STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676197	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeview Rehabilitation and Skilled Nursing	206 Walls Dr Cleburne, TX 76033

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observations, interviews, and record review, the facility failed to refer all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review for one (Resident # 21) of eight residents reviewed for PASRR services. The facility failed to refer Resident #21 for a PASRR level II evaluation to the State-designated authority. This failure could place residents at risk of not receiving specialized PASRR services which would enhance their highest level of functioning and could contribute to residents decline in physical, mental, and psychosocial well-being. Findings included: Record review of Resident #21's face sheet, dated 09/18/24, reflected the resident had a primary diagnosis of chronic obstructive pulmonary disease (common lung disease that makes it difficult to breathe) and other diagnoses were listed as dementia, schizoaffective disorder, bipolar disease. Record review of Resident #21's quarterly MDS Assessment, dated 07/03/24, revealed she was admitted to the facility on [DATE] with diagnoses which included non-Alzheimer's dementia, schizophrenia, and bipolar disorder. Resident #21's BIMs score of 15 indicated the resident's cognition was intact and she was able to make decisions for herself. Record review of Resident #21's PASRR Level I screening, dated 03/27/23, reflected the resident did not have a history of mental illness. Record review of Resident #21's Form 1012, Mental Illness/Dementia Resident Review , dated 01/24/20, reflected the resident had a primary diagnosis of dementia. An observation and interview on 09/17/24 at 10:50 AM with Resident #21 revealed she was lying in bed. She was awake, alert, and oriented. She said she did not receive PASRR services and she did not know what PASRR was. (continued on next page)

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 09/18/24 at 9:53 AM with MDS Nurse B revealed she had worked at the facility since 2008. She said Resident #21 did not have a PASRR Level II screening. She said the PASRR Level 1 screening reflected the resident did not have mental illness. MDS Nurse B said instead of completing a new PASSR Level 1 screening, she filled out a form 1012. She said she did not know she had to do a new PASSR Level 1 screening if the first one was incorrect. She said the form 1012 was a paper form that was not sent to the mental health authority and she did not think that it needed to be sent to them. She said she was the only person in the facility who completed PASRR forms. She said there was a risk that the resident could miss services she was entitled to if the PASRR forms were not filled out correctly. An interview on 09/18/24 at 12:52 PM with the DON revealed she had worked at the facility for the last 6 years. She said MDS Nurse B was responsible for completing PASRR forms and the DON did not oversee the work that she did. The DON said she did not know a whole lot about PASRR. She said she did not know what the PASRR policy said until 09/18/24. An interview on 09/19/24 at 2:24 PM with the Administrator revealed MDS Nurse B was responsible for ensuring PASRR assessments were correct. He said there was no one in the facility who reviewed the work of MDS Nurse B. Record review of the facility policy PASSR Policy and Procedure revised January 2024, reflected: Policy It is the policy of our company to ensure that all PASRR requirements are followed as set forth and regulated by The Texas Department of Health and Human Services and Centers for Medicaid and Medicare Services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35747 37028 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames that met the residents clinical and psychosocial needs that were identified in the comprehensive assessment for 2 (Resident #19 and Resident #22) out of 8 residents reviewed for care plans. The facility failed to ensure that Resident #19's comprehensive care plan included her diagnosis of pain. The facility failed to ensure that Resident #22's Care Plan was updated to reflect that he no longer had an indwelling catheter. This failure could place residents at risk of having received inadequate interventions not individualized to their care needs and diagnoses. Findings Included: 1.) Record Review of Resident #19's quarterly MDS assessment dated [DATE], revealed she was an [AGE] year-old male who admitted to the facility on [DATE]. Her diagnoses included chronic obstructive pulmonary disease (disease of the lungs that makes it difficult to breathe). The resident was receiving scheduled and as needed pain medication. Resident #19 had a BIMS score of 15 indicating no cognitive impairment. Record review of Resident #19's Order Summary Report, dated 09/18/24, reflected: 1. 07/11/23 Biofreeze external gel 4 % (Topical pain medicine). Apply to mid back topically every 8 hours as needed for pain. 2. 04/16/24 Lidocaine external kit 4 % (Topical pain medicine). Apply to both shoulders topically in the morning for right shoulder pain and remove per schedule. 3. 05/20/24 Lidocaine external patch 4 % (Topical pain medicine). Apply to right foot topically as needed for pain. 4. 07/11/23 Mobic oral tablet 15 milligrams (pain medicine). Give 1 tablet by mouth at bedtime for pain. 5. 03/14/24 Tizanidine HCl oral tablet 2 milligrams (pain medicine.) Give 1 tablet by mouth two times a day for pain/muscle spasms. 6. 03/21/24 Tramadol HCl oral tablet 50 milligrams (pain medicine). Give 1 tablet by mouth two times a day for pain. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview with Resident #19 on 09/17/24 at 12:55 PM revealed she was lying in bed. She said she suffered with chronic pain and took scheduled pain medication. Record Review of Resident #19's comprehensive care plan, no date reflected, reflected she did not have a care plan for pain. An interview on 09/19/24 at 1:55 PM with MDS Nurse D revealed she did not know why Resident #19 did not have a care plan for pain. She said she and the managers were responsible for creating care plans. She said there was a risk to the resident of having increased pain if she did not have a care plan for pain. An interview on 09/18/24 at 4:12 PM with the DON revealed she did not know why Resident #19 did not have a care plan for pain. She said MDS Nurse D was responsible for creating the care plan. The DON said care plans were important because they directed care. 2.) Review of the Resident Face Sheet dated 09/19/24 revealed Resident #22 was an [AGE] year-old male originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident #22's active diagnoses include: dysphagia (difficulty swallowing), acute cough, allergies, type 2 diabetes mellitus with diabetic polyneuropathy (a complication of diabetes that causes nerve damage in the hands, legs, feet, and arms), chronic obstructive pulmonary disease (ongoing lung condition caused by damaged lungs), acute and chronic respiratory failure with hypoxia (impairment of gas exchange between the lungs and the blood causing low levels of oxygen in the bloody tissues), mood disturbance, psychotic disturbance, dementia, heart failure, heart disease, cataract (a cloudy area in the eye), acute kidney failure, hypokalemia (occurs when the amount of potassium in the blood was low), pulmonary fibrosis (scarring and thickening of the tissue around in the lung between the air sacs), vitamin b deficiency, other retention of urine, abnormalities of gait and mobility, and falls. Review of the Admission MDS assessment dated [DATE] revealed Resident #22's cognition was moderately impaired. Resident #22 required limited assistance with the support of one staff for bed mobility and extensive assistance with the support of one staff for transfers. Resident #22 used a wheelchair for mobility. Resident #22 had an indwelling catheter (including suprapubic catheter and nephrostomy tube - a thin, flexible tube that drains urine directly from the kidney into a bag outside the body). Review of the Care Plan dated 01/12/18 revealed Resident #22 had an indwelling Foley catheter: Neurogenic bladder. Date Initiated: 11/16/2023 Revision on: 05/28/2024 Resident #22's Goal: Resident #22 will be/remain free from catheter-related trauma through review date. Date Initiated: 05/28/2024 Target Date: 05/21/2024 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #22's Interventions: Catheter: The resident has 16F 30cc balloon foley catheter. Position catheter bag and tubing below the level of the bladder and away from entrance room door. Date Initiated: 11/16/2023 Revision on: 05/28/2024 Monitor/document for pain/discomfort due to catheter. Date Initiated: 11/16/2023 Monitor/record/report to MD for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Date Initiated: 11/16/2023 Record review of Resident #22's Physician's Order for 06/05/2024 stated, May replace foley catheter for leaking every 24 hours as needed for leaking. Record review of Resident #22's Progress Notes for 08/20/2024 written by LVN G reflected, Nurse talk to Hospice nurse. Regarding catheter reinsertion. Nurse informed her that resident didn't tolerated reinsertion attempt well, even though he was premedicated with Morphine. [Staff] informed nurse that Resident #22's family member was fine with resident remaining in brief for the night and she would come out to attempt reinsertion on 8/21/2024 in am. If reinsertion isn't possible hospice would send him to ER for reinsertion. Record review of Resident #22's Progress Notes for 08/20/2024 written by LVN H revealed, This nurse notifed residents hospice nurse when returned phone call of residents [NAME] on penis from catheter being possible pulled out. This nurse explained to hospice nurse of [NAME] and blood and that the penis was torn. This nurse also explained when trying to insert another catheter resident grimcing in pain. Hospice nurse asked if this nurse could try again to insert another catheter. At 07:00, Nurse was notified by aide that resident was up and walking and catheter on floor. When tried to replace catheter with a new one, resident had no urine returne, small spots of blood. This nurse stopped the catheter insurtion and notified DON and notified hospice . [sic] Record review of Resident #22's Progress Notes for 08/21/24 - 09/05/2024 reflected the resident did not have a catheter. During an observation of Resident #22 on 09/19/24 at 12:55 PM revealed he was sitting on his bed and eating lunch. Resident #22 was observed without a catheter. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/19/2024 at 12:59 PM, Resident #22 stated that he no longer had a catheter. Resident #22 stated that he currently wore underwear, and he no longer needed a catheter. Resident #22 stated that he had some issues with his catheter, and it was causing some pain. He stated that he did not know what kind of issues he was having with his catheter, but it was causing him pain, therefore the staff decided to remove the catheter. In an interview on 09/19/24 at 1:07 PM with CNA F, she confirmed that Resident #22 no longer had an indwelling catheter. She reported approximately 2 months ago Resident #22 had an indwelling catheter and he was getting up from his bed and held onto his wheelchair and he used his bedside table for support and his indwelling catheter ripped out. She stated that staff at the facility attempted a few times to reinsert Resident #22's indwelling catheter but were unsuccessful. CNA F stated that Resident #22's hospice nurse was contacted and stated that she would try to reinsert Resident #22's indwelling catheter and if unsuccessful, she would have Resident #22 sent to the emergency room at the hospital to have his indwelling catheter reinserted. CNA F stated that Resident #22's incontinence hadimproved, and he no longer needed his indwelling catheter, and she did not remember how long Resident #22 had been without his indwelling catheter. She stated that she was unaware that Resident #22's Care Plan and MDS Assessment reflected him still having the indwelling catheter. CNA F stated that the risk the facility's medical records being improperly coded on Resident #22's Care Plan , which reflected that he currently had an indwelling catheter could be a form of neglect. She further stated that if someone was to review Resident #22's Care Plan in PCC (a cloud-based healthcare software provider for long-term and post-acute care) to inquire about his incontinence and the system said that he had an indwelling catheter, it could lead to him having infections. In an interview on 09/19/24 at 1:21 PM with the DON, she stated that Resident #22 had a medical diagnosis of neurogenic bladder, which was a urinary condition that lacked bladder control due to a brain, spinal cord or nerve problem. The DON reported that Resident #22 was on hospice and that he had an incident (unknown timeframe) in which his catheter was accidently ripped out by the resident. She stated that the staff attempted to replace Resident #22's catheter but were unsuccessful and his hospice nurse was notified. She reported that after the incident Resident #22 was wearing briefs and had been without his catheter for 3-4 days and the staff were excited. She stated that Resident #22 was doing well with his incontinence, therefore his hospice provider decided to remove his physician order for the catheter. She stated that the MDS Nurses are responsible for the revisions of residents Care Plan. She stated that she was unaware that Resident #22's Care Plan was not updated. She stated that she did not feel as though there were any risk or harm that could have been done with Resident #22's Care Plan reflecting that he had a catheter. She stated that it would not hurt him and there would be more hurt to Resident #22 if he needed or required a catheter and did not have one. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/19/24 at 1:56 PM, MDS Nurse D, she stated that she was responsible for managing resident Care Plans. She stated that the management at the facility have weekly meetings on Mondays and sometimes Thursdays to discuss the changes that needed to be made, if any to residents Care Plans. She stated that Care Plan meetings were conducted at the facility to ensure that residents Care Plans were accurate or needed to be changed. MDS Nurse D stated that she was unsure when the Care Plan meetings are conducted at the facility, but she knew that they were done. MDS Nurse D stated that she was unaware that Resident #22's Care Plan reflected that he still had a catheter. She stated that she was responsible for documenting the discontinuation of the catheter on Resident #22's Care Plan. She stated that a risk of Resident #22's Care Plan not being properly documented to reflect that he no longer had a catheter would be that he could be overlooked for incontinence checks. She stated that the error on Resident #22's Care Plan could possibly cause harm due to skin breakdown if the staff did not regularly check on him because they thought he had a catheter. In an interview on 09/19/2024 at 2:24 PM, the Administrator stated that he had 2 MDS Nurses (MDS Nurse B and MDS Nurse D) that were responsible for inputting and revising the residents' adjustments made to the Care Plan. The Administrator stated that MDS Nurse B was responsible for the revisions of the residents Care Plan for residents who were at the facility for short term. He stated that MDS Nurse D was responsible for the revisions of the residents Care Plan and for residents who were at the facility for long term, including Resident #22. He stated that there were not a person that oversees the MDS Nurses work, but the facility had QRM a company that helps them oversee the duties that the MDS Nurses perform. He stated that the facility reviewed the recommendations and changes in QA and LOC meeting in which management reviewed things that they covered and caught in the meetings, which could include the oversights from QRM. He stated that both MDS Nurses looked over each other's work to cover themselves. The Administrator stated that he was unaware that Resident #22's Care Plan were not updated to reflect that he no longer had a catheter. He stated that he did not feel as though there were any risks or harm to Resident #22 due to his Care Plan not being updated to reflect that he no longer had a catheter. He confirmed that Resident #22's Care Plan should have been updated to reflect the changes for Resident #22 no longer having a catheter. Record review of the facility's policy titled Care Plans, Comprehensive Person-Centered Care Plans, dated March 2022 revealed the following elements: Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 4. b. identify individuals or roles to be included; c. request meetings; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. request revisions to the plan of care; e. participate in establishing the expected goals and outcomes of care; f. participate in determining the type, amount, frequency and duration of care; g. receive the services and/or items included in the plan of care; and h. see the care plan and sign it after significant changes are made. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; (2) any specialized services to be provided as a result of PASARR recommendations; and (3) which professional services are responsible for each element of care; includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions. 8. Services provided for or arranged by the facility and outlined in the comprehensive care plan are: a. provided by qualified persons; b. culturally competent; and c. trauma-informed. 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clinical decision making. 10. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment. 13. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observation, interview, and record review, the facility failed to provide treatment and care in accordance with professional standards of practice and the comprehensive care plan for 1 of 8 residents (Resident #4) reviewed for quality of care. The facility failed to ensure Resident #4 was not misdiagnosed with schizoaffective disorder. This failure could place residents at a risk of being misdiagnosed and receiving incorrect treatment. Findings included: Record review of Resident #4's quarterly MDS assessment dated [DATE] reflected she was a [AGE] year-old-female admitted to the facility on [DATE]. The resident had a BIMS score of 3 indicating severe cognitive impairment. The resident's diagnoses included hip fracture, non-Alzheimer's dementia, and schizophrenia. Record review of Resident #4's comprehensive care plan, dated 07/19/24, reflected: Resident uses psychotropic medications related to behavior management, schizoaffective/bipolar type, and dementia with psychotic disturbance. Record review of Resident #4's History and Physical, dated 04/05/24, and completed by Physician E reflected: Patient seen and examined in bed with family present. Per the patient's family, she has had short-term memory issues for the past few months that have been markedly worse since anesthesia following her knee operation. She was given Geodon and Ativan at the hospital and became psychotic. She has a history of poor reaction to these medications in the past. We discussed the need to discontinue Seroquel. Family says that she has never been formally diagnosed with dementia though she clearly exhibits the signs. Admit History: [AGE] year-old female with past medical history of high blood pressure, depression, and advanced dementia who presented to the emergency roiagnom on [DATE] following a ground level fall onto her left side. She underwent surgery which markedly worsened her psychosis from her dementia and possible urinary tract infection. She was treated for urinary tract infection and given Seroquel. She does not have a history of borderline personality disorder or schizophrenia. Psychologic: Normal mood/affect, Insight Impaired. Cognitive Status: Forgetful, confused, dementia. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's Behavioral Health Organization Diagnostic Assessment, dated 04/15/24, and completed by the Psychologist reflected: New referral: Patient has a history of depression and schizoaffective disorder. She also has a history of dementia. Patient was referred to determine her ability to benefit from psychological services at this time. Patient denies history of psychiatric hospitalization , depression, and schizoaffective disorder. Patient was a poor historian due to the severity of her cognitive impairment. Clinical Assessment: Based upon clinical interview, brief symptom screening, and a review of records, resident currently meets criteria for major depressive disorder, recurrent episode, mild. In addition, she qualifies for unspecified dementia, moderate, with agitation. Lastly, patient has a historic diagnosis of schizoaffective disorder. Service Plan: No therapy recommended. Record review of Resident #4's Psychiatric Subsequent Assessment, dated 09/05/24, and completed by the Psychiatric-Mental Health Nurse Practitioner reflected: Reason for referral: Agitation, Irritability, Psychosis, Confusion, Short Term Memory Problems, Long Term Memory Problems, Verbal Aggression, Physical Aggression, Medication Evaluation. Psychosis: Staff reports no current symptoms of auditory hallucinations, delusions or disorganized speech. Assessment/Plan: 1. Recurrent depressive disorders is being treated with Zoloft 25 milligrams daily. 2. Dementia in other diseases classified elsewhere, unspecified severity, with agitation is being treated with Namenda 5 milligrams two times a day. 3. Unspecified psychosis being treated with Seroquel 12.5 milligrams every night. No overt symptoms of psychosis noted or reported, will monitor closely. There was no diagnosis of schizoaffective disorder. An observation on 09/17/24 at 10:23 AM revealed Resident #4 was lying in bed asleep. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 09/17/24 at 12:04 PM with the representative party for Resident #4 revealed the resident did not have a history of schizoaffective disorder. An interview on 09/18/24 at 3:09 PM with MDS Nurse B revealed Resident #4 had a diagnosis on the MDS assessment for schizoaffective disorder because it was listed on a psychologist note dated 04/15/24. She said the resident did not have the diagnosis when she was admitted . An interview on 09/18/24 at 3:40 PM with the Medical Director revealed Resident #4 did not have a history of schizophrenia or schizoaffective disorder. An interview on 09/19/24 at 12:14 PM with the Psychologist revealed he documented the resident as having schizoaffective disorder in his note for 04/15/24. He said he later found out it was a false diagnosis and he said he notified an unknown facility staff about the error on unknown date. An interview on 09/19/24 at 2:18 PM with the DON revealed she signed the MDS assessment dated [DATE] for Resident #4. She said that she signed all MDS assessments but did not review every single one and could not remember if she reviewed Resident #4's MDS. She said for Resident #4, the misdiagnosis did not affect the resident. Record review of the facility policy, Antipsychotic Medication Use, dated 2001, reflected: 4. The attending physician and facility staff will identify acute psychiatric episodes, and will differentiate them from enduring psychiatric conditions. Record review of the facility policy, MDS Completion and Submission Timeframes, revised July 2017, reflected: Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676197	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeview Rehabilitation and Skilled Nursing	206 Walls Dr Cleburne, TX 76033

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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** 37028 Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (Resident #62 and Resident #188) of 8 residents observed for infection control. 1. LVN A failed to clean the blood pressure cuff after using it on Resident #188 who was on enhanced barrier precautions. LVN A used the same blood pressure cuff on Resident #62. 2. The facility failed to post signage on Resident #188's that he was on enhanced barrier precautions. The failures could place residents at risk for healthcare associated cross contamination and infections. Findings included: Record review of Resident #188's face sheet dated 09/17/24, revealed he was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included 3rd degree burns on his left leg and malignant neoplasm of the brain (brain cancer). Record review of Resident #62's face sheet dated 09/17/24, revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included metabolic encephalopathy (brain dysfunction). An observation and interview on 09/17/24 at 9:23 AM with LVN A revealed she was administering medications. She said it was her first day as an employee at the facility, but she had worked at the facility before as an agency nurse. LVN A prepared medications for Resident #188. There was no signage or PPE in front of Resident #188's room. LVN A did not wear PPE in Resident #188's room. LVN A took the medications and blood pressure cuff into Resident #188's room and set the medications and blood pressure cuff on the resident's lap tray. LVN A took the resident's blood pressure and administered his medications. LVN A took the blood pressure back to the medication cart and laid it on top of the cart. An observation on 09/17/24 at 9:42 AM revealed two therapy staff put on full PPE and entered Resident #188's room. An observation and interview on 09/17/24 at 9:47 AM revealed LVN A took the blood pressure cuff, that she did not sanitize, and used it on Resident #62. LVN A said she was supposed to clean the blood pressure cuff between using it on residents but forgot to. She said she was supposed to clean it to prevent infection. LVN A left and said she would return shortly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676197	A. Building B. Wing	09/19/2024

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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	An observation and interview on 09/17/24 at 9:50 AM revealed LVN A returned to the medication cart. She said she found out Resident #188 was supposed to be on enhanced barrier precautions because he had a Foley catheter. She said she did not know because there was no signage on the door and there was no PPE outside of his room. She said she should have worn PPE (gown and gloves) before entering Resident #188's room. A follow-up interview on 09/17/24 at 1:03 PM with LVN A revealed she completed infection control check-offs while she was an agency nurse at the facility. She said she did not know why Resident #188 did not have signage on the door. She said she did not know who was responsible for making sure signage on resident doors. She said she did not know of any other residents who did not have signage and PPE available for enhanced barrier precautions. She said it was important to don PPE for residents on enhanced barrier precautions to prevent the spread of infection. An interview on 09/18/24 at 11:14 AM with the ADON revealed she was able to identify all residents who were on enhanced barrier precautions. She said she did not know why Resident #188 did not have his signage posted on his door. She said it was possible that other residents were taking them down. She said she and the DON were responsible for making sure that residents on enhanced barrier precautions had the proper signage and PPE available. The ADON said there was a risk of infection to residents if PPE was not worn as needed. She said medical equipment was supposed to be cleaned between each resident used to prevent exposure to infection. An interview on 09/18/24 at 1:06 PM with the DON revealed Resident #188 was on enhanced barrier precautions because he had leg wounds. She said she did not know why Resident #188 did not have the signage on his door. She said the facility was going to order a different type of device to hold the signs so that the residents could not take them down. The DON said it was everyone's responsibility to ensure signage was posted on the resident's door. Record review of the facility policy, Infection Control, dated November 2017, reflected: c. Standard and transmission-based precautions to be followed to prevent the spread of infections .