Large opened cardboard box that contained frozen Pork Egg Rolls was not sealed.</li> <li>-large opened cardboard box that contained diced Chicken Meat was not sealed.</li> <li>-Refrigerator#3 had dried white stains and food particles.</li> <li>-Large opened cardboard box that contained frozen Cheese Omelets was not sealed.</li> <li>-Large opened cardboard box that contained Sopapilla Dough was not sealed.</li> <li>-large, opened box of frozen muffins was opened and was partially wrapped with Saran wrap was not sealed.</li> <li>-10 cardboard boxes of can goods were on the floor next to the metal rack in the Dry Storage Room.</li> <li>-Fire extinguisher by hand sink was full of dust and had dried white stains.</li> <li>-Tile floor in dish washing room was full of food particles and dried food stains.</li> </ul> <p>Record review of Dietitian Consultant Sanitation Audit Dated [DATE] revealed Directions: Place an X under the. NA column if item is not applicable. Under the Y column, enter 1 if the line item is acceptable, Otherwise, enter a 0. Equipment: Can Opener-0. Refrigerator: Items dated and labeled- 0. Leftovers dated &lt; than 7 days- 0. Items sealed &amp; covered- 0. No expired foods- 0. Maintenance: chemical closet- 0. Pots &amp; Pans: Dirty &amp; Clean items stored separately- 0.</p> <p>Record review of Dietitian Consultant Sanitation Audit Dated [DATE] revealed Directions: Place an X under the. NA column if item is not applicable. Under the Y column, enter 1 if the line item is acceptable, Otherwise, enter a 0. Equipment: Juice Machine-0. Food Prep Area: No staff beverages or food 0. Refrigerator: Items dated and labeled- 0. Leftovers dated &lt; than 7 days- 0. Items sealed &amp; covered- 0. No expired foods- 0.</p> <p>(continued on next page)</p> |

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| NAME OF PROVIDER OR SUPPLIER<br><br>Tierra Este Nursing and Rehabilitation Center  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>14300 Pebble Hills Blvd<br>El Paso, TX 79938 |  |
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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Confidential interview [DATE] at 1:30 PM, revealed the facility did not have a Dietary Manager for two months. The kitchen staff do not do their work due to lack of over-sight supervision, that is why the kitchen is not clean, foods are not properly stored in the refrigerator and/or freezer, foods are not promptly stored after deliveries and frozen foods are left on the floor for long periods of time. It was reported that the dietary staff spend a lot of time on their cell phones instead of doing their jobs. These concerns have been reported to the dietary manager and no efforts have been made to address these areas of concerns. It was reported that the dietary staff had been trained to store food in sealed containers and dating food prior to storing them in the refrigerators and freezers. That is not being done, this is an on-going problem.</p> <p>In an interview on [DATE] at 2:00 PM, with [NAME] O revealed the cooks were responsible for cleaning the fryers and equipment after each use. She said a cook had quit on Sunday and that is why the fryer was not clean after use and was full of crumbs and pieces of chicken in the oil pan. She said, dietary aides use their cell phones a lot during meal preparation and do not clean their work areas. She said dietary staff had been trained to store food in sealed containers or plastic bags, and to date the containers prior to placing them in the refrigerators or in the freezer. She said the black stains on the tile floors could not be removed with the chemicals that were used in the kitchen.</p> <p>In an interview on [DATE] at 2:41 PM, with Dietary Manager dietary staff are responsible for cleaning their own working areas. He said the dietary aids assist with dishes and cleaning. He said the number of dietary staff varies based on resident census. He said, I give them verbal order. I do not have written assignments. He said he addressed concerns voiced by the staff as soon as possible. He said the Dietary Consultant conducted monthly inspections of the kitchen and the last inspection was completed less than two weeks ago. The surveyor requested copies of the Dietician Consultants monthly visits.</p> <p>Dish washroom:</p> <p>In an observation on [DATE] at 1:36 PM, with Dietary Manager revealed Drain cover in dish washroom was broken and had black stains.</p> <p>Three compartment Sink:</p> <p>In an observation and interview on [DATE] at 1:27 PM, with dietary supervisor revealed [NAME] M, was washing pots and pans in the three-compartment sink. The Surveyor requested that he check the chemical level in the sanitize compartment in the three-compartment sink. He said he had just started working at facility and did not know which strips to use to check the chemical level. He said that he was not aware of the Three -Compartment sink procedures posted directly above the three-compartment sink written in English and Spanish.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>In an observation and record review on [DATE] at 1:31 PM, revealed the dietary manager took a test strip from the Precision QAC QR5 container strip to check the Chlorine level in the sanitize compartment of the 3-compartment sink. When the Dietary Manager verified the chemical level on color chart on the container it revealed the chemical level was 0ppm (parts per million is a unit used to describe very small concentrations of a substance in a large solution). The Manager kept insisting test strip was showing the chemical level was at 100ppm. The Manufacturer label stated Use dry fingers to remove strip vial. Remove one strip and dip strip for one second into solution to be tested . Allow five seconds to develop, then compared to color chart below. The Dietary Manager reached down under the sink and tighten the dispensing hose connected to 2.5 Gal of Auto-Chlor Solution QA Sanitizer. The Dietary Manager pulled the container and confirmed that the container was empty. The Manufacturer label on the container revealed active ingredient: dimethyl benzyl ammonium chloride. The Dietary Supervisor said failure to properly sanitize pots and pans could cause food borne illnesses.</p> <p>Food Code 2022</p> <p>(C) PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S ,d+[DATE].18.</p> <p>,d+[DATE].15 Package Integrity. FOOD packages shall be in good condition and protect the integrity of the contents so that the FOOD is not exposed to ADULTERATION or potential contaminants.</p> <p>Review of facility's undated policy &amp; procedure on Sanitation Inspection revealed, Policy: It is the policy of this facility, as part of the department's sanitation program, to conduct inspections to ensure food service areas are clean, sanitary and in compliance with applicable state and federal requirements. Policy Explanation and Compliance Guidelines: The department shall establish a sanitation program for food services based on applicable state and federal requirements. The sanitation program will provide for inspections to be conducted of the food service areas. Sanitation inspections will be conducted in the following manner: Daily: Food service staff shall inspect refrigerators. Freezer, storage area temperatures, and dishwasher temperatures daily. Weekly: The dietary manager shall inspect all food service areas weekly to ensure the areas are clean and comply with sanitation and food service regulations. The dietary manager shall develop and provide food service personnel with standard operating procedures for sanitation and daily inspections. Manager may familiarize staff with these procedures through various means such as monthly meetings, posted memorandums, training session and orientation of new personnel. The dietary manager as part of the department's QAPI program, will perform an in-depth analysis of the data obtained during the inspection.</p> <p>Review of facility's undated policy &amp; procedure on Date Marking for Food Safety revealed, Policy: The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food. Policy Explanation and Compliance Guidelines for Staffing: The food should be clearly marked to indicate the date or date by which the food shall be consumed or discarded. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. The head cook or designee shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard accordingly. The dietary manager, or designee shall spot check refrigerators weekly for compliance and document accordingly. Corrective action should be taken as needed.</p> |   |  |

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| <p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Dispose of garbage and refuse properly.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 20026</p> <p>FACILITY</p> <p>Kitchen</p> <p>Observation on 07/29/24 at 6:38 AM during the initial tour in the kitchen revealed:</p> <p>Food Preparation Area:</p> <ul style="list-style-type: none"> <li>-The shelf directly above the food preparation table by the stove where spice bottles are stored was full of particles food particles.</li> <li>-Stainless steel tables had dried white stains under the steamer and sides of the table</li> <li>-Steamer had white dried stains on the sides</li> <li>-Deep Fryer was full of crumbs and pieces of chicken strips were in the oil</li> <li>-Tile floor between the deep fryer and steamer had dried black stains and there was a piece of chicken on the floor. The sides of the stove had dried stains and grease build-up</li> <li>-broken toaster was full of dust and food particles</li> <li>-storage shelve under stainless steel table had dried white stains and food particles</li> <li>-tile floor throughout the kitchen had black grease build-up and food particles</li> <li>-Multiple Spice bottles were opened, bottles had grease build-up on lids and sides of bottles</li> <li>-small bottle of food color had dried drippings on cap and sides of bottle</li> <li>-Stainless steel shelf in dish washing room had food particles and dried white stains</li> <li>-Large Trash can in food preparation area was uncovered</li> <li>-Hand Sink had dried white stains</li> <li>-Mobile Dish [NAME] had dust and food particles on the bottom of storge columns</li> <li>-Stainless steel table directly below spice rack was dusty, dried food stains, and pieces of paper on top of table</li> <li>-Stainless steel table where blender as stored had dried red liquid stains, and grease build up</li> </ul> <p>(continued on next page)</p> |

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| <p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>-Ice Scoop was stored in a zip-lock bag that was not sealed on top of ice machine. The top of the ice machine was full of dust</p> <p>-3 card board boxes labeled keep frozen that contained Super-crisp Regular Fries and Mighty Shakes were on the floor by the Dietary Manager's office</p> <p>-6 boxes of 2% Reduced Fat Milk and two other boxes of frozen foods were on the floor in the dry storage room by the refrigerator; The [NAME] reported that the food delivery had come this morning and they had not had time to put the food away because they were preparing the breakfast meal.</p> <p>Interview and review of photos taken during initial tour of the kitchen on 08/01/24 at 2:04 PM, with the Dietary Manager revealed, that he did not have written assignments to clean the kitchen, because each worker was responsible for cleaning their own area were they worked. It was reported that the kitchen was cleaned after each meal. The Dietary Manager reported that the Deep Fryer should be cleaned after each use. It was reported that the commercial toaster was not broken.</p> <p>Dry Storage Area:</p> <p>- large plastic container with a white lid that was stored on the metal rack in the Dry Storage Room had grease built up and food particles around the top of the lid.</p> <p>-large white plastic container that contained onions had several onions that had black mold and were mushy.</p> <p>-three Mobile Ingredient Bins had dried white stains and food residual on the lids.</p> <p>-6 boxes of 2% Reduced Fat Milk were on the floor next to the refrigerator</p> <p>Foods Stored in Refrigerators:</p> <p>- bowl of cornflakes covered with Saran wrap stored in the refrigerator that was not dated.</p> <p>-a red open container of Whipped Light Cream that opened and did not have a cover was stored in the refrigerator</p> <p>-large stainless steel food pan contained cooked broccoli was stored in refrigerator was covered with Saran wrap and was not dated</p> <p>-large stainless steel food pan contained Chile with meat dated 07/26/24 Saran wrap was not completely sealed</p> <p>-small disposable plate that contained a peanut butter and Jelly sandwich was covered with Saran wrap was not dated</p> <p>-large plastic container with a red covered that contain a red liquid was stored in the refrigerator and the container was not labeled or dated. The lid had a white powder substance and small food particles on the lid.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <ul style="list-style-type: none"> <li>-large stainless steel food pan dated 07/02/24 contained Picadillo was covered with Saran Wrap was not completely sealed</li> <li>-large zip lock bag stored that contained chicken strips was not dated</li> <li>-sliced cheese wrapped in Saran wrap was not dated</li> <li>-large meal tray that had glasses of milk were not dated</li> <li>-large plastic bag that contained coleslaw dice mix had a lot of liquid in the bag and contents was mushy</li> <li>-large opened cardboard box stored on the bottom shelf of the refrigerator had dried light red liquid stains on the front and side of the box</li> <li>-bottom shelves of Refrigerator # had large piece of dried lettuce and food particles</li> <li>-packet of lettuce wrapped in Saran wrap dated 07/27/24 had black mold and was mushy</li> <li>-large metal container that contain two large rolls of ground meat that were defrosting on the bottom shelf, revealed there were dried white stains and food particles on the edges of the refrigerator</li> <li>-large opened cardboard box that contained beef patties that was opened and dated 07/11/24 was not sealed.</li> <li>-large opened cardboard box that contained frozen Pork Egg Rolls was not sealed</li> <li>-large opened cardboard box that contained diced Chicken Meat white and dark was not sealed</li> <li>-The bottom shelves of the refrigerators had dried white stains and food particles</li> <li>-large opened cardboard box that contained frozen Cheese Omelets was not sealed</li> <li>-large opened cardboard box that contained Sopapilla Dough was not sealed.</li> <li>-large opened box of frozen muffins was opened and was partially wrapped with Saran wrap was not sealed</li> <li>-10 cardboard boxes of can goods were on the floor next to the metal rack in the Dry Storage Room</li> <li>-fire extinguisher by hand sink was full of dust and had dried white stains</li> <li>-Tile floor in dish washing room was full of food particles and dried food stains</li> </ul> <p>Pureed Food Preparation:</p> <p>Observation on 07/29/24 with Cesar [NAME] revealed facility had 16 residents on Pureed Food and was going to prepare 20 servings.</p> <p>(continued on next page)</p> |

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| <p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Beef Patties-Placed 20 patties in Food Processor and added 4 cups of broth</p> <p>Mixed Vegetables-3 lbs. of vegetables and added 1 cup of thickener</p> <p>Bread-add a loaf of sliced bread and added 3 cups of chicken broth</p> <p>Mashed Potatoes-used potato flakes added 2 lbs. of potato flakes to 4 quarts of water. [NAME] stated, I just eye ball the amount of water and potato flakes to get the correct consistency and amount of potato flakes to get 20 servings.</p> <p>Interview and record review on 08/01/24 at 1:58 PM, with Jesus Pina Dietary Manager revealed, the following:</p> <p>Pureed Country Fried Steak Serving Size: #8 Scoop. Instructions-To get the actual serving size, puree the number of portions needed. Add liquid, if needed broth, to assist with pureeing. Puree with a blender or food processor until smooth. If needed, gradually add thickener. The desired thickness should be mashed potato or pudding. There should be no large lumps or particles.</p> <p>Pureed Mixed Vegetables Serving Size: #10 Scoop. Instructions-To get the actual serving size, puree the number of portions needed, adding adequate liquid needed to achieve desired consistency as appropriate for resident, then divide the total amount equally by the number of portions pureed. Measure number of servings using the regular prepared recipe portion. Drain well to minimize the use of thickener to obtain appropriate consistency. Place in a blender or food processor. Add liquid, if needed, to assist with pureeing. Water should not be used as a liquid to puree foods. The desired thickness should be mashed potato or pudding. There should be no large lumps or particles.</p> <p>Pureed Sliced Bread Instructions-To get the actual serving size, puree the number of portions needed, adding adequate liquid needed to achieve desired consistency as appropriate for resident, then divide the total amount equally by the number of portions pureed.</p> <p>Pureed Mashed Potatoes Instructions-Follow manufacturer directions for exact amounts. The Dietary Supervisor stated, I don't understand why you are concerned about the [NAME] not following the manufacturer directions if the consistency of the potato was adequate.</p> <p>Interview and record review on 08/01/24 at 1:54 PM, with Jesus Pina Dietary Supervisor revealed, [NAME] had not followed manufacturer directions. Review of the instructions on the Mashed Potatoes container of Serving Chart revealed 1/4 Carton Potatoes, 1/2 Gallon of Boiling Water, 1 1/2 teaspoon Salt, 4 oz servings 19.</p> <p>08/01/24 Surveyor requested copy of Pureed Bread Recipe.</p> <p>Food Temperatures and Serving Size checked before Lunch Meal at 11:53 AM revealed:</p> <p>Bread-will be using #15 scoop</p> <p>Meat-will be using #8 scoop</p> <p>Mashed Potatoes-will be using #1 scoop</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Mechanical Consistency-will be using #6 scoop</p> <p>Green ladle-4 oz</p> <p>Red ladle-2 oz</p> <p>Pureed Food Temps:</p> <p>Bread-168 degrees Fahrenheit</p> <p>Mashed Potatoes-181 degrees Fahrenheit</p> <p>Mixed Vegetables-175 degrees Fahrenheit</p> <p>Mechanical Meet-177 degrees Fahrenheit</p> <p>Regular Meat-174 degrees Fahrenheit</p> <p>Regular Mixed Vegetables-189 degrees Fahrenheit</p> <p>Carrot Soup-169 degrees Fahrenheit</p> <p>Gravy-178 degrees Fahrenheit</p> <p>Refried Beans-180 degrees Fahrenheit</p> <p>Dish Washing Area:</p> <p>-Drain cover in dish wash room was broken and had black stains</p> <p>07/31/24 12:22 PM Test Tray requested to check food temperatures. Food temperatures were checked by Dietary Manager using facility thermometer.</p> <p>Beans 150 degrees Fahrenheit</p> <p>Rice 153 degrees Fahrenheit</p> <p>Chicken 149 degrees Fahrenheit</p> <p>Mixed Vegetables 140 degrees Fahrenheit</p> |

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| <p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>Deficiency Text Not Available</p> |

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| <p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>20026</p> <p>Based on interviews and record review, the facility failed to maintain a quality assessment and assurance committee consisting at a minimum the required committee members for 5 of 9 meetings reviewed for QAPI.</p> <p>The facility did not ensure the MD, or a representative attended QAPI meetings.</p> <p>This failure could place residents at risk for quality deficiencies being unidentified, no appropriate plans of action developed and implemented, and no appropriate guidance developed.</p> <p>Findings included:</p> <p>Interview on 08/02/24 at 12:27 AM, with the Administrator revealed the facility held monthly QAPI meetings. The DON stated all department heads, and the Medical Director attended the QAPI meetings. The DON stated the Medical Director had only attended one QAPI meeting in 2023 and none in 2024.</p> <p>Record review on 08/02/24 12:50 AM with the Administrator of QAPI Signature Sheets for 2023 and 2024 revealed the following:</p> <p>07/13/23 Medical Director and/or designee did not attend QAPI meeting.</p> <p>08/23/23 Medical Director and/or designee did not attend QAPI meeting.</p> <p>04/24/24 Medical Director and/or designee did not attend QAPI meeting.</p> <p>05/22/24 Medical Director and/or designee did not attend QAPI meeting.</p> <p>07/24/24 Medical Director and/or designee did not attend QAPI meeting.</p> <p>Review of facility's policy &amp; procedure on Quality Assurance and Performance Improvement (QAPI) dated 07/2022 revealed: Policy: It is a policy of this facility to develop, implement and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcome of care and quality of life and addresses all the care and unique services the facility provides. Policy Explanation and Compliance Guidelines: The QAA Committee shall be interdisciplinary and shall: Consist at a minimum of: The Director of Nursing Services, Medical Director, at least three other members of the facility's staff, at least one of which must be the Administrator and Infection Preventionist. Meet at least quarterly and as needed to coordinate and evaluate activities under QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects under the QAPI program, are necessary.</p> |   |  |

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| NAME OF PROVIDER OR SUPPLIER<br><br>Tierra Este Nursing and Rehabilitation Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>14300 Pebble Hills Blvd<br>El Paso, TX 79938 |  |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide and implement an infection prevention and control program.</p> <p>20026</p> <p>Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program, designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections, for 1 of 1 treatment car; and 3 of 4 resident halls reviewed for infection control practices.</p> <p>-The facility failed to ensure dirty linen hampers were covered.</p> <p>-The facility failed to ensure opened packages of gauze non-sterile sponges were stored in sealed plastic bags.</p> <p>-The facility failed to store mattress off the floor in storage.</p> <p>-The facility failed ensure facility staff did not store personal belongings in clean linen closet.</p> <p>This failure could place residents at risk for cross contamination and the spread of infection.</p> <p>Findings included:</p> <p>Hall 300:</p> <p>In an observation on 07/29/24 at 7:16 AM, in the 300 Hall revealed dirty linen hamper was full and cover was not sealed.</p> <p>Treatment Cart:</p> <p>In an observation and interview on 07/29/24 at 8:46 AM, with Treatment Nurse revealed there was an opened bag of Gauze Sponges non-sterile stored in the drawer of the treatment cart. Treatment Nurse said opened bags of Gauze Sponges non-sterile should be stored in a sealed plastic bag to prevent cross contamination.</p> <p>Storage Room Hall 100:</p> <p>In an observation on 08/01/24 at 3:34 PM, with Central Supply Clerk K revealed 6 Mattresses were stored on the floor in storage room where they stored the oxygen concentrators. He said, the mattresses should not be stored on the floor to prevent cross contamination.</p> <p>Hall 400 Linen Closet:</p> <p>In an observation on 08/01/24 at 3:37 PM with Housekeeper P revealed there was a backpack stored in the clean closet room in the 400 Hall. Housekeeper P stated facility staff had been trained not to store their personal belongings in the clean linen closets to prevent cross contamination.</p> <p>Hall 200 Medication Cart:</p> <p>(continued on next page)</p> |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>In an observation at 08/02/24 at 10:22 AM with DON reveal an opened paper package of 4 x 4 non-Woven sponges was stored in one of the drawers in the medication cart. DON said opened package should be stored in a sealed plastic bag to prevent cross contamination.</p> <p>Review of facility's policy and procedure on Standard Precautions Infection Control dated 07/200 revealed, Policy: All staff are to assume that all residents are potentially infected or colonized with an Organism. That could be transmitted during the course of providing resident care services. Therefore, all staff shall adhere to standard precautions to prevent the spread of infections to residents, staff and visitors. Policy Explanation and Compliance Guidelines: Storage of medications in accordance in accordance with manufacturer's recommendations. Resident-Care Equipment: Policies and procedures have been established for handling and storage of resident equipment. Care of the Environment: Policies and procedures have been established for routine cleaning of environmental surfaces as indicated by the level of resident contact and degree of soiling.</p> |

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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026</b></p> <p>Based on observations, interviews, and record reviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public in four of four halls reviewed for environmental conditions.</p> <p>-The facility failed to clean facility over the weekend of 07/28/24 due to not having sufficient personal to clean the resident rooms and common areas.</p> <p>-The facility failed to maintain the environment free of accident hazards.</p> <p>This deficient practice could place residents at risk of not living in a safe, functional, sanitary, and comfortable environment.</p> <p>Findings included:</p> <p>Hall 100:</p> <p>In an observation on 07/29/24 at 6:30 AM, revealed tile floors by the entrance of the facility and resident halls were full of dust, dried black stains, and paper particles. There was a white tablet on the floor by the decentralized nurse's station in the 300 Hall.</p> <p>Observation on 07/29/24 at 7:26 AM, in room [ROOM NUMBER] revealed, floor was covered with food particles .There was toothette oral swab under the side of Bed B.</p> <p>In an observation and interview on 07/29/24 at 7:45 AM, with Med Aide E, revealed sharp container on the side of medication cart in Hall 100 was full. There was a blue glove above the black marker on the sharps container that indicate the container was full. Med Aide E said, she did not know who was responsible for checking if the sharps containers needed to be replaced.</p> <p>In an observation on 07/29/24 at 7:34 AM, revealed there was a white sheet on the floor soaked with water and caution sign directly in front of Janitor's Closet.</p> <p>In an observation on 07/29/24 at 8:05 AM, revealed water was leaking from the condensation pipe in the Mechanical Room, the drain was full of water and water was leaking into the hallway and Janitor Room next to the Mechanical Room.</p> <p>In an observation on 07/29/24 at 8:05 AM, revealed water was leaking through the floor base into the Janitor room from the Mechanical Room. It was observed the floor was full of dust and a piece of paper and piece of clear plastic were on the floor.</p> <p>(continued on next page)</p> |

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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>In an observation and interview on 07/29/24 at 8:10 AM, with Maintenance Supervisor revealed, the flapper in the drain in the mechanical room was rusted, the edges were cracked, edges were missing on half of the flapper seal, round tube connected to the flapper was cracked. The maintenance Director said, If no water was dripping from the condensation pipe, the flapper dried and would get stuck on the drain and will not allow the water to drain into the drain. That why the water was overflowing to the floor, was leaking into the wall of the Janitor's room and into the hallway. He said no one had had called him to report water was leaking to the hallway from the Mechanical Room. He said he checked the drain once a week and had not noted any problems with the drain.</p> <p>Observation on 07/29/24 at 10:00 AM, revealed Central Supply Clerk K, was replacing the sharp container in the Hall 100.</p> <p>In an interview on 08/02/24 at 12:37 PM, with the Administrator, revealed, the facility was short two housekeepers on the weekend on 07/27/24 and 07/28/24. Administrator stated, It was a perfect storm, that is why the facility was not cleaned on the weekend.</p> <p>Hall 200:</p> <p>In an observation at 8:39 AM, revealed housekeeper had mopped 3/4 of one side of the hallway and placed caution signs.</p> <p>In an observation and interview on 07/29/24 at 8:43 AM, revealed Social Worker had disregarded the Caution Signs, and was observed walking on the wet floor towards the resident rooms. The Social Worker said she was going to get residents from their rooms to take them to the dining room.</p> <p>In an observation and interview on 07/29/24 at 8:58 AM, with Housekeeper Q revealed she had been trained to mopped 3/4 and to place two caution signs to alert the residents and staff that the floor was wet.</p> <p>Observation on 07/29/24 at 8:58 revealed that Housekeeper T was mopping the floor on the side of the nurse's station by the director of nurse's office and only had one caution sign, alerting others that the floor was wet. The housekeeper said they had been trained to mop a small area of the floor and to place two caution signs until the floor was dry. She said she only found one caution sign and that is why she had placed her housekeeping card on the other end, to block the area and keep people from walking on the floor.</p> <p>Observation on 07/29/24 at 7:58 AM, in the 200 Hall revealed was a dead cricket was on the floor in the hallway.</p> <p>Observation on 07/29/24 at 9:05 AM revealed in the 400 hall there was a white tablet on the floor. The surveyor confirmed the findings with LVN D who was assigned to work on the 300 Hall.</p> <p>Laundry Room:</p> <p>(continued on next page)</p> |

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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Observation and interview on 08/01/24 at 3:43 PM, with Housekeeper P revealed, the chemical dispensers connected to the washing machines was squirting solution on the walls and floors. There were dried white stains on the walls and on the floor by the washing machines. The Hand sink had white calcium buildup around the edges of the sink and there were light gray stains in the sink around the drain.</p> <p>Oxygen Storage Room:</p> <p>Observation and interview on 08/02/24 at 8:38 AM, with central supply clerk K revealed oxygen tanks were stored in storage racks. The floor was full of dust, paper particles, hair, and plastic seals. He said he had not noticed that oxygen needed to be cleaned.</p> |