STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455850	A. Building B. Wing	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hurst Plaza Nursing & Rehab	215 E Plaza Blvd Hurst, TX 76053

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48122 Based on observation, interview and record review the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a centralized staff work area for 2 of 14 residents (Residents #41 and #62) reviewed for physical environment. The facility failed to ensure Residents #41's and #62's call lights were accessible. This failure could place residents at risk of not having their needs met. Findings included: Record review of Resident #41's face sheet, dated 02/22/2024, reflected an original admitted [DATE] and readmitted on [DATE]. Resident #41's diagnoses included Cerebral Infarction (stroke; occurs when a clot blocks a blood vessel that feeds the brain), Unspecified; Unspecified Dementia (dementia without a specific diagnosis, also known as mild or mixed dementia); Type 2 Diabetes Mellitus Without Complications (long-term medical condition in which your body doesn't use insulin properly, resulting in unusual blood sugar levels); Chronic Obstructive Pulmonary Disease; Acute Kidney Failure; Abdominal Aortic Aneurysm, (enlargement of the aorta, the main blood vessel that delivers blood to the body, at the level of the abdomen) Without Rupture, Unspecified; Dysphagia (difficulty swallowing foods or liquids, arising from the throat or esophagus), Oropharyngeal Phase; Difficulty In Walking, Not Elsewhere Classified; Muscle Wasting And Atrophy; Other Abnormalities Of Gait And Mobility; Cognitive Communication Deficit; Heart Failure, Unspecified; Altered Mental Status, Unspecified. Record review of Resident #41's most recent quarterly MDS assessment, dated 11/26/2023, revealed a BIMS score of 03, indicating severe cognitive impairment. Review of the MDS, dated [DATE], reflected Resident #41 was totally dependent with two-person assist for toilet use, dressing, hygiene, and transfers. Resident #41 utilized a manual wheelchair for mobility. Observation and interview in Resident #41's room area on 02/22/2024 at 8:55 AM revealed the call light along the bedframe between the mattress and the grab bar with the call light button on the floor. Resident was in bed, bed was in a mid-height position, wearing casual clothing, and eating breakfast. When asked, Resident #41 said he did not know where his call light was. Observation on 02/23/2024 of Resident #41's room area revealed resident in bed asleep, bed was in the lowest position, and the call light was again in the same position between the bedframe, mattress, and grab bar with the call light button on the floor. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #62's face sheet, dated 02/22/2024, reflected an original admitted [DATE] and readmitted [DATE]. Resident #62's diagnoses included Unspecified Dementia (dementia without a specific diagnosis, also known as mild or mixed dementia), Acute Kidney Failure, Muscle Weakness (Generalized), Other Lack of Coordination, Cognitive Communication Deficit (difficulty with thinking and how someone uses language). Resident #62 was not a native English speaker. Record review of resident #62's most recent quarterly MDS assessment, dated 12/29/2023, revealed a BIMS score could not be obtained due to a language barrier. Resident #62's MDS showed a Staff Assessment for Mental Status indicated this resident was Severely Impaired for Cognitive Skills for Daily Decision Making. Resident #62 was documented to be totally dependent with two-person assist for showering/bathing, needing supervision for tub/shower transfer. Observation on 02/21/2024 at 10:35 AM of Resident #62's room area revealed resident in bed asleep, bed in lowest position, room area clear of any hazards, and the call light was on the roommate's bed between the grab bars and mattress along the bedframe with the call light button on the floor. Observation of Resident #62's room area on 02/22/2024 revealed the call light was in the same position as the previous day between the roommate's grab bar and mattress along the bedframe with the call light button on the floor. Interview on 02/23/2024 at 9:55 AM, CNA B stated that call lights should be on the beds of each resident within reach of the resident if they were in bed. CNA B stated that everybody was responsible to check the call lights as a resident could have a fall or a need and not be able to let anyone know. The call lights were tested weekly by the nursing staff and routinely by maintenance to ensure they were working according to CNA B. CNA B stated the call light, even if functioning properly, is no good if not in easy reach of the resident when they need it. Interview on 02/23/2024 at 10:21 AM with LVN D revealed this was the LVN's second day working at the facility. LVN D stated that at the start of a shift rounding and looking at each room, looking for any hazards, and checking for call light placement was a high priority task for each staff member. LVN D stated that if a staff member saw a call light on, they should ask the resident who they were to make sure it is the correct patient in the bed or room area, ask how they were doing and what the need was, converse with the resident, and make sure the call light was within reach by placing it on the chest or in the hand of the resident, then take care of their need. LVN D stated that call lights are to be checked by any staff that sees it activated; all are responsible for checking no matter what their position was. Interview on 02/23/2024 at 10:39 AM, the ADON stated that call lights are everyone's responsibility. The ADON expects that at any time a staff member was in a resident's room they were to look for call light placement and move it to an appropriate area if not already. The ADON shared that the nurses are responsible to go behind the CNAs to look for call light placement, hazards in the room, and anything that may be out of place or not functioning properly when conducting rounds at the beginning of and throughout their shift. The ADON and DON stagger their shift time to ensure one was always available for any issue that may arise. The ADON stated she expects for a call light to be within reach of a resident if they were in their room because without the call light nearby a resident could lose their balance and fall if not able to call for help. A resident could need help with repositioning, transferring to a wheelchair, need water/hydration, or have an inability to get what they need when they need it if the call light is not functioning or within reach which could cause an injury. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/23/2024 at 11:19 AM, the ADM stated the expectation of all staff was to answer any call light in a timely manner, and the facility goal is for call lights to be answered in less than 10 minutes in busy times. Staff are expected to be sure to acknowledge all call lights and to communicate with the resident and any other staff in the area who will address the resident's need and if a delay is anticipated to advise the resident of why. All call light buttons are to be in reach of a resident when that resident was in or near their bed, call light buttons should be easy for the resident to get to, and the call light button should always be within reach of the resident. The ADM stated that it is the responsibility of anyone who goes into a resident room to check for call light placement. Interview on 02/23/2024 at 11:30 AM, the DON stated the expectation of any staff going into a resident's room should be to check that each call light was in reach and working for each bed, each resident had a drink in reach on the bedside table, and the bed was in the correct position in the room. Record review of facility policy titled, Answering the Call Light (C)2001 (Revised July 2023), revealed The purpose of this policy is to ensure timely response to the resident's requests and needs. General Guideline #1 stated Upon admission and periodically as needed, explain and demonstrate use of the call light to the resident. General Guideline #4 stated Be sure the call light is plugged in and functioning at all times. General Guideline #5 stated Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49733 Based on interviews and record review, the facility's interdisciplinary team (IDT) failed to ensure the resident's person-centered comprehensive care plan was reviewed and revised for 1 of 8 (Resident #15) residents reviewed for care plans. The facility failed to revise Resident #15's care plan to update and remove conflicting hospice status. This failure could place residents at risk for harm with conflicting care plans and having personalized plans developed to address their specific needs. The findings included: Record review of Resident #15's Face Sheet, retrieved on 02/23/2024, showed a [AGE] year-old female with an original admitted [DATE]. Diagnoses included Chronic Obstructive Pulmonary disease (unspecified)(a group of lung diseases that block airflow and make breathing difficult), unspecified Dementia (decline in cognitive abilities that impacts a person's ability to perform everyday activities), unspecified Parkinsonism (a disorder of the central nervous system that affects movement, often including tremors), other Alzheimer's disease (other type of the disease that destroys memory and other important mental functions), Mood disorder due to known physiological condition (marked disruptions in emotions), and Anxiety disorder due to known physiological condition (disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). The resident's face sheet revealed an advance directive showing a code status of DNR/DNI. Record review of Resident #15's MDS quarterly assessment dated [DATE] reflected a BIMS score of 03 indicating severe cognitive impairment. Record review of Resident #15's care plan dated 02/08/2024 showed a focus on Hospice care related to: end stage Parkinson's. The care plan revealed the hospice focus was initiated on 09/02/2021 and revised on 09/02/2021 . Record review of Resident #15's physician's orders summary retrieved on 02/23/2024 showed the orders summary active as of 02/23/2024. Resident #15's order summary reflected an active Admit to [hospice provider] for Dx of Parkinson's verbal order dated 08/25/2021. A prescriber written order dated 04/15/2023 revealed an active Discharge from [hospice provider] related to extended prognosis for Resident #15. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/23/2024 at 3:16 PM with the facility Administrator, he said that the MDS coordinator usually updated and reviewed care plans. He said care plan reviews were conducted quarterly or after a resident's significant change of condition. He said the IDT met regularly to review care plans. He said the IDT consists of all department heads: wound care nurse, rehabilitation, MDS nurse, and all department heads. He said end of life care was decided by the resident's physician after having a conversation with the resident and/or the resident's family. He said a care conference with the family was then scheduled and if all parties agreed, hospice was contacted. He said that entering and discharge from hospice would be considered a significant change of condition that would require updating a resident's care plan. During an interview on 02/23/2024 at 3:28 PM with the Social Worker, she said that care plan meetings and care conferences were held quarterly with the residents and their families. She said that during the meetings, concerns were expressed. She said the meetings were conducted early morning on Wednesdays. She said during the meetings, they discussed any situations or issues about the residents. She said if a significant change of condition existed, a care conference was set up. She said end-of-life care was decided through meetings with the nursing department. She said the DON would bring any issues that were observed to the table and also bring the resident's families into the discussion. She said a Hospice company was often involved in deciding a resident's need for end-of-life care. She said entering and discharge from Hospice would require a change in the resident's care plan. She said the MDS coordinator was typically responsible for reviewing and updating care plans. She said resident updates were discussed during care conference meetings which allowed the staff to update and make changes to care plans. She said the resident care plans were the knowledge about the resident and allowed the staff to care for the resident appropriately, so it was important for the care plan to be reviewed and updated. During an interview on 02/23/2024 at 3:37 PM with the MDS Coordinator, she said that a resident's significant change of condition required an updated care plan. She said after an MDS was completed, she reviewed and updated the care plans. She said that care conferences allowed the department heads/IDT to contribute to the meetings regarding the residents' care. She said that entering and discharge from hospice would require an update to the residents' care plan. She said if care plans were not reviewed and updated, it could cause some confusion for the nurses. She said that orders should reflect if the residents were on or discharged from hospice. During an interview on 02/23/2024 at 4:10 PM with the DON, he said he had been with the facility since 3/20/2023. He said two reasons that would trigger a discharge from hospice would be if the resident had been on hospice for a while or if a resident's family member wanted the resident discharged from hospice. He said if a resident was discharged from hospice, the care plan should be changed to reflect the change. He said there were morning meetings with the IDT to work on issues together and address these types of issues. He said if care plans were not updated, problems that arose with the resident would not be properly addressed. Record review of the facility's Care Planning-Interdisciplinary Team policy dated March 2022 showed, The interdisciplinary team is responsible for the development of resident care plans. Resident care plans are developed according to the timeframes and criteria established by S483.2. Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT).

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders for one (Resident #14) of four residents reviewed for intravenous fluids. The facility failed to ensure LVN C used proper technique of flushing Resident #14's midline (a midline is a long flexible tube that is inserted into the large vein in the upper arm) with 0.9 % sodium chloride and avoiding pushing air into the midline intravenous (IV) catheter. This failure could cause a resident to get an air bubble into their blood stream and cause hospitalization . Findings included: Review of Resident #14's Admission Record on 02/23/2024, revealed an [AGE] year old female with no known allergies admitted to the facility on [DATE] with diagnoses of cellulitis of the lower legs (a condition in which the skin has a bacterial infection), surgery of skin and fat tissue, type 2 diabetes (body has trouble controlling blood sugar), heart failure, depression, heart burn, dementia, pacemaker (a device that helps the heart to pump blood), muscle weakness, and high blood pressure. Review of Resident #14's MDS dated [DATE], did not reveal a BIMS screen. Review of Resident #14's order summary dated 02/22/2024, revealed antibiotic Zosyn Intravenous Solution Reconstituted 3.375 (3- 0.375) GM (Piperacillin Sodium-Tazobactam Sodium) Use 3.375 gram intravenously every 8 hours for wound infection for 10 Days, start date 02/15/2024 to 02/26/2024. Sodium Chloride Solution 0.9 % Use 10 ml intravenously every 8 hours for flush before and after IV medication Start date 02/15/2024. Review of Resident #14's care plan dated 02/07/2024, reflected focus: Resident is receiving ABT [antibiotics] and has. Potential for complications r/t ABT. Date initiated 01/24/24 Goal: Resident will be free from s/s [signs & symptoms] of infection daily through next 90-day review. Date Initiated: 01/24/2024. Interventions: . Evaluate for proper infection control procedure, monitor for s/s of infection eg: a) increased temperature, b) redness, c) warmth, d) purulent (pus) drainage, e) N/V [nausea and vomiting], f) odor. Use good standard precautions before and after providing care Date Initiated: 01/24/2024. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with LVN C on 02/22/2024 at 08:43 AM revealed Resident #14 had patchy redness around the IV area on her left upper arm. The IV had one port opening that was open to air. IV dressing was dated 02/16/24. LVN C verified that Resident #14 had a midline IV for medication. LVN C verified medication in the EMR with the medication bag in hand. LVN C prepared the tubing for the IV medication. She cleaned the midline IV port opening with an alcohol swab and then LVN C opened a 10 milli liter (10 mL) syringe filled with 0.9 % sodium chloride (normal saline) from a plastic wrapper and she pushed the fluid from the syringe into Resident #14's IV. She emptied the entire syringe of saline into the midline. LVN C did not check the midline to verify IV line worked and was open before connection to the IV medication. LVN C said that the physician was aware of the redness around the IV. She said that the physician asked nursing staff to watch for swelling or spread in the area. She said that Resident #14 might be allergic to the IV adhesive tape. LVN C said that she forgot to remove the air out of the syringe before flushing the IV. She said that the risk was that the resident could get an air embolus (An air embolus is a blockage of blood supply caused by air bubbles in the blood vessels or the heart). Interview with ADON on 02/22/2024 at 11:57 AM, revealed that she expected nursing staff to follow proper IV medication administration and IV site assessment before medication administration. She said she expected them to aspirate (take air out the syringe) before pushing the saline fluid in the IV line. She said that pushing air in an IV line is a risk for embolus. ADON said she would start to in-service the nursing staff on Peripheral and Midline IV catheter and flushing. Interview with DON on 02/23/2024 at 04:08 PM revealed that LVN C had already told him that she had made an error during medication administration. DON said that he expected all staff to follow facility policy and procedures. He said the risk of emptying the entire saline syringe without either taking air out or leaving 1 mL of the 10 mL in the syringe into the IV line could cause an air embolus. He said that he and ADON would start an in-service immediately. Review of facility policy titled Peripheral and Midline IV catheter Flushing and Locking revised march 2022 reflected, . a physician order is not needed to flush a peripheral short catheter, .use preservative-free 0.9 % sodium chloride (normal saline) for flushing a Peripheral and Midline IV catheter, . leave 0.5 to 1 mL of preservative-free 0.9% sodium chloride in the syringe to avoid pushing air into the catheter, frequency; For short and long PIV's and midline catheters used for intermittent infusions, flush the catheter and aspirate for return of blood return prior to each infusion

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48122 Based on observations, interviews, and record reviews the facility failed to review the risks and benefits of bed rails and enabler/grab bars (smaller bars used by the person in bed to reposition themselves), with the resident or resident representative and obtain informed consent prior to installation for one (Resident #40) of 3 resident rooms observed and reviewed for bed rails/enabler bars. The facility failed to have evidence of informed consent, assessment of the resident for risk of entrapment, or a physician's order for the quarter bed rails/enabler bars for Resident #40. This failure could affect residents who used bed rails/enabler bars at risk of the resident/responsible party not being aware of the risks, informed consent not being obtained from the resident or responsible party, physician not being aware of use of the enabler/grab bars, and care plan not being properly documented. Findings included: 1. Record review of Resident #40's face sheet, dated 02/23/2024 revealed resident was originally admitted on [DATE] with diagnoses of Unspecified Dementia (dementia without a specific diagnosis, also known as mild or mixed dementia), Insomnia, unspecified (difficulty initiating or maintaining sleep, characterized by frequent awakenings or problems returning to sleep after awakening), Unsteadiness on Feet, Generalized Anxiety Disorder (worrying constantly and cannot control the worrying), Muscle Weakness (Generalized), Difficulty in Walking, not elsewhere classified, Cognitive Communication Deficit (difficulty thinking and with how someone uses language), Mild Neurocognitive Disorder Due to Known Physiological Condition Without Behavioral Disturbance (condition in which people have more memory or thinking problems than others their age), Other Specified Disorders of the Brain, Arthropathy (surgical procedure to restore function to a joint), unspecified, Per the face sheet, Resident #40's responsible party was a family member. Review of Resident #40's MDS assessment (quarterly), dated 01/17/2024, and signed by RN A as assessment coordinator verifying assessment completion, revealed the resident had a BIMS (Brief Interview for Mental Status; assessment of cognitive functioning that is performance-based) score of 03 (a score of 0-7 indicates severe cognitive impairment), is noted to have wandering tendencies 4 to 6 days of the week, is dependent for showering/bathing, and tub/shower transfer. Resident #40 uses a manual wheelchair for mobility. Resident #40's assessment indicated no assistance needed with bed mobility, oral hygiene, meals, dressing, toileting, and personal hygiene. Record review of Resident #40's Care Plan, dated 1/18/2024 as reviewed, revealed no indication of bed rail or enabler bar discussion of risks and benefits with Resident or responsible party. Resident #40's Care Plan has no reference to an assessment that was completed for bed rails or enabler bars. Review of Medical record of Resident #40 revealed no written Physician Order for quarter bed rails/enabler bars for mobility and positioning. No assessment for use of enabler bars or bed rails was located in the medical record for Resident #40. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Medical Record of Resident #40 revealed no Physical Device Acknowledgement form (bed rail/enabler bar consent) for the quarter bed rails/enabler bars signed by the resident or resident's responsible party or noted to have verbal permission for the enabler bars. Observations on 02/21/2024 at 10:40 AM, 02/22/2024 at 9:05 AM, and 02/23/2024 at 9:35 AM revealed Resident #40's room had the resident's bed with quarter bed rails/enabler bars raised on both sides of the bed with the call light wrapped around the enabler bars. Resident #40 was not observed in the bed as he had already been assisted with getting ready for the day and was in the activity room with other residents. In an interview on 02/23/2024 at 11:19 AM, the ADM reviewed the facility process for bed rail and grab bar use. The ADM stated the bed rails/grab bars were used for residents for positioning and comfort. The ADM stated that a resident is to be assessed for appropriateness for use and if safety can be maintained. Consent must be received from the resident or responsible party for use of bed rail/grab bars, and orders from the doctor must be received and documented in the resident's chart. Maintenance will fit the appropriate bar to the bedframe once the correct assessments and consents have been placed in the chart and the work order has been placed. The ADM was able to discuss some of the hazards of grab bars being inappropriately placed, such as the resident feeling restrained, and potential for entrapment resulting in bruising, skin tears, or limbs being broken. ADM stated the nursing staff as directed by the DON are responsible for ensuring the assessment is completed, and consent and orders are received before the bars are added to the resident's bed. In an interview with the DON on 02/23/2024 at 11:30 AM, it was expressed that the expectation for grab bars or any type of bed rail was for evaluation of the resident appropriateness with the bed rail/grab bar in place, resident ability to safely utilize the bed rail/grab bar safely, consent from the resident or responsible party based on understanding of hazards and risks of the bed rail/grab bar placed on the resident's bed, care planning of the bed rail/grab bar and what the specific use is for and goal of the bed rail/grab bar, and provider orders. DON was able to speak to the hazard of bed rails/grab bars to a resident included resident getting hung up in the bed rail/grab bar with potential for injury such as bone fracture, skin tears, and bruising, resident who required assistance getting out of bed attempting to do so unassisted resulting in injury, the resident viewing the bed rail/grab bar as a restraint or not understanding the use of the devices. DON stated the nursing staff should make sure each resident has been deemed appropriate for use of bed rails/grab bars and have correct documentation in the electronic health record. DON stated that he didn't think there were any residents in the secure unit with grab bars however other residents had the consents, assessments, and care planning completed. Interview with ADON on 2/23/2024 at 10:39 AM was completed about bed rail or grab bar use in the facility. ADON stated that residents should have been evaluated for use of bed rails/grab bars to make sure the resident can be safe. ADON stated that there must also be a consent on file from either the resident or responsible party, a doctor's order, and therapy evaluation. ADON recognized hazards of bed rails/grab bars as entrapment, balance issues if resident is not appropriate, and injury from a false sense of helping during care by using bars without being cued or asked. Interview with CNA B on 02/23/2024 at 09:55 AM revealed that inappropriate use of bed rails/grab bars could result in resident injury including entrapment, broken arms or legs, or suffocation if a resident were to become trapped between the bar and mattress. CNA B stated that bed rails are not used in the facility and that use of grab bars is determined when a resident is admitted by the IDT. (continued on next page)

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	455850	A. Building B. Wing	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hurst Plaza Nursing & Rehab	215 E Plaza Blvd Hurst, TX 76053

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's provided Bed Safety and Bed Rails, (C)2001 (Revised August 2022), revealed the policy statement Resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup. The use of bedrails is prohibited unless the criteria for use of bed rails have been met. Policy Interpretation and Implementation item #1 states The resident's sleeping environment is evaluated by the interdisciplinary team. Policy Interpretation and Implementation item #2 states Consideration is given to the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment. Policy Interpretation and Implementation item #10 states additional safety measures are implemented for residents who have been identified as having a higher than usual risk for injury including bed entrapment (e.g. , altered mental status, restlessness, etc.). Under the Use of Bed Rails section item #1 states . For the purpose of this policy bed rails include: a. Side rails; b. Safety rails; and c. Grab/assist bars Use of Bed Rails section item #3 states The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. Use of Bed Rails section item #5 states If attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the use of bed rails. This interdisciplinary evaluation includes: a. an evaluation of the alternatives to bed rails that were attempted and how these alternatives failed to meet the resident's needs; b. the resident's risk associated with the use of bed rails; c. input from the resident and/or representative; and d. consultation with the attending physician. Use of Bed Rails section item #8 states Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent: a. The assessed medical needs that will be addressed with the use of bed rails; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. The resident's risks from the use of bed rails and how these will be mitigated; c. The alternatives that were attempted but failed to meet the resident's needs; and d. The alternatives that were considered but not attempted and the reasons.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review, the facility failed to ensure that all drugs and biologicals used in the facility are labeled in accordance with professional standards, including expiration dates and with appropriate accessory and cautionary instructions for storage of drugs and biologicals for 1of 2 medication rooms reviewed for storage and labeling. The facility failed to ensure Influenza (flu) and Tuberculosis (TB) vaccines were dated with an open date. This failure could cause resident to receive less effective and or less strength vaccines. Finding included: Observation and interview with DON on [DATE] at 11:14 AM revealed two medication refrigerators. One refrigerator had 1 open vial of Tuberculosis (TB) vaccines with no open date. The vaccine read House Account, Tubersol 5T/ UINT [unit]/0.1 ML VIAL, for house use ON [DATE]. Discard 30 days after opening. The second refrigerator had 1 box of Tuberculosis (TB) vaccines with no open date and 2 open vials of Influenza (flu) with no open date. The Influenza Vaccine read Influenza vaccine, Flucelvax Quadrivalent , d+[DATE] formula. DON said that the vaccines should be dated with an open date. He said it was the responsibility of every nurse to date a vaccine and any other medicine after it is opened. He said that he expected nurses to date the vaccine vials when opened so that they can be discarded after 30 days of being open. He said that he was however not sure the discard date for the open flu vaccine vials because it did not specify as the TB boxes were labeled with warning to discard after 30 days. He said the risk was administration of low potency vaccines and it would not produce the desired protection outcome. He said that the infection control preventionist was expected to monitor the vaccines and to in-service on how to administer vaccines. Interview with LVN E on [DATE] at 03:28 PM, revealed that she was the infection control preventionist. She said that the floor nurses gave the vaccines but on occasion she gave the flu and pneumonia vaccines. She said that she always wrote the open date and discard dates on any vaccines she opened. She said that all nursing staff are supposed to write the date on the box or vial of the vaccine when opened. She said that the vaccines in the refrigerator were to be used on various residents (multi dose), however, they should be discarded 30 days after opening. She said that she was not sure who was responsible for tracking the vaccines. She said every nurse was responsible for making sure vaccines were dated and unexpired prior to administration. She said that if she found an open vaccine vial without a date, she would remove it from the refrigerator and dispose of it according to facility policy. She said that she has not done an in-service on vaccines. She said the risk to residents was that the vaccine vials would be ineffective. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy titled Influenza vaccine revised [DATE], reflected .administration of the influenza vaccine will be made in accordance with current Centers for Diseases Control and Prevention (CDC) recommendations at the time of the vaccination . Review of facility policy titled Medication Labeling and Storage revision date February 2023, reflected . Medication is stored separately from food and labeled accordingly, .multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43843 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 the facility's only kitchen. The facility failed to ensure foods stored in the refrigerator and freezer were labeled with the use by date. These failures could place resident at risk for food-borne illness and food contamination. Findings included: Observation on 02/21/2024 at 9:11 am revealed in the refrigerator a plastic container containing a mixture of tomatoes and okra covered with plastic wrap was not labeled with the use by date. Observation on 02/21/2024 at 9:12 am revealed in Freezer #3 a plastic zip lock bag contained two sausage links without a label with the use by date. Interview on 02/21/2024 at 9:13 am with Dietary Manager revealed she did not know who prepared the tomato and okra mix and placed it in the refrigerator. She stated that the sausage was used for breakfast. Interview on 02/23/2024 at 10:00 am with Dietary Manager revealed that the person who prepares the dish is responsible to label and date the dish prior to storage. She stated that not properly labelling and dating the dish may result in contamination and food being in the danger zone means temperatures above 41 degrees Fahrenheit (F) and below 135 degrees F that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness. Potentially Hazardous Foods (PHF) or Time/Temperature Control for Safety (TCS) Foods held in the danger zone for more than 4 hours (if being prepared from ingredients at ambient temperature) or 6 hours (if cooked and cooled) may cause a foodborne illness outbreak if consumed. The policy Food : Preparation dated 2/2023 reflected 17. All refrigerated, ready-to-eat TCS prepared food that are to be held for more than 24 hours at a temperature of 41 degrees Fahrenheit or less, will be labeled and dated with a prepared date (Day 1) and a use by date (Day 7).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43843 Based on observations, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 2 of 8 residents (#1 and #43) reviewed for infection control practices, in that: The Nursing Scheduler failed to follow proper infection control practices when assisting Resident #1 with her meal. The LPN failed to maintain a safe, sanitary surface during wound care for Resident 43. The failure could place residents at risk for the spread of infection. Review of Resident #1's Admission Record, reflected a [AGE] year-old female admitted to the facility on [DATE] whose diagnoses included: Unspecified sequelae of unspecified cerebrovascular disease (paralysis of some parts of the body such as arms or legs or hemiplegia). Review of Resident #1's Medication Review Report reflected, regular diet soft and bite size texture, thin (regular) 1 consistency. Review of Resident #1's MDS assessment reflected, BIMS summary score of 15 indicating cognition is intact. Eating self-performance 4- Total dependence full staff performance every time during entire 7-day period. Support- 2 one person physical assist. Observation of assistance with feeding on 02/22/2024 at 12:00 PM revealed Nursing Scheduler assisting resident #1 with lunch. Resident #1 stated that the soup was hot., Staff was observed lifting the spoonful of soup to her mouth and blowing on it in an effort to cool off the soup. Observation revealed the staff member blew on the spoonful of soup three separate times. Interview with Nursing Scheduler on 02/23/2024 at 1:41 pm revealed, staff member stated that she blew on the soup to cool it off for the resident because the resident stated it was hot. In an effort to not upset the resident by waiting for the soup to cool off naturally she blew on the soup. She stated that the risk was spread of germs with saliva. Interview with LPN on 02/23/2024 at 3:57 PM revealed, they cannot allow staff to blow on a resident's food. This is an infection control issue and there is a risk of COVID and respiratory infections. Interview with DON on 02/23/2024 at 4:08 PM revealed, the risk is infection control and respiratory infections. Review of Resident #43's Admission Record reflected, a [AGE] year-old male admitted on [DATE] whose diagnoses included acquired absence of other left toe(s), acquired absence of right leg below knee, Type 1 diabetes mellitus with Ketoacidosis (The condition develops when the body can't produce enough insulin) without coma. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #43's Medication Review Report reflected, left heel wound; cleanse with n/s gauze pat dry, apply xeroform, cover with dry dressing daily and as needed one time a day for wound care. Observation of wound care performed by LPN on 02/22/2024 at 9:43 AM revealed LPN did not apply a draping on Resident #43's air mattress prior to performing wound care. During wound care resident's wound began to bleed. Blood landed on the air mattress. After cleaning the wound, the nurse noticed blood had dripped on the bed and cleaned the area with antibacterial wipes. In an interview with LPN on 02/22/2024 at 10:00 AM., she revealed she was aware that Resident #43's wound bled on the uncovered air mattress. She stated that the wound does not usually bleed and that is why she did not take the precaution of placing a draping on the mattress. She stated that the risk is infection control. Review of Infection Control policy dated 10/2018, Reflected All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control. The depth of employee training shall be appropriate to the degree of direct resident contact and job responsibilities.