STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675650	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace Alzheimer's Center of Excellence	7500 Oakmont Blvd Fort Worth, TX 76132

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review the facility failed to ensure residents received parenteral fluids administered consistent with professional standards of practice and in accordance with physician orders for 2 (Residents #15 and #81) of 2 residents reviewed for peripheral intravenous care. 1.The facility failed to attach Resident #81's needleless connector (connects to the end of a catheter to delivery IV therapy) to the IV every seven days as indicated in the physician's orders. (A midline is a long flexible tube that is inserted into the vein in the upper arm to administer medication or fluids intravenously) and failed to date the IV dressing. 2.RN G failed to disinfect the midline catheter prior to securing the needleless connector on the IV for Resident #81. 3.The facility failed to date Resident #15's chemo port dressing (this is a small implantable device that allows for easy access to veins for medical treatments) and failed to date Resident #81's intravenous midline dressings. 4.LVN F failed to wear appropriate PPE when accessing Resident #15's chemo port. The failures placed residents at risk of developing an infection. Findings included: 1. Review of Resident #81's face sheet, dated 11/05/24, revealed the resident was a [AGE] year-old female, admitted on [DATE], with diagnoses of cervical region spondylosis with myelopathy (this is a condition that occurs when the spinal code in the neck deteriorated due to aging, Escherichia coli (a type of infection), and bacteremia, and Alzheimer's disease with late onset (this is a brain condition that progressively destroys memory and other important mental functions). Review of Resident #81's physician orders, dated 11/05/24, revealed the following: - IV: Midline Catheter - Change needleless connector every day shift every 7 day(s) AND as needed and with blood draws or transfusions with start date of 11/06/24 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #81's care plan, dated 11/05/24, revealed the resident had dehydration or potential fluid deficit due to E. coli Bacteremia Infection and is on IV medication. The goal was Resident #81 would be free of symptoms of dehydration and maintain moist mucous membranes and good skin turgor. The resident is also on enhanced barrier precautions due to IV medications (Ceftriaxone) for Bacteremia and E. coli. The goal was for the resident to be free of complications from IV therapy. Interventions included: IV dressing: Observe every shift and change dressing and record observation of site as ordered. Observe signs and symptoms of infection at the site of the IV such as drainage, inflammation, swelling, redness, and warmth. Review of Resident #81's MDS admission assessment, dated 10/30/24, revealed no pertinent information related to the resident's IV. Review of Resident #81's MAR for November 2024, revealed the needleless catheter was last changed on 11/06/24, the date surveyor made the observation and again on 11/07/24. Observation and interview on 11/05/24 at 01:19 PM, with RN G revealed Resident #81 with a single IV catheter tube in her left upper arm. The dressing around the IV catheter was undated and the IV catheter tube had no needleless connector (connects to the end of a catheter to delivery IV therapy) to it. RN G stated Resident #81 had a midline with a single lumen (central venous catheter with a single distal port for drug infusion, blood drawing, etc .). He stated he did not know what happened to the needless connector and he did not know when the dressing was changed. He stated he would put the cap back on the midline. RN G wheeled Resident #81 out of her room and put on gloves and put a green cap at the end of IV catheter tube without the needless connector. The needless connector was still missing from the end of the IV catheter tube. RN G did not disinfect the midline catheter before securing the green cap to it. Resident #81 was non interviewable about the midline. She smiled and said hello. Observation and interview on 11/06/24 at 8:01 AM of Resident #81 with RN G revealed Resident #81 was attached to the IV pole with antibiotics done. Resident #81's midline IV dressing had been changed and dated 11/05/24. The needless connector was attached at the end of IV catheter tube. RN G stated the needless connector was used for filtration and to keep infection out of the midline. He stated he did not know who had removed it yesterday. He stated when he had administered Resident #81's antibiotics on 11/05/24 at 1:00 PM the needless connector was there. RN G stated he should have cleaned the IV catheter before putting on the green cap and he should have secured another needleless connector to the midline IV catheter. He stated it might have fallen off during the night shift. RN G was asked if he noticed it missing during the morning IV medication administration to which he responded he was not aware the needless connector was missing. 2. Review of Resident #15's face sheet, dated 11/07/24, revealed a [AGE] year-old male, admitted to the facility on [DATE], with the diagnoses of esophageal obstruction (a blockage or narrowing of the esophagus), cancer of esophagus, Gastrostomy status (this is a feeding tube that is placed through the abdominal cavity area into the stomach for nutritional purpose and medication for individual who have a difficulty swallowing), and chronic kidney diseases . Review of Resident #15's physician's orders, dated 11/07/24, revealed Saline flush solution. Use 10 ml intravenous every 3 months starting on the 28th for 10 days for port to implanted port-valved when not accessed. The physician's orders did not reflect dressing changes and monitoring. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #15's Care Plan initiated 10/22/24 revealed Resident #15's care plan did not reflect a chemo port and interventions. Observation and interview on 11/06/24 at 10:17 AM, revealed Resident #15 was in his room. The door sign reflected STOP Enhanced Barrier Precautions. Everyone must clean their hands before entering the room and when leaving the room. Providers and staff must wear gloves and gown for the following: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use such as; central lines, urinary catheter, feeding tube, tracheostomy (surgical procedure that involves creating an opening in the neck to access the trachea). Wound care: any skin opening requiring dressing. LVN F washed her hands upon entry to go into Resident #15's room. She wore gloves on her hands, but she did not wear a gown as she accessed Resident #15's port that was located on his right upper chest area. The dressing was clean, intact, and undated. LVN F opened the port and flushed it with 10 ml of saline. Resident #15 stated the port was put in when he was doing chemo and radiation for his cancer. He stated it had not been used since he was at the facility. LVN F stated that she had to flush the chemo port per physician's order with saline. LVN F stated she forgot to wear a gown before accessing Resident #15's port. She stated the purpose of enhanced barrier precautions was to keep infection from the residents. Phone Interview on 11/07/24 at 01:08 PM with the ADON, she stated she had done an in-service on IVs; it was about tubing, dressing changes, and IV administration. That was the most recent and it had been within the last week. The ADON stated midline dressings, the clear one, was changed weekly. LVN I stated it should be dated. She stated it should have a needleless connector on it. The ADON stated if the needleless connector was not on, there was a risk for infection. She stated the nurse who administered medications through the IV would have been the first person to make sure it was attached, and the floor nurse would monitor the IV. The ADON stated if she saw that the resident did not have the connector, she would have assess the resident and ensured Resident #81 had the connector and attached it, and before she put it back on, she would clean the site first. She stated she would clean the site with alcohol. The ADON stated they had plenty of supplies for dressing changes, and had extra supplies stored. The dressing change was a sterile one. The needleless connector was treated as sterile. The ADON stated the port access should be done according to physician's orders and infection control precautions should be followed accordingly. She stated she was unaware that Resident #15 had a port. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/07/24 at 3:15 PM with LVN I revealed she administered antibiotics to Resident #81 via IV on 11/04/24, Monday. She stated she did not remember what the little part that was connected to the IV was (needleless connector). LVN I stated the dressing was dated when she changed it, and it had the twist part that connected, but she could not remember the name. She stated it was to allow fluids to flow through and she would close it up to protect the tubing from bacteria. The surveyor showed LVN I a picture of the dressing that was undated as of 11/05/24. LVN I stated Resident #81 would pull off the dressing and that someone must have replaced it since she did not know why it was not dated. She stated the dressing was sterile for infection control. LVN I stated last month she thought they did EBP training, and they did it for IV, and she did a whole course on it about a month and a half ago. She stated there was no in-service the past week though. LVN I stated she was an IP nurse, so she had to do training on IV. She stated the ADON does most of it, but LVN I stated she stepped up when the ADON was out of the facility. She stated she was mainly on the floor. She stated EBP was for any resident with wounds, catheters, IV . there were a lot of different ones that were required to be on EBP. She would expect the staff to wear PPE to provide care for a midline or port. The purpose was to protect staff and the resident from spreading bacteria. LVN I stated it was a precaution. LVN I revealed that residents admitted with a chemo port doctor's orders were followed regarding the care of the chemo port site. She stated they would document the chemo port on admission, the dressing, how it looked and what it was, and whatever the orders were. If there was no order for dressing or anything, she would reach out to the physician. LVN I stated the admitting nurse would be responsible for verifying the orders with the physician and on their daily rounds with the DON and the IDT. She stated they would confirm and double check those orders. LVN I stated she was not sure about whether they were allowed to change the dressing and would have to look at the policy. LVN I stated she had never dealt with a chemo port nor had she done anything with it. She stated if the chemo port had a dressing that needed to be changed or cleaned, they would do that, but there would have to be orders in place to even do that. She stated the NP would get with the doctor who would deal with the port. LVN I stated sometimes they got orders from physicians that they see outside the facility. LVN I stated she has never changed a dressing on a chemo port, nor does she know how. LVN I stated if someone had an undated dressing on a port, she would not touch it. She stated she would get someone who knew how and would find out what she was even allowed to do with the chemo port. LVN I stated she would reach out to DON first, then the physician. She stated she would not touch it without doing that first. LVN I stated she would not want to do anything without asking, because it would be outside of her scope as she was not an RN. LVN I stated she would want a date on the dressing because they need to know if it was clean and how long the dressing had been on. She stated if the dressing had been on for 10 days there were probably a lot of germs under it. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/07/24 at 4:11 PM with the DON revealed her expectations of IV dressings was to make sure they were dated all the time. She stated she had a conversation with the Pharmacist because when they placed the midline, they came in without a date, and nurses had to check for that. The DON stated the blue cap (needless connector), the green cap, and the date were missing in the photo of the midline for Resident #81. She stated the blue cap (needless connector) was placed so residents do not have infection, because the line was direct from the vein, and it was exposed. The DON stated the nurses were responsible for ensuring the cap was on there. She stated the nurse should not have placed the green cap directly without the blue part (needless connector) on the line. She stated they did training with the nurses and even had someone from outside come in and train the nurses. The DON stated the RNs already had IV certification, so it was the LVNs who needed training. The DON revealed when a resident had a port, like a chemo port, the expectation was that nurses do not touch the chemo port. She stated there was an order for the port, which needed to be flushed every three months with heparin (anticoagulant, to help prevent clots in the port) by the provider. The DON stated if the hospital gave them orders to flush it, they would do it. She stated she has never flushed the chemo port, and her staff do not change the dressing. The DON stated if the dressing was not dated, she would call the provider and ask them to come and change the dressing. She stated they usually come within two days. She was aware of the port, and stated she saw the provider when he came, because she spoke to his case manager when he came. The DON stated she spoke to the provider regarding the port, and they were not required to do anything with it. She stated she did not tell them it was undated. The DON stated she had a lot of conversations and could not remember if she talked to them about the dating. She stated she did not remember if LVNs were allowed to access the port, or flush it and would have to look at the policy After reviewing the orders, the DON stated she looked at the order, and it did say flush with saline, however, there was no order for the dressing. The DON stated it was important to ensure dressings were done in order to monitor the port and dressing for signs of infection, and because he was on chemo he was susceptible to infection. The DON stated when accessing the port, the nurse should have followed EBP for infection control. The DON stated she did not know when the port dressing for Resident #15 was done. She stated the order should have been to flush [NAME] every 3 months instead of saline. She stated the facility was not allowed to change the port dressing and orders should have been put in to reflect that. Review of the facility's in-service dated 06/14/24, enhanced barrier precaution by the ADON revealed, LVN F and RN G had completed training. Review of facility's competency check off for IV revealed the checks were completed by LVN F and RN G on 11/05/24. Review of the facility's Midline Catheter Dressing Change policy, revised 06/2024, revealed, .sterile dressing change using transparent dressing is performed .at least weekly .label dressing with date, time and nurses' initials . Review of the facility's Enhanced Barrier Precautions policy, revised 03/21/24, revealed, .EBP are indicated for residents with any of the following: 1. Infection or colonization with a CDC-targeted MDRO .Wounds and/or indwelling medical devices even if a resident is not known to be infected or colonized with a MDRO . post signage .high-contact resident care activities requiring gown and glove use . (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no facility policy on needleless connectors. Internet search What Is A Needleless Connector?, dated 02/23/21, revealed, .Needleless connectors (NCs) are devices connected at the end of vascular catheters. Once connected to the vascular catheter, two critical clinical activities could be done: (1) infusion can be done through it, or (2) aspiration can be performed . prevent the unnecessary entry of disease-causing microorganisms while infusion or aspiration is occurring

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care, consistent with professional standards of practice, for three (Residents #18, #25, and #133) of ten residents reviewed for oxygen: The facility failed to ensure the humidifier water was changed according to the facility policy for Residents #18, #25 , and #133 and failed to ensure oxygen tubing was changed weekly per facility policy for Residents #18 and #25. This deficient practice could affect residents who received oxygen therapy by causing them to receive incorrect or inadequate oxygen support and could expose them increased infection risk, resulting in infections and a decline in health. Findings included : 1. Review of Resident #18's face sheet, dated 11/05/24, reflected he was a [AGE] year-old male, admitted to the facility on [DATE], and having diagnoses of heart disease with heart failure, acute and chronic respiratory failure, and chronic obstructive pulmonary disease (a condition which makes breathing difficult). Review of Resident #18's quarterly MDS Assessment, dated 10/14/24, revealed Resident #18 had a BIMS score of 14, which indicated the resident was cognitively intact. Resident was dependent on toileting, required substantial assistance in bathing, and dressing. Resident #18 had an active diagnosis of respiratory failure and chronic obstructive pulmonary disease, and was on oxygen therapy. Review of Resident #18's care plan, dated 11/06/2024, revealed the resident was at risk for shortness of breath due to a diagnosis of COPD. The goal indicated the resident would have no complications related to shortness of breath. Interventions included: Administer oxygen as ordered, maintain clear airway by encouraging resident to clear own secretions with effective coughing. If secretions cannot be cleared, suction as needed to clear secretions. Review of Resident #18's order summary, dated 11/05/24, reflected: - Change oxygen tubing and nebulizer circuit every night shift every Sun With an order date of 05/28/2024 and a start date of 06/02/2024. - Clean oxygen concentrator filter with soap and water weekly every Sun With an order date of 05/28/2024 and a start date of 06/02/2024. - Oxygen at _2-5_ liters/minute per nasal cannula as needed With an order date of 05/28/2024 and a start date of 05/28/24. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Oxygen at 2_5 liters/minute continuously per nasal cannula. Document every shift With an order date of 05/28/2024 and a start date of 05/28/24. - Oxygen sat rates every shift With an order date of 05/28/2024 and a start date of 05/28/24. - Oxygen sat rates every shift may titrate to keep above_96__% With an order date of 05/28/2024 and a start date of 05/28/24. - There was no order mentioned replacing the humidifier water. Observation on 11/05/24 at 10:00 AM with Resident #18 revealed the resident was asleep. Observation of Resident#18's oxygen concentrator revealed 5 L of compressed air attached to him, the humidifier water was dated 10/27 on one side and 11/03 on the other side. The oxygen tubing dated 08/24. 2. Review of Resident #25's face sheet, dated 11/06/24, revealed the resident was a [AGE] year-old male, admitted on [DATE], with the following diagnoses of acute respiratory failure with hypoxia (low levels of oxygen in body tissue), heart failure, and COVID-19 . Review of Resident #25's care plan, dated 11/06/24, revealed the resident had shortness of breath due to history of PNA and respiratory failure. The goal indicated Resident #25 would have no complications related to shortness of breath. Interventions included: Administer oxygen as ordered, encourage sustained deep breaths .using incentive spirometer. Review of Resident #25's quarterly MDS assessment, dated 10/02/24, revealed the resident had a BIMS score of 15, which indicated the resident was cognitively intact. The resident required extensive assistance in bathing and dressing. Review of Resident #25's physician orders, dated 11/06/24, revealed the following: Change oxygen tubing and nebulizer circuit every night shift every Sunday, start date 08/14/24. Change oxygen tubing as needed, start date 08/12/24. Clean oxygen concentrator filter with soap and water weekly every Sunday, start date 08/18/24. Observation on 11/05/24 at 10:26 AM with Resident #25 revealed his oxygen tubing was dated 08/24 on an orange label attached to his oxygen tubing. The family stated Resident #25 had been wearing oxygen since he was diagnosed with pneumonia. 3. Review of Resident #133's face sheet, dated 11/06/24, revealed the resident was a [AGE] year-old female, admitted on [DATE], with the following diagnoses of acute and chronic respiratory failure with hypoxia, obstructive sleep apnea, and moderate persistent asthma. Review of Resident #133's MDS assessment, dated 10/29/24, revealed the resident had a BIMS score of 14, which indicated the resident was cognitively intact. The resident was dependent on toileting and hygiene and required extensive assistance with bathing and dressing. Resident #133 was diagnosed with respiratory failure and asthma. Resident #133 was on oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #133's care plan, dated 10/25/24, revealed the resident had shortness of breath due to asthma. The goal indicated Resident #133 would be free of complications from asthma. Interventions included: Administer oxygen as ordered, give medications as ordered, and observe for signs and symptoms of impending asthma attack. Review of Resident #133's order summary, dated 11/07/24, reflected: - Change oxygen tubing and nebulizer circuit every night shift every Sun with an order date of 10/29/2024 and a start date of 11/03/2024. - Oxygen at _2-5__ liters/minute continuously per nasal cannula with an order date of 10/29/2024 and a start date of 10/29/2024. - Oxygen at 2-5_ liters/minute per nasal cannula as needed with an order date of 10/29/2024 and a start date of 10/29/2024. - Oxygen sat rates every shift with an order date of 10/29/2024 and a start date of 10/29/2024. - Oxygen sat rates every shift may titrate to keep above __95_% with an order date of 10/29/2024 and a start date of 10/29/2024. Observation on 11/05/24 at 10:30 AM with Resident #133 revealed the resident seated in her recliner chair drinking coffee. Her oxygen was attached to a compressor, then to her nose. Resident #133's oxygen concentrator revealed 3 L of compressed air, and the humidifier water was dated 10/27 on one side and 11/03 on the other side. The tubing was dated 11/03. Resident stated she was watching her favorite TV show and did not want to interview. In an interview on 11/05/24 at 2:30 PM with LVN F, she stated she knew how to change the oxygen tubing and the humidifier water. She stated that the facility did not have a respiratory therapist, and the nurses were responsible for changing the tubing every Sunday. She stated the humidifier water was only changed when it ran out. She stated the risk to not changing tubing was infection due to residents breathing in the germs. Interview on 11/07/24 at 3:15 PM with LVN I, revealed she had some residents on oxygen in the secured unit and named them. She stated she knew how to change the tubing and filter water, and it was done every Sunday, usually it was the night shift that changed them. She stated when she arrived on Monday morning and it was not changed, she made sure it was changed. LVN I stated she has seen staff scratch the date off the humified water and she has told them to re-do it because she had no way of knowing if they changed the date or not. She was reticent to see who she had told. She stated she wanted to make sure residents get enough oxygen, because if tubing was old, kinks and bacteria could grow in the humidified water. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview with DON on 11/05/24 at 3:20 PM, revealed she went around to Resident #25's room and took the old tubing out. She then went into Resident #133 and into Resident #18's rooms and stated that the tubing and humified water were expected to be changed every Sunday and as needed if the humidified water ran out. She stated it was unacceptable for a nurse to cross off a date and write a new date on the humidification bottle. She stated the whole bottle should be changed and a new date written on it. She stated nursing staff were responsible for monitoring the oxygen and she was also responsible for making sure nursing staff was following policy. Humidification on O2 was changed every Sunday night, every 7 days. The nurse on duty did it. It is not ok to cross out a date and write a new date. They change it weekly. They change it weekly because everything goes back to infection control. That is the risk. Review of the facility's Oxygen Administration (Safety, Storage, and Maintenance), revised 10/11/24, revealed, .Change oxygen supplies weekly and when visibly soiled. Equipment should be labeled with patient name and dated when setup or changed out .Humidifier/Aerosol bottles should be dated and replaced every 7 days regardless of H2O level .

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	675650	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace Alzheimer's Center of Excellence	7500 Oakmont Blvd Fort Worth, TX 76132

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review, the facility failed to provide pharmaceutical services including procedures to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs to meet the needs of each resident for 1 of 3 Residents reviewed for pharmaceutical services for 2 (med rooms A and B) of 2 reviewed for medication storage 1. The facility failed to dispose of expired medications. This failure could place residents at risk of not receiving the intended therapeutic benefit of the medications. Findings included: Observation on 11/07/24 at 08:07 AM of med room A with the Regional Nurse revealed expired TB vaccine dated 9/27 on one side and 10/13 on the other side. There was no year. The Regional Nurse stated that vaccines were good for 30 days. She said that the vaccine potency was the risk for expired vaccines. In a phone Interview on 11/07/24 at 01:08 PM the ADON stated all nursing staff were responsible for ensuring meds were not expired. She stated the pharmacist checks monthly for expired meds. If the meds are frozen or sitting in water, that is not good. She stated freezing can change the structure and make it lose effectiveness. Review of facility policy titled Storage and Expiration, dating of medication, Biological, revision dated 08/07/23 reflected .reflected in part .Once any medication or biological package is open, the Facility should follow manufacturer/supplier guidelines with respect to expiration date for opened medications. Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) when medication has a shortened expiration date once opened or opened.5.3. If a multi-dose vial of an injectable medication has been opened or accessed (e.g., needle punctured) the vial should be dated with dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial.11. Facility should monitor refrigerator storage for evidence of moisture and condensation (humidity) and may consult with the pharmacy regarding medication integrity .

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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** Based on observation, interview, and record review, the facility failed to currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for storage of drugs and biologicals under proper temperature controls, and provide separately locked, permanently affixed compartments for storage of medications for 2 (med rooms A and B) of 2 reviewed for medication storage. 1. The facility failed to ensure medication rooms A and B were clean and well-lit. 2. The facility failed to ensure the fridge/freezer was at an appropriate temperature, which caused medications to freeze over in medication room A. This deficient practice could affect residents prescribed medications in the facility and place them at risk of receiving compromised or contaminated medications. Findings included: Observation on [DATE] at 08:07 AM of med room A with the Regional Nurse revealed a refrigerator with temperature of the fridge was 30 degrees Fahrenheit with no narcotics in the fridge. The Regional Nurse stated that they did not use the sink and that they would have to go across the hallway to wash hands in case of spills. She stated they also did not mix any medications in the med rooms. An interview and observation on [DATE] at 08:20 AM with the Regional Nurse of med room B revealed lightning was dark, which made it difficult to see the inside the refrigerator. The refrigerator contained no narcotics. The IV medication for Resident #81 had visible ice particles in both bags. Insulin and vaccine vials were stored in the bottom of the refrigerator in standing water and were wet. The temperature on the door of the refrigerator was observed to be 30 degrees Fahrenheit. The Regional Nurse stated the medication was cool. The Regional Nurse stated that the risk to residents who had medications with ice particles in them was improper dosage and potency of medication. She stated the nursing staff was responsible for cleaning the med rooms and for reporting non-working refrigerators and lighting. In a phone Interview on [DATE] at 01:08 PM the ADON stated all nursing staff were responsible for making sure medication rooms were clean, and medications were not expired. If the meds are frozen or sitting in water, that was not good. She stated freezing could change the structure and make it lose effectiveness. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on [DATE] at 3:15 PM with LVN I, she stated when she gave Resident #81 her antibiotics on Monday ([DATE]), the meds were not frozen. She stated if they were, she would have called the pharmacy. She stated, You can't let it thaw and use it. She stated the process would have been to call pharmacy for a new one because residents need it, and she would not want the resident to miss her dose. LVN I stated she would not give meds that were compromised because it was not in the purest form anymore, with ice particles and water, the medicine could be diluted. She stated she believed the night staff were responsible for cleaning the med rooms. She stated she was not sure if they were also responsible for the refrigerators, but any nurse was permitted to discard old things. LVN I stated she felt there was enough lighting but recently, a light did go out and they replaced it. She stated when it went out, they called the maintenance man, and he came to do things when they ask him. She stated she was here on Monday and did not see the light out until this morning, so it might have gone out Tuesday. She told the maintenance man this morning. She told his assistant. She has never used [work order system], she just requested of him verbally. In an Interview on [DATE] at 4:11 PM with the DON all the nurses were responsible for the med rooms, to make sure things were working properly. She stated staff checked temps each shift in the fridge. The DON stated if the fridge was frozen, they would have to defrost it. The DON stated she thought maybe they did not wait for them to defrost fully. She stated medication that was frozen was not good as it might change the quality of the medication. She stated they called housekeeping when a nurse was there for them to clean it. The DON stated she saw the sink in med room B and they had a housekeeper clean it today. She stated nurses did not mix meds in the med rooms. They did not use the sinks. She stated they have done in-services on med rooms. She stated all staff should know how to use [work order system] to report broken items as the administrator had sent out an email to everyone. DON stated housekeepers clean the nourishment fridge. Review of facility policy titled Storage and Expiration, dating of medication, Biological, revision dated [DATE] reflected .reflected in part 3.4. Facility should ensure that infusion therapy products and supplies are stored separately from other medications and biologicals, under appropriate temperatures and sterility conditions, according to the manufacturers or suppliers' recommendations .4. Facility should ensure that medication and biological that: (1) have an expired date on the label;(2) have been retained longer than recommended by the manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier. 5. Once any medication or biological package is open, the Facility should follow manufacturer/supplier guidelines with respect to expiration date for opened medications. Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) when medication has a shortened expiration date once opened or opened.5.3. If a multi-dose vial of an injectable medication has been opened or accessed (e.g., needle punctured) the vial should be dated with dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial.11. Facility should monitor refrigerator storage for evidence of moisture and condensation (humidity) and may consult with the pharmacy regarding medication integrity .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide Food that accommodates resident allergies, intolerances, and preferences for one (Resident #131) of 3 residents reviewed for food preferences. The facility provided Resident #131 a lunch meal that contained meat in it, which did not match her vegetarian preferences. This failure could affect residents who ate meals from the facility's only kitchen by placing them at risk of not having their choices and food preferences accommodated, possible weight loss, and a diminished quality of life. Findings included: Review of Resident #131's face sheet, dated 11/06/24, revealed the resident was a [AGE] year-old female, admitted on [DATE], with the diagnoses of anemia, major depressive disorder, and hypertension (high-blood pressure). Review of Resident #131's initial MDS assessment, dated 11/01/24, revealed no pertinent information. Review of Resident #131's care plan, dated 11/05/24, revealed she was at risk for weight fluctuation due to current health status. The goal was to maintain Resident #131's current weight. Resident #131's diet was listed as regular. No documentation of the residents' dietary preferences was found. Interview on 11/05/24 at 09:19 AM with Resident #131 revealed she was recently admitted and that she generally did not eat much. Resident #131 stated she was a vegetarian and liked salad. Observation and interview on 11/06/24 at 11:46 AM with Resident #131 in her room revealed that she did not like the taste of the pasta because there was meat in it. She stated she did not eat meat. Resident #131 stated the person who brought her food took out the bigger chunks of meat but there was still meat on the pasta. She stated that was, however, the first time that she had been served anything with meat since she was admitted . Observation of Resident #131's meal revealed chunks of meat in the gravy and the pasta. Review of Resident #131's meal ticket revealed, Reg Texture, Thin, Veg .no meat . In an interview on 11/06/24 at 11:50 AM with the Dietitian revealed Resident #131 was a vegetarian. The Dietitian offered a grilled cheese sandwich to Resident #131. She stated the procedure was to check the plates to ensure accuracy of the resident's meal preferences. The Dietitian stated it was important to honor preferences. The Dietitian stated she talked to Resident #131 regarding her meal preference and about getting yogurt. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/06/24 at 11:56 AM with CNA E revealed she took the lunch tray to Resident #131 and did not open it to look at the meal. She stated she was aware the resident was vegetarian. CNA E stated Resident #131's preference was on the meal slip and the resident herself had told her. CNA E stated she would have told Resident #131 to give her a second and get her a different tray had she had known. CNA E stated residents that did not eat meat should not be given meat. Interview and observation on 11/06/2024 at 12:07PM with [NAME] A and the Dietitian revealed that [NAME] A stated the gravy used in Resident #131's lunch meal was beef flavored gravy with no actual meat. Observation of the gravy mix revealed it was [Brand Name] gravy mix and contained ingredients of chicken fat and gelatin. [NAME] A stated that she cooked the meat and gravy separately. The Dietitian stated the chunks on Resident #131's pasta could have been the noodles or gravy mix. The Dietitian stated that she had an extensive length talk with Resident #131 yesterday, 11/05/2024, about her dietary preferences. She discussed that Resident #131 didn't like the flavor of meat and was offered options as an alternative to what was being served each day. She stated cottage cheese was ordered for Resident #131. [NAME] A and the Dietitian confirmed that Resident #131's meal card instructions reflected her dietary preference was vegetarian. Phone Interview on 11/07/24 at 01:08 PM with the ADON revealed the facility conducted training with the staff on the meal tickets and on reading it, if residents had a like or dislike. The facility would also, during orientation, ask new patients to tell them what they disliked, and if they had a special diet. She expected the staff to do the set-up of the plate for meals, which was a part of the meal service. The ADON stated they were to open the plate up, make sure residents had all of their items. She stated that was part of the dining experience. The ADON stated it was a problem when staff didn't notice when the meal did not match food preferences. She stated the aide would normally notify the kitchen, let the nurse know, and get the resident a substitute. The nurse would review the dietary slip so they could solve the problem. The ADON stated it was a problem because it was Resident #131's right to have food she could eat, and the resident could get upset. She stated if the resident did not get food she wanted, she would not eat. Interview on 11/07/24 at 2:04 PM with the Dietary Manager revealed [NAME] A cooked all the gravies the kitchen used such as chicken, beef, and turkey, and the only one Resident # 131 was supposed to have was the brown gravy, because each of the other gravies had meat in them. The Dietary Manager stated [NAME] A gave her beef gravy instead of brown gravy. The Dietary Manager confirmed Resident #131's lunch meal had chunks of meat in the gravy and pasta. She stated normally the meat was cooked separately, cooked first, and when it was done, it was combined with the gravy. She stated the staff knew Resident #131 was vegetarian and did not have any problems with that before. The Dietary Manager stated she reviewed all the different diets with the kitchen staff, and they had a chart they can read about any special diet, celiac (immune reaction to gluten), anything. She stated she watched facility staff to ensure they were abiding by resident preferences. The Dietary Manager stated when she was not in the kitchen, she would hope staff would do the right thing, and she was not right there when Resident #131 was served a meal with meat in it. She stated it was the right of the residents to get served food that met their preferences. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/07/24 at 3:15 PM with LVN F revealed if a resident was vegetarian or had an allergy she knew where to look for it. She stated if the resident was vegetarian, she would check to see if there was anything on the meal tray that was not vegetarian such as any meat or anything their diet stated they were not supposed to have. LVN F stated that could affect the resident as they may not know what kind of reaction the resident would have. LVN F stated she talked to the CNAs about checking trays. She stated the nurses check the plates before the CNAs deliver them. She stated it was important to check trays to make sure everyone had the right texture, first off, because she doesn't want anyone to choke. Interview on 11/07/24 at 4:11 PM with the DON revealed she looked at the photo of the noodles with gravy with meat chunks on them for Resident #131's lunch meal and stated that she would take the tray back to the kitchen. She stated staff should let the nurse know if they see the meal did not match the meal ticket and take the tray back to get another preference. The DON stated the nurses check the trays before the CNAs deliver them. She stated that was protocol for both halls, not just the secured unit. She stated checking trays was in place to prevent choking and making sure people have the right diet. Interview on 11/07/24 at 5:31 PM with the Administrator revealed honoring food preferences for residents was a resident's right. The Administrator stated the risk of not honoring food preferences could be allergic reactions, could cause mental stress, and GI issues. Review of the facility's Resident Satisfaction with Food and Dining policy, revised 04/25/23, revealed, Facility will have a process in place to monitor the quality of food and beverages delivered to the residents .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food safety in the facility's only kitchen. 1. The facility failed to ensure kitchen staff had a hair net on while in the kitchen. 2. The facility failed to ensure food items in the dry storage were dated, labeled, and securely stored. 3. The facility failed to ensure two cans of canned goods were free from dents. 4. The facility failed to ensure food items in the walk-in freezer were labeled, dated, and secured. 5. The facility failed to ensure a metal container of melted fat held on the gas stove was properly covered and dated. 6. The facility failed to ensure cleaning equipment was not placed against clean dishes. 7. The facility failed to ensure nourishment refrigerators were free from cross-contamination? 8. The facility failed to prevent a fan from severing and blowing towards the food area . These failures could place residents at risk for food-borne illnesses. Findings include: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/05/24 at 08:13 AM upon entry to the kitchen, revealed a staff member Dietary aide D was observed with a fast-food bag and a drink in the kitchen area without a hairnet on . Another staff member [NAME] B was observed with a white hat worn backwards, and another staff member the Dietary manager was observed without a hair net on either. Of the four staff in the kitchen, only Dietary aide C had a hair net on. Observation and interview on 11/05/24 at 08:15 AM of the dry storage with the Dietary Manager revealed the following: One bag of nacho chips tied up with what appeared to be plastic wrap dated 10/17. The Dietary Manager stated the nachos were used last week and lasted up to 7 days after opening. She was unsure if the labeled date was from when the nacho chips were delivered or used. One can of marinara sauce and one cream of celery soup were dented. The Dietary Manager stated if canned goods were dented or not safe for consumption, they were not accepted at delivery. Observation on 11/05/24 at 08:20 AM of the walk-in freezer with the Dietary Manager revealed the following: One package of sausage had a use by date of 8/X/2024. The month and year were visible, but day was not. One bag of opened frozen hush puppies, with no date, and not properly packaged for storage (bag was open in freezer). Observation on 11/05/24 at 08:30 AM of the kitchen revealed the following: A metal container of [NAME] sitting on the gas stove top shelf. The container was 75% covered with aluminum foil, exposing the [NAME] to air. The mop handle without a head was leaning up against clean bowls. Interview on 11/05/24 at 08:32 AM with the Dietary Manager revealed the mop head and the attachment should be in the storage room. Observation and interview on 11/06/24 07:53 AM of the kitchen fan close to entry inside the kitchen on blowing and severing towards the steam table, food lids were open. Dietary aide C stated she did not know who turned it on. Dietary aide C stated she always wore a hairnet when before she entered the kitchen to prevent hair from falling into the food and it was a requirement. She stated [NAME] B and Dietary aide D did not come to work today. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/07/24 at 2:04 PM with the Dietary Manager revealed she was not aware of the staff food in the preparation area. She stated there was a locker where staff normally stored their food. The Dietary Manager stated staff knew their items did not go out on her floor (the kitchen areas where food was prepared and stored.) She stated it was not allowed because she was preparing residents' meals, and that was a policy she upheld. She stated it could cause cross-contamination. The Dietary Manager stated when she saw Dietary Aide D with the food, she was coming out of the right area with it, so she probably put it in there when she saw the State. She stated they were not supposed to have the fan swerving, and it was supposed to blow directly toward the dish area. She stated she was not aware that a second fan was also going. She stated they would not want that, because it was blowing whatever is in the air, and it could change the temperature of the food. The Dietary Manager stated the aide, and cooks were responsible for dating and labeling when they stored things. She stated she had a new aide and a new cook. She had a label and date sheet to show them the time frames things were supposed to be dated with, and she was constantly telling them to use it. The Dietary Manager stated she had in-serviced everyone on that. She stated the fat on the stove was butter and it was not supposed to be stored with foil. It was a daily-use item, and they took a block of butter out each day and used it throughout the day. Cooks were supposed to discard it at the end of the day. She stated the night cook was supposed to discard it. The Dietary Manager stated the freezer had sausage links that were dated wrong, and she has her order form to show that. She stated the hushpuppies were also dated wrong, and she knew who did it and had already done an in-service with them. She stated when she talked to that employee, and asked her why, the employee said she did not know they were not supposed to put the date they used the food on it. The Dietary Manager stated if they cooked something and it had (was good for) three days, they put three days on it. She stated she had a cook who went through and made sure expired foods were not in there, but he was usually pretty good with it. She did not know what happened this time. She stated he had a log he marked off when he did it. The Dietary Manager stated the stove was a gas stove, and the problem with the exposed container of fat over was that it could cause a fire. Whoever was working on the day they got a truck that was responsible removing the dented cans, and she knew Dietary Aide D put the dented cans there. The Dietary Manager stated Dietary Aide D told her that the can only had a little dent, so she in-serviced her and told her about the harm a little dent could cause. The Dietary Manager stated the risk was that the aluminum could get into the product. She stated that there was a risk for food poisoning from even a small dent. The Dietary Manager stated the risk of cleaning equipment being against clean dishes could cause contamination. She was very nervous, she said. The Dietary Manager revealed the risk of cleaning equipment being against clean dishes could cause contamination . When asked about the staff not wearing hair nets, she said she had just stepped into the area and normally did not answer the door without her hair net, but she barely had a chance to put her things down before the surveyor knocked on the door. She said the other two staff were written up for not wearing [NAME], because one of them was an established employee and knew better, and the newer employee had been counseled about it already, and told to put a hair net on under her hat. She said the problem with not wearing them was also the risk of contamination. Interview on 11/07/24 at 5:31 PM with the Administrator revealed his expectation was for the kitchen to remain clean, food items dated/labeled and safe as it could lead to contamination and unsanitary conditions. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Food Safety policy, revised 04/26/23, revealed, .pre-packaged food is placed in a leak-proof, pest-proof, non-absorbent, sanitary .container with a tight-fitting lid .container is labeled with the name of the contents and date (when item is transferred to a new container). 'Use by Date' is noted on the label or product when available .dented, leaky, rusted and swelling cans that could affect food safety are returned to the vendor but stored in a designated area away from other food . Review of the U.S. Public Health Service Food Code, dated 2017, reflected: .3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A food specified in 3-501.17(A) or (B) shall be discarded if it: . (2) Is in a container or package that does not bear a date or day; (3) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section; or 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when packaging food using a reduced oxygen packaging method as specified under § 3-502. 12, and except as specified in (E) and (F) of this section, refrigerated, ready-to eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5ºC (41ºF) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1 . Review of the U.S. Public Health Service Food Code, dated 2017, reflected: .3-202.15 Package Integrity. Food packages shall be in good condition and protect the integrity of the contents so that the food is not exposed to adulteration or potential contaminants .

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	675650	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace Alzheimer's Center of Excellence	7500 Oakmont Blvd Fort Worth, TX 76132

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain an Infection Prevention and Control Program designed to help prevent the standard and transmission-based precautions to be followed to prevent the spread of infections or diseases for 4 of ten (Resident #15, #18, and #25) reviewed for infection control. 1. LVN F failed to ensure PPE was worn for residents on EBP (Residents #15 and #25). 2. CNA J failed to perform hand hygiene during breakfast in A hall dining room and after assisting Resident #18. The failures could place residents that require assistance with personal care at risk for healthcare associated cross-contamination and infections. Findings included : Review of Resident #15's face sheet, dated 11/07/24, revealed a [AGE] year-old male, admitted to the facility on [DATE], with the diagnoses of esophageal obstruction (a blockage or narrowing of the esophagus), cancer of esophagus, Gastrostomy status (this is a feeding tube that is placed through the abdominal cavity area into the stomach for nutritional purpose and medication for individual who have a difficulty swallowing), and chronic kidney diseases . Review of Resident #15's care plan, dated 11/06/24, revealed the resident was on enhanced barrier precautions due to dysphagia (difficulty swallowing) which required tube feeding and esophageal cancer. The goal indicated Resident#15 to remain free of complications with tube-feeding. Interventions included: Administer peg tube feedings as ordered and provide local care to J-tube site as ordered. Review of Resident #15's physician's orders, dated 11/06/24, did not reflect dressing change and monitoring. Review of Resident #18's face sheet, dated 11/05/24, reflected he was a [AGE] year-old male, admitted to the facility on [DATE], and having diagnoses of heart disease with heart failure, acute and chronic respiratory failure, and chronic obstructive pulmonary disease (a condition which makes breathing difficult). Review of Resident #18's quarterly MDS Assessment, dated 10/14/24, revealed Resident #18 had a BIMS score of 14, which indicated the resident was cognitively intact. Resident was dependent on toileting, required substantial assistance in bathing, and dressing. Resident #18 had an active diagnosis of respiratory failure and chronic obstructive pulmonary disease, and was on oxygen therapy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #25's face sheet, dated 11/06/24, revealed the resident was a [AGE] year-old male , admitted on [DATE], with the following diagnoses of acute respiratory failure with hypoxia, heart failure, and COVID-19. Review of Resident #25's quarterly MDS assessment, dated 10/02/24, revealed the resident had a BIMS score of 15, which indicated the resident was cognitively intact. The resident required extensive assistance in bathing and dressing. Review of Resident #25's physician's orders, dated 11/06/24, revealed the following Open area to Left heel everyday shift for Open area clean area with wound cleanser, pat dry, apply anasept (antiseptic) with collagen powder. cover with Gauze Island with boarder dressing apply once daily for 30 days. Order active on 11/05/24. Open area to Right HEEL everyday shift for Open area to right heel clean area with wound cleanser, pat dry, apply anasept with collagen powder. Cover with Gauze Island w/ bdr apply once daily for 30 day. Review of Resident #25's care plan, dated 11/06/24, revealed the resident was on enhanced barrier precautions due to stage 3 pressure wounds ulcer to Left Heel and Right Heel and is at a Stage IV (wound that extends below subcutaneous fat into deep tissues, including ligaments and tendons) pressure ulcer development related to dehydration, Immobility Date Initiated: 08/23/2024. The goal was that the resident's pressure ulcer would show signs of healing and remain free from infection by/through review date. The interventions indicated to administer treatments as ordered and Enhanced barrier precautions. Review of Resident #21's face sheet, dated 11,07/24, revealed the resident was an [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses were colon cancer, perforated intestine due to pulps (diverticulosis), shingles without complication and high blood pressure. Review of Resident #81's face sheet, dated 11/05/24, revealed the resident was a [AGE] year-old female, admitted on [DATE], with the diagnoses of cervical region spondylosis with myelopathy (this is a condition that occurs when the spinal code in the neck deteriorated due to aging, Escherichia coli (a type of infection), and bacteremia, and Alzheimer's disease with late onset (this is a brain condition that progressively destroys memory and other important mental functions). Review of Resident #81's MDS admission assessment, dated 10/30/24, revealed no pertinent information on her IV. Review of Resident #81's physician's orders, dated 11/05/24, did not reflect dressing change and monitoring for her IV. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #81's care plan, dated 11/05/24, revealed the resident had dehydration or potential fluid deficit due to E. coli Bacteremia Infection and is on IV medication. The goal was Resident #81 would be free of symptoms of dehydration and maintain moist mucous membranes and good skin turgor. The resident is also on enhanced barrier precautions due to IV medications (Ceftriaxone) for Bacteremia and E. coli. The goal was for the resident to be free of complications from IV therapy. Interventions included: IV dressing: Observe every shift and change dressing and record observation of site as ordered. Observe signs and symptoms of infection at the site of the IV such as drainage, inflammation, swelling, redness, and warmth. Observation and interview on 11/06/24 at 10:17 AM, revealed Resident #15 in his room. The door sign read STOP Enhanced Barrier Precautions. Everyone must clean their hands before entering the room and when leaving the room. Providers and staff must wear gloves and gown for the following: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use such as; central lines, urinary catheter, feeding tube, tracheostomy. Wound care: any skin opening requiring dressing. LVN F washed her hands upon entry to go into Resident #15's room, she wore gloves on her hands, but she did not wear a gown as she accessed Resident #15's port that was located on his right upper chest area and dressing was clean, intact, and undated. LVN F stated she forgot to wear a gown before accessing Resident #15's port. She stated the purpose of Enhanced barrier precautions was to keep infection from the residents. Observation and interview with LVN F on 11/06/24 10:56 AM, revealed Resident #25 in his wheelchair, pain assessed to which the resident replied it was 2.78% LVN F stated she was going to do wound care on both his feet. The bedside table was cleaned. Wax paper used for contamination. LVN F completed wound care without wearing a gown during wound care. H and hygiene was completed afterward. LVN F assessed Resident #25 again for pain before cleaning and sanitizing the bedside table. Hand hygiene was completed . LVN F stated she forgot to wear her gown. She stated she had been trained on EBP and a resident with wounds was put on EBP for infection control. She stated the gown was worn not to spread infection to the resident and others. Observation on 11/07/24 at 07:59 AM revealed CNA J coming from Resident #21's room after asking her for one of the straws. Resident #21 asked, Why are you taking my straw? CNA J stated, You have so many. I will not take them all. CNA J did not perform hand hygiene after leaving Resident #21's room, before going to the dining room, or before removing the wrapper from the straw for Resident #18. CNA J placed the straw in Resident #18 's drink. CNA J then went to pick up a tray without performing hand hygiene and placed it on the cart before entering Resident #25's room to open a sugar packet to pour onto Resident #25's food . CNA J mixed the food with the sugar before giving the resident a bite while standing over him. Then CNA J went to pick up another tray before finally performing hand hygiene complete. Interview on 11/07/2024- 8:45 AM with CNA J revealed he got a straw from a resident's room and took it to another resident. He stated he put the straw in the drawer and then realized they had no straws left for Resident#18, who needed to sip his drink. CNA J stated Resident #18 couldn't drink without a straw. CNA J stated he did not go to the kitchen to get a clean one, because he knew where he could grab one. He stated it was not appropriate to get things from one resident's room for another resident. CNA J stated when he took a meal tray, he realized he had to sanitized his hands but when he discovered Resident #25 couldn't help himself, and he had not been eating well. He went to go assist him and failed to sanitize his hands along the way. CNA J stated he did not know what happened to him today and was not able to explain why he did not follow infection control protocol. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a phone interview on 11/07/24 at 01:08 PM with the ADON, revealed Resident #15 admitted with the g-tube and she was aware he had a chemo port. The ADON did not think she was unsure whether it was dated. She stated she had in-serviced staff on enhanced barrier precautions. She stated if someone was accessing a midline or port, they have to use PPE and for wound care, as well. The ADON stated It was an extra layer of protection between staff and the patient, and for anyone who had any type of opening (such as a catheter). She stated they have to gown-up to make beds, touch the patient, and any direct care with the resident. The ADON stated she had done multiple in-services on EBP. The ADON stated getting a straw from another resident and having no hand hygiene during meal services was not acceptable. She stated that was an example of bad hand hygiene. She stated she did a [competency] checkoff, had signs up, and monitored staff. The ADON stated if staff took something out of a resident's room and take it to another, that was already the start of a bad situation. They have been in-services on hand washing and staff would sing the happy birthday song in front of her to show competency. The ADON stated her checkoffs and in-services were in binders. The ADON stated the risk was cross contamination from the moment that person took the straw from one resident to the other, that was already cross contamination. Interview on 11/07/24 at 4:11 PM with the DON revealed CNA J at mealtime with straw should have been doing infection control, with hand hygiene. The straw was infection control, and she would expect him to get the straw from the med cart or the boxes they had. The DON stated when accessing the port or midline, the nurse should have followed EBP for infection control. The DON stated she did not know when the port dressing for Resident #15 was done. Review of the facility's in-service dated 06/14/24, enhanced barrier precaution by the ADON revealed, LVN F and RN G had completed training. Review of the facility's Midline Catheter Dressing Change policy, revised 06/2024, revealed, .sterile dressing change using transparent dressing is performed .at least weekly .label dressing with date, time and nurses' initials . Review of the facility's Enhanced Barrier Precautions policy, revised 03/21/24, revealed, .EBP are indicated for residents with any of the following: 1. Infection or colonization with a CDC-targeted MDRO .Wounds and/or indwelling medical devices even if a resident is not known to be infected or colonized with a MDRO . post signage .high-contact resident care activities requiring gown and glove use . Review of the facility's policy dated November 9, 2022, and titled Standard Precautions revealed .Standard precautions are used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status .hand hygiene is performed with soap (anti-microbial or non-antimicrobial) or alcohol-based hand rub before and after contact with the resident .