STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676374	A. Building B. Wing	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midlothian Healthcare Center	900 George Hopper Road Midlothian, TX 76065

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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 - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45070 Based on observations, interviews, and record reviews, the facility failed to ensure residents received services in the facility with reasonable accommodations of each resident's needs for 2 of 7 residents (Residents #16 and #18) reviewed for call lights in that: The facility failed to ensure Residents #16 and #18's call lights were within reach. This failure could affect residents who needed assistance with activities of daily living and could result in needs not being met. Findings included: Record review of Resident #16's admission record dated 10/26/23 revealed a [AGE] year-old male admitted on [DATE]. Resident #16's diagnoses included: acute chronic diastolic heart failure (damage to the left heart ventricle), hypertensive heart and chronic kidney disease with heart failure and chronic kidney disease (Kidneys are damaged and cannot filter blood as they should.), acute kidney failure (sudden episode of kidney failure), essential primary hypertension (high blood pressure that is not due to another medical condition), chronic respiratory failure with hypercapnia (too much carbon dioxide in your blood), sequelae of cerebral infarction (residual effects or condition following a stroke), muscle weakness (lack of physical or muscle strength), and localized edema (swelling caused by fluid in your body's tissues). Record review of Resident #16's quarterly MDS assessment dated [DATE], revealed Resident #16 had a BIMS score of 14 indicating the resident was cognitively intact. The MDS also revealed the resident required limited assistance in various areas of bed mobility, transfers, walking in room, walking in corridor, locomotion on unit, locomotion off unit, dressing, toilet use, and personal hygiene. Record review of Resident #16's care plan date 10/26/2023, revealed Resident #16 was care planned for risk for falls related to muscle weakness, impaired physical mobility, impaired visual functioning and is at risk for a decrease in ADLs and injuries, and risk for self-care deficit: bathing, dressing, feeding r/t cognition. Observation of Resident #16 on 10/25/2023 at 9:45 am revealed his call light button was laying on left side of his bed on the ground. Resident #16 was not interviewed due to Resident #16 leaving for a medical appointment. (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 - Few	Record review of Resident #18's admission record dated 10/26/23 revealed a [AGE] year-old male admitted on [DATE]. Resident #18's diagnoses included: Infection and inflammatory reaction due to indwelling catheter subsequent encounter (discomfort and contributes to a breakdown in tissue integrity maybe caused by frequent insertion of catheters), Paroxysmal atrial fibrillation (when an erratic heart rate begins suddenly and then stops on its own within 7 days), hematuria (red blood cells in the urine), essential primary hypertension (high blood pressure), Cerebral infraction due to unspecified occlusion or stenosis of unspecified cerebral artery (when one of the blood vessels supplying blood to the brain is blocked), and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems). Record review of Resident #18's quarterly MDS assessment dated [DATE], revealed Resident #18 had a BIMS score of 14 indicating the resident was cognitively intact. The MDS also revealed the resident required extensive assistance in various areas of bed mobility, transfers, locomotion on unit, locomotion off unit, dressing, toilet use, and personal hygiene. Record review of Resident #18's care plan date 10/26/2023, revealed Resident #18 was care planned for an actual fall r/t: poor balance, unsteady gait, cognitive impairment, intermittent confusion, bladder incontinence r/t Alzheimer's, dementia, disease process, history of uti, impaired mobility, risk of falls r/t muscle weakness, risk of pain r/t immobility and history of frequent falls. Observation of Resident #18 on 10/24/2023 at 10:15 am revealed his call light button was laying on the left side of his bed on the ground. An interview with Resident #18 on 10/24/2023 at 10:15 am, revealed Resident #18 stated that his call button was often on the ground and out of his reach. Resident #18 stated that he must remind staff often to place the call light button where he can reach it. Resident #18 stated if his call button is not in reach he will yell for assistance or wait for a staff to come in his room. An interview with CNA A on 10/26/2023 at 11:23am, revealed CNAs make round at least once an hour but sometimes rounds are conducted more frequently. CNA A stated if a call light button is not in reach of a resident the resident will not be able to get assistance. CNA A stated she believes it everyone who enters the room responsibility to ensure that residents call light are in reach. An interview with DON on 10/26/2023 at 1:55pm, revealed DON stated the purpose of the call light was to reach out for help if residents needed assistance in care. DON stated if the call light is not in reach then the residents are not able to get assistance, and they could try to do something themselves and fall. DON stated that everyone that enters the room should be ensuring the resident call lights are in reach. An interview with the ADM on 10/26/23 at 1:50 pm, revealed ADM stated the purpose of the call light are to alert staff that a resident needs help. ADM stated that if the resident's call light was not in reach then they could not receive the assistance they need. The ADM stated that the quality of life group of department heads go around and check to see if residents have water, and that the call light is in reach. ADM stated the quality of life group has list of items they are to look for when making rounds. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Bedrooms policy not dated revealed Policy statement all residents are provided with clean, comfortable and safe bedrooms that meet federal and state requirement. 5. All residents rooms are equipped with a resident call system that allows resident to call for staff assistance. Calls are directed to either staff member or to a centralized work area.

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 Based on interviews and record reviews, the facility failed to ensure residents were free from abuse for 1 of 7 residents (Resident # 38) reviewed for abuse, neglect, and exploitation. The facility failed to ensure Resident #38 was free from physical abuse. This failure placed residents at risk for of physical and psychosocial harm. Findings include: Record review of Resident # 38's admission record indicated that Resident # 38 was a [AGE] year-old male who was residing at Midlothian Healthcare Center sine 4-28-2023. Resident # 38 was diagnosed with Type 2 Diabetes, Major Depressive Disorder, Generalized Anxiety Disorder, Unspecified Dementia, and an Adjustment Disorder with Mixed Anxiety and Depressed Mood. Record review of Resident # 38's BIM's Evaluation indicated a BIM score of 10. Record review of Resident # 38's care plan, indicated an update on 10-11-2023 which addressed problematic behaviors with the resident characterized by ineffective coping, verbal aggression; and cursing/using racial slurs towards staff. The updated intervention directed staff to have the resident's attention before speaking and not to argue or condemn resident; The updated care plan indicated to use clear and concise explanations when speaking to the resident and to use a low pitch calm voice to decrease or eliminate undesired behaviors. Record review of the facility's PIR (3613-A), dated 10-16-2023, indicated that Resident # 38 was the recipient of alleged abuse on 10-11-2023 at 10:15 AM. The allegation was described as, While performing care with the nursing students, [CNA A] was attempting to turn [Resident # 38] over so the students could assist with giving him a bed bath. [Resident # 38] was cussing [CNA A] out and told [CNA A] that [Resident #38] was going to hit [CNA A.] CNA A] asked [Resident # 38] not to and [Resident # 38] went to hit [CNA A] with [Resident # 38's] right hand. [CNA A] grabbed [Resident # 38's] right hand as [Resident # 38] tried to hit [CNA A] to stop [Resident # 38] from hitting [CNA A.] [CNA A] then slapped [Resident # 38's] hand with [CNA A's] other hand and then put it back down. The PIR indicated that Resident # 38 identified the alleged perpetrator, CNA A, by name. The PIR indicated that the alleged perpetrator, CNA A, was confirmed. The PIR indicated that there were two eyewitnesses present; the two eyewitnesses were CNAT A and CNAT B. Record review of CNAT A's written statement, made on 10-11-2023, of an allegation of abuse from CNA A on Resident # 38 indicated that CNAT A and fell ow student, CNAT B, were in Resident # 38's room on 10-11-2023 at 10:15 AM having been instructed by CNA A on how to give a resident a bed bath. CNAT A stated Resident # 38 was verbally abusive to CNA A and threatened to hit CNA A. CNAT A stated CNA A was on the left side of Resident # 38 and was getting ready to turn Resident # 38 towards CNA A. The statement indicated that Resident # 38 reached out with Resident # 38's right hand to strike CNA A. The statement indicated that Resident # 38 made contact CNA A's arm. After the physical contact, CNA A removed Resident # 38's hand from CNA A's arm and then hit Resident # 38 on the right arm. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of CNAT B's written statement, made on 10-11-2023of an allegation of abuse from CNA A on Resident # 38 indicated that CNAT B and fell ow student, CNAT A, were in Resident # 38's room on 10-11-2023 at 10:15 AM being instructed by CNA A on how to give a resident a bed bath. CNAT B described that Resident # 38 was verbally abusive to CNA A and threatened to hit CNA A. CNAT B's statement indicated that CNA A verbally responded to Resident # 38's threat to hit CNA A with 'come on then! The statement further indicated that Resident # 38 hit CNA A with Resident # 38's right hand. After the contact, the statement indicated that CNA hit him back on Resident # 38's right arm. Record review of the facility's PIR (3613-A) indicated that CNA A was suspended and was required to take continuing education for elder abuse and healthcare burn out. CNA A was given a final written warning. As a result, any other infractions of the facility's policy would result in termination. Record review of the facility's Employee Counseling Notice dated 10-12-2023 indicated that CNA A was counseled for a final written warning for unsatisfactory performance. The counseling form's Action Plan for Improvement indicated responses to a resident's physical or verbal combativeness would result in (1) attempting to redirect or (2) removing yourself from the situation and reapproaching later. The Employee Counseling form was signed by CNA A, the DON, and the ADM on 10-12-2023. Interview on 10-26-2023 at 8:35 AM with Resident # 38 revealed that Resident # 38 remembered a recent incident that pertained to Resident # 38 having been hit by a staff member that occurred recently in Resident # 38's room. Resident # 38 stated there were three staff members in the room. Resident # 38 described two staff members to the right, CNAT A and CNAT B, and one to the left, CNA A. Resident # 38 stated that Resident # 38 reached out to hit CNA A with Resident # 38's right arm when Resident # 38 received care. Resident # 38 stated that he tried to hit CNA A because he did not like CNA A and thought CNA A was rude. Resident # 38 held up his right arm a few inches and motioned with voice and body language to indicate which hand they used when he tried to strike CNA A, as well as which arm was struck by CNA A. Resident # 38 stated that it hurt and that he wanted to slap CNA A back because he was mad, but he could not. Resident # 38 stated that he felt safe at the facility. Interview on 10-26-2023 at 8:15 AM with CNA A revealed that CNA A and two trainees, CNAT A and CNAT B, were in Resident # 38's room on 10-11-2023 at 10:15 AM performing care in the form of a bed bath. CNA A stated CNA A was on the left side of Resident # 38's bed and that the two trainees, CNAT A and CNAT B were on the opposite side, the right. CNA A stated that when Resident # 38 was rolled to Resident # 38's left side, Resident # 38 reached out with Resident # 38's right arm across Resident # 38's body to strike CNA A, who was on Resident # 38's left side. CNA A stated that CNA A reached out with CNA A's left hand, fingers extended, to block the strike. CNA A stated that CNA A guided Resident # 38's back down to Resident # 38's right side with CNA A's right hand. CNA A denied having verbally responded with come on then! when Resident # 38 threatened to hit CNA A. CNA A denied striking Resident # 38 on Resident # 38's right arm. CNA A stated that care giving duties were restricted with Resident # 38. CNA A stated that CNA A was not allowed to provide care to Resident # 38. CNA A stated they were not involved in any similar incidents or allegations. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 10-26-2023 at 1:20 PM with the DON revealed that the DON interviewed both CNAT A and CNAT B after the incident of alleged abuse on 10-11-20213 at 10:15 AM. The DON asked the CNATs to demonstrate what occurred in Resident # 38's room at the time of the incident. Both CNAT A and CNAT B recounted the details that Resident # 38 tried to strike CNA A and that CNA A blocked the strike and CNA A slapped Resident # 38 on his right arm. The DON stated that she interviewed CNA A afterwards. The DON stated that CNA A described the events differently in that CNA A blocked Resident # 38's strike with CNA A's left hand and used CNA A's right hand to secure Resident # 38's right arm on Resident # 38's right side. The DON stated that CNA A denied striking Resident # 38. The DON stated the negative effects of abuse on residents' placed residents at risk of physical pain, psychosocial pain, withdrawal, and fear from reaching out to ask for help. Interview on 10-26-2023 at 1:45 PM with the ADM revealed the ADM did not believe that CNA A physically assaulted Resident # 38. The ADM believed that CNA A blocked Resident # 38's attempt to strike CNA A and CNA A grabbed Resident # 38's arm to move it away from being able to strike again. The ADM stated that CNA A was suspended during the facility's investigation and was allowed back to work when it was completed. The ADM stated that CNA A was remorseful for of the events that occurred on 10-11-2023 in Resident # 38's room. CNA A was counseled and given a final written notice and that CNA A could be terminated for the slightest infraction of facility policy. The ADM felt that CNA A deserved a second chance because CNA A had not been involved in any similar incidents. CNA A was instructed to take additional training based on the allegation of abuse. The ADM had CNA A attend additional training for Preventing Elder Abuse on 10-13-2023 and Dementia Care III; Understanding and Managing Difficult Behaviors on 10-16-2023. CNA A was allowed back at work. The ADM stated that the facility protected residents from physical and emotional abuse, which would place residents at risk of pain and misery. Record review of five safe surveys administered on10-12-2023 to Residents # 36, # 8, # 6, # 62, and # 19 indicate that staff treat them in a respectful manner; have not been physically harmed by CNA A (specifically); and feel safe at the facility. Interviews and observations from 10-24-2023 till 10-26-2023 with Residents # 61, # 4, # 53, # 72, # 37, # 54, and # 25, along with LAR # 54 and # 25, did not reveal incidents of staff abuse. Record review of CNA A's personnel file did not indicate prior incidents of abuse or neglect with any resident in the facility. Record review of CNA A Criminal History Conviction Name Search on 1-9-2023 resulted with no search results found. Record review of CNA A's NAR and EMR on 5-14-2023 search resulted in No for unemployable and EMR Listing. Record Review of the facility's Acknowledgement of Abuse Policy and Reporting Requirements was signed on 1-25-2021by CNA A. The policy indicated that the facility will not tolerate any conduct that may be considered abuse or neglect of its residents. Record review of the facility's Statement of Resident Rights was signed on 1-25-2021 by CNA A. The policy, dated December 2016 and enforced by the ADM, indicated that residents had the right to be free from abuse. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of a facility's in-service on Abuse and Neglect- Clinical Protocol, dated March 2018, and the Abuse Prevention Program, dated December 2016, were signed by CNA A on 8-26-2023. The policy indicated that Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. Record review of a facility in-service on Prohibition of Abuse and Neglect, undated revision, was signed by CNA A on 6-8-2023. The policy indicated that each resident has the right to be free from abuse, mistreatment, neglect, corporal punishment, involuntary seclusion, and financial abuse.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 Based on observations, interviews, and record reviews, the facility failed to store foods properly and maintain a sanitized food preparation area for the facility's only kitchen reviewed for food and nutrition services. 1. The facility failed to properly seal food containers in the facility's only pantry, walk-in cooler, and freezer. 2. The facility failed to maintain clean kitchen surfaces/appliances. These failures placed residents at risk of exposure to food borne pathogens. Findings include: Observations on 10-24-2023 at 7:15 AM of the facility's dry food storage area reflected one unsealed package of graham cracker crumbs WLD; one unsealed bag of yellow corn meal WLD; one five-pound plastic container of chili mix inside a red cooking pot with product directions to keep frozen; two unsealed bags of dry pasta WLD; and one white bulk container of sugar, undated, partially covered and it's metal scooper to the left coated with 1/8 inch build-up of sugar. Observations on 10-24-2023 at 7:30 AM of the facility's walk-in cooler reflected one unsealed bag of iceberg lettuce WLD; one partially consumed plastic 2.27-kilogram container of mixed pasta WLD; and two unsealed plastic bags containing Swiss, American, and cheddar cheese. There was an 8.5 x 11-inch sign posted outside of the entry to the cooler/freezer that stated, 'do not place food items in this cooler/freezer without labeling and dating it first.' Observations and interview on 10-24-2023 at 8:00 AM reflected food particle build-up on the top of an oven in the food prep area and a two-basket fryer with grease and food particles build-up inside its internal working parts. An interview on 10-24-2023 at 8:05 AM with [NAME] A revealed that the fryer had not been cleaned since 10-23-2023. Observations on 10-24-2023 at 8:15 AM reflected food particle build-up and a brown colored oily substance on the top of the dishwashing machine. Further observations of the dishwasher reflected that the stainless-steel hood located directly over the dishwasher machine had build-up a dark brown oily substance on its top and all four sides. The stainless-steel hood had a visible 3 x 5-inch sticker with instructions how to be cleaned and maintained. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 10-26-2023 at 1:19 PM with the DM revealed that food needed to be stored, labeled, and dated correctly to make sure that the food was fresh when served. The DM stated that food stored improperly could create food-borne pathogens that could cause health issues with residents with compromised immune systems. The DM stated that surfaces in the kitchen area needed to be cleaned on a regular basis to kill germs, viruses, bacteria, and to avoid cross-contamination. The DM stated that negative outcomes of exposure to food borne pathogens could cause upset stomachs, nausea, and diarrhea. Interview on 10-26-2023 at 1:51 PM with the ADM revealed that food needed to be stored correctly and kitchen surfaces needed to be sanitized regularly to avoid food-borne pathogens. The ADM stated that the failure placed the residents in the facility at risk for diarrhea, nausea, or violent illnesses. Record review of the kitchen sanitizing schedule, created by the DM, from 10-18-2023 through 10-26-2023, indicated that staff members were assigned to clean the fryer/steamer and the oven/vents. Record review of the facility's Food Receiving and Storage Policy, dated July 2014 indicated that (8) all foods stored in the refrigerator or freezer will be covered, labeled, and dated (use by date); and that (14 e) other opened containers must be dated and sealed. Record review of the facility's Sanitization Policy, dated October 2008, indicated that (2) all utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks, and chipped areas that may affect their use or proper cleaning. Seals, hinges, and fasteners will be kept in good repair; and (13) kitchen wastes that are not disposed of by mechanical means shall be kept in clean, leakproof, non-absorbent, tightly closed containers and shall be disposed of daily; and (16) kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime; and (17) the food services manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas. Food service staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 45070 Based on interview and record review, the facility failed to electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS, in that: The facility failed to submit staffing information to CMS for the 3rd quarter of the Fiscal Year 2023. The facility's failure could place residents at risk for personal needs not being identified and met, decreased quality of care, decline in health status, and decreased feelings of well-being within their living environment. The findings included: Record Review of the facility's Civil Rights form (3761) dated 10/24/23 indicated the following staffing information: 5 RNs 15 LVNs 30 Direct Care Staff 10 Dietary Staff 10 Housekeeping & Laundry 26 All Others 96 Total Record review of the facility's CMS form 672 (Resident Census and Conditions of Residents) dated 10/24/23 provided by MDS Coordinator indicated a total of 82 residents in the facility. Record review of the CMS PBJ Staffing Data Report, CASPER Report 1705 D FY Quarter 3 2023 (April 1 - June 30), dated 10/18/2023, indicated the following entry: Failed to Submit Data for the Quarter ; Triggered ;Triggered=No Data Submitted for the Quarter. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the ADM on 10/26/23 at 3:20 pm, the ADM said the Payroll Based Journal staffing hours were submitted by the CPA. The ADM stated, he prompted the CPA office to submit the data on time as towards the end of the 3rd quarter when he had noticed no data was submitted by the CPA. He said he was under the impression that it was submitted by the CPA office as they promised him that the report would be sent out on time. The ADM stated they did not have a policy regarding submitting the Payroll Based Journal.

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	676374	A. Building B. Wing	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midlothian Healthcare Center	900 George Hopper Road Midlothian, TX 76065

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 45070 Based on observation, interview and record review, the facility failed to maintain an infection and prevention control program that included, at a minimum, a system for preventing and controlling infections for 2 (Residents #79 and #55) of 5 residents reviewed for usage of wrist blood pressure monitor, as indicated by: MA A observed not cleaning and disinfecting the wrist blood pressure monitor while using it on Resident # 79 and Resident #55. This failure could place the residents at the facility at risk of transmission of disease and infection. Findings included: Review of Resident #79's face sheet, dated 10/24/23, reflected Resident #79 admitted to the facility on [DATE]. He was a [AGE] year-old male diagnosed with Acute Respiratory Failure, Acute Kidney Failure, Chronic Kidney Disease, Fall on same level from slipping, Tripping and Stumbling, Atrial Fibrillation (irregular rapid heart rhythm), Congestive Heart Failure Review of Resident #79's care plan, dated 7/14/23, reflected that Resident#79 was on antibiotic therapy and effort would be made to monitor labs, cultures and report abnormal to MD. Review of Resident #55's face sheet, dated 10/24/23, reflected Resident #55 admitted to the facility on [DATE]. She was a [AGE] year-old female diagnosed with Hypertension, Lack of coordination, gastro-Esophageal Reflux Disease, Dementia, Psychotic Disturbance, Mood Disturbance, Anxiety, History of falling, Alzheimer's Disease and Difficulty in Walking. Review of Resident #55's care plan, dated 10/11/23, reflected that Resident#55 was on antibiotic therapy for UTI and effort would be made to monitor labs, cultures and report abnormal to MD. During an observation on 10/24/23 beginning at 10:30 AM MA A was administering medications to the residents. As part of the medication administration process MA A took the blood pressure of Resident #79 with a wrist blood pressure monitor and then administered the ordered medications. Once the medication administration to Resident#79 was completed, MA A moved on to Resident #55 who resides in the same hall and used the same blood pressure monitor on Resident #55 without sanitizing it. After the blood pressure was taken, she stored the blood pressure monitor on the med cart. MA A failed to sanitize the wrist blood pressure monitor before and after using it on Resident #79 and before and after using it on Resident #55. During an interview on 10/24/23 at 10:45AM MA A, stated she was aware that the blood pressure monitor should be sanitized in between the residents. MA A said she simply forgot to sanitize it because she was in a hurry. MA A stated there was a danger of transmitting diseases from one resident to another if the equipment was not sanitized properly. MA A stated she had not received in-service on disinfection of medical equipment in the recent past. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676374	A. Building B. Wing	10/26/2023

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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	During an interview on 10/26/23 at 3:00 PM the DON stated her expectation was that the nursing staff must follow facility policy/procedure for handwashing and sanitization of medical equipment that includes sanitizing blood pressure monitor every time after the use on residents was essential to stop spreading transmittable diseases. When asked about how the facility identified deficient practices by nursing staff, she stated the DON and ADON observe and/or participate in nursing care with the nurses, MAs and CNAs. DON stated the facility conducted in -services on sanitizing medical equipment at the facility. Record review on 10/25/23 of facility in-services revealed, on 09/08/23 MA A attended an in-service Sanitize Equipment Between Residents(Blood pressure Cuff, Glucometers, Thermometers). Review on 10/25/23 of facility policy Cleaning and Disinfection of Resident -Care Items and equipment dated October,2018 reflected: Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Blood borne Pathogens Standard . . d. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment). (i)Single resident-use items are cleaned/disinfected between uses by a single resident and disposed of afterwards (e.g., bedpans, urinals). e. Single-use items are disposed of after a single use (e.g., thermometer probe covers) . . 3.Durable medical equipment (DME) must be cleaned and disinfected before reuse by another resident. 4.Reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturers' instructions .