STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676012	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mystic Park Nursing & Rehabilitation Center	8503 Mystic Park San Antonio, TX 78254

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 of 4 resident units (200 unit) reviewed for dignity. CNA K and the MDS Nurse walked into several resident rooms in the 200 unit without knocking. This failure could place residents at risk for diminished quality of life, loss of dignity and self-worth. The findings included: Record review of Resident #25's face sheet dated 1/24/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included abnormalities of gait and mobility and presence of right artificial knee joint. Record review of Resident #25's most recent admission MDS assessment, dated 12/5/24 revealed the resident was cognitively intact for daily decision-making skills and had a functional limitation in range of motion to the lower extremity. Observation on 1/21/25 beginning at 12:33 p.m., revealed CNA K entered the following resident rooms on the 200 unit without knocking: - room [ROOM NUMBER] at 12:33 p.m., CNA K was observed moving a chair from the A side (nearest the bedroom door) of the room to the B side (farthest from the bedroom door) of the room. - room [ROOM NUMBER] at 12:33 p.m. - room [ROOM NUMBER] at 12:33 p.m., CNA K was observed straightening up the room During an interview on 1/21/25 at 12:37 p.m., CNA K stated she had entered the above-mentioned rooms to make sure the residents were doing ok. CNA K stated, normally I knock, some of the residents weren't in the room, but I'm sure I should have been knocking. CNA K revealed she should have been knocking on resident bedroom doors because it was a matter of privacy. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 1/21/25 beginning at 12:41 p.m., revealed the MDS Nurse entered the following resident rooms on the 200 unit without knocking: - room [ROOM NUMBER] at 12:41 p.m. During an interview on 1/21/25 at 12:42 p.m., the MDS Nurse stated he had often worked the floor and was working the 200 unit. The MDS Nurse denied he did not knock on the bedroom door to room [ROOM NUMBER]. During an interview on 1/23/25 at 1:59 p.m., the DON revealed it was her expectation for staff to knock on resident bedroom doors, but if the resident were not in the room, and the main CNA knows where the resident is, if they are not in their room, it's ok for them to enter without knocking. The DON stated, if the CNA was aware a resident was in the room, then staff should knock on the bedroom door before entering. During an interview on 1/24/25 at 1:51 p.m., Resident #25 stated he had only been in the facility for about a month and stated staff sometimes knocked on his bedroom door and sometimes they didn't. Resident #25 stated there were times he would be sleeping and then realize staff were in his room without knowing. Resident #25 stated, I don't like it, but what can I do, they work here. Record review of the facility policy and procedure titled Resident Rights, Dignity and Respect, undated revealed in part, .It is the policy of this facility that all residents be treated with kindness, dignity, and respect . Staff members shall knock before entering the Resident's room .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 3 of 21 residents (Residents #61, #148, and #95) whose assessments were reviewed. 1. Resident #61's MDS assessment inaccurately reflected the resident received insulin injections when he did not. 2. The facility failed to ensure Resident #148's admission MDS, dated [DATE], correctly assessed the resident's hospice status as evidenced by coding No hospice receive in Section O-Special treatment, procedures, and program. However, Resident #148 was receiving hospice services. 3. Resident #95's discharge MDS assessment inaccurately reflected the resident was discharged to the hospital when he was discharged home. These failures could place residents at-risk for inadequate care and services. The findings included: 1. Record review of Resident #61's face sheet dated 1/22/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included type 2 diabetes with hyperglycemia (blood sugar levels that are higher than normal due to insulin resistance or insufficient insulin production). Record review of Resident #61's most recent annual MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making skills and was incorrectly identified on the MDS, Section N-Medications, Insulin, as having been treated with insulin. Record review of Resident #61's comprehensive care plan, with revision date 7/2/24 revealed the resident had type 2 diabetes with hyperglycemia with interventions that included to adhere to medication parameters as directed by physician. Record review of Resident #61's Order Summary Report, dated 1/22/25 revealed the following: - Metformin tablet 1000 mg, give 1 tablet by mouth one time a day related to type 2 diabetes with hyperglycemia, with order date 8/8/23 and no stop date. - Trulicity Subcutaneous Solution Pen-injector 0.75 mg/0.5 ml (Dulaglutide), inject 0.5 ml subcutaneously in the morning every Monday related to type 2 diabetes with hyperglycemia with order date 8/8/23 and no stop date. Further review of Resident #61's Order Summary Report did not indicate the resident was treated with insulin. During an interview on 1/21/25 at 2:14 p.m., Resident #61 stated he did not take insulin. Resident #61 further stated that he received an injection weekly but was not sure what it was for. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/24/25 at 10:36 a.m., LVN L stated she was familiar with Resident #61 and after reviewing the resident's electronic medical record revealed Resident #61 received a Trulicity injection every Monday. LVN L stated Trulicity was an insulin but was not sure if the medication was a long acting or fast acting insulin. During an interview on 1/24/25 at 11:00 a.m., the DON revealed Resident #61 was treated with Metformin, and Trulicity was administered via injection once a week. The DON stated, Trulicity was a diabetic medication but was not an insulin. The DON stated Resident #61's MDS inaccurately indicated the resident was receiving insulin when he was not. The DON stated the MDS was important as it should accurately describe the resident assessment and services received. During an interview on 1/24/25 at 11:10 a.m., the MDS Nurse revealed Resident #61 received Metformin and Trulicity injections for the treatment of diabetes. The MDS Nurse stated he was not sure if Trulicity was an insulin and further revealed, the MDS had an RAI manual that listed medications to refer to but didn't really look at the list. During a follow-up interview on 1/24/25 at 11:18 a.m., the MDS Nurse stated, the (MDS) assessments are assessments, there is a modification button, if it was coded differently, and if Trulicity was coded incorrectly it can be corrected. It's not definite. The MDS Nurse revealed, the purpose of having the MDS was for clinical reasons and for financial purposes. 2. Record review of Resident #148's face sheet, dated 01/24/2025, revealed the resident was a [AGE] years old male and an admission date of 01/08/2025 with diagnoses that included: anoxic brain damage (complete lack of oxygen to the brain), quadriplegia (paralysis of all four limbs), epilepsy (seizure), acute respiratory failure (inadequate gas exchange by the lung), and acute kidney failure (Kidney lose the ability to remove waste and balance fluids). Record review of Resident #148's admission MDS assessment, dated 01/15/2025, indicated his BIMS score was 0 reflecting he had severe cognitive impairment. Further record review indicated K1. Hospice care in the Section O (Special treatment, procedures, and program) was answered No. Record review of Resident #148's comprehensive care plan, dated 01/09/2025, reflected [Resident #148] admitted to facility on hospice services, and the intervention was Hospice nurse will visit weekly, hospice to provide shower with visits, no x-ray and labs without hospice approval, and work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs are met. Record review of Resident #148's physician order, dated 01/08/2025, reflected Resident #148 was admitted to the hospice for diagnosis of anoxic brain damage (complete lack of oxygen to the brain) on 01/08/2025. Interview on 01/24/2025 at 11:17 a.m. the DON stated Resident #148 was receiving hospice services since the resident was admitted to the facility on [DATE], and it was very important the MDS was accurate, so the facility might provide accurate care to Resident #148. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/24/2025 at 2:00 p.m. the MDS nurse stated Resident #148's admission MDS, dated [DATE], was inaccurate because Resident #148 was receiving hospice services since the resident was admitted to the facility on [DATE]. It should have been answered Yes in the Section O (Special treatment, procedures, and program). The MDS nurse said he did not know what reason he coded No, and it was mistake. 3. Record review of Resident #95's face sheet dated 1/24/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and discharged on 11/18/24. Further review of Resident #95's face sheet, under Miscellaneous Information revealed the resident discharged home. Record review of Resident #95's most recent MDS discharge assessment dated [DATE] inaccurately indicated the resident was discharged to a short-term general hospital. Record review of Resident #95's Discharge Summary Report dated 11/18/24 revealed the resident was admitted to the facility on [DATE] for respite care and discharged on 11/18/24 to a foster home. During an interview on 1/24/25 at 3:31 p.m. the DON revealed Resident #95 was admitted to the facility for respite care and discharged to a foster home. The DON revealed, Resident #95 was not discharged to a hospital and the discharge MDS was coded incorrectly. During an interview on 1/24/25 at 3:38 p.m., the MDS Nurse revealed he had incorrectly indicated on Resident #95's discharge MDS the resident discharged to a hospital when he should have indicated the resident discharged to a home. The MDS Nurse stated the MDS was important because it determined the status of the resident and was determined how the facility got paid. Record review of the CMS MDS 3.0 Manual dated October 2023 revealed in part, . The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each resident. The MDS 3. 0 is part of that assessment process and is required by CMS . Record review of the facility policy and procedure titled Resident Assessment, Comprehensive Assessment, undated, revealed in part, .It is the policy of this facility to complete a comprehensive assessment of the resident's needs which are based on the State's specific Resident Assessment Instrument (RAI) and the facility's interdepartmental assessment forms .Completion of the Resident Assessment Instrument (MDS and RAP's) will be completed as directed by the State .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 2 of 3 residents (Resident #27 and #82) reviewed for incontinence care. 1. When CNA-E and CNA-F were providing incontinent care to Resident #27 on 01/23/2025, CNA-E did not clean the resident's right buttock area. 2. The facility failed to ensure Resident #82's indwelling urinary catheter drainage bag and tubing were not touching the floor. These failures could place residents with indwelling urinary catheter devices and who required incontinence care at risk for cross contamination and the development of new or worsening urinary tract infections. The findings included: 1. Record review of Resident #27's face sheet, dated 01/24/2025, revealed a [AGE] year-old male, originally admitted to the facility on [DATE], and re-admitted on [DATE] with diagnoses that included hereditary spastic paraplegia (inherited disorders that involves weakness and spasticity, which is stiffness of the legs), contracture-right knee (permanent tightening of the muscle), reduced mobility, muscle weakness, and seizures. Record review of Resident #27's most recent quarterly MDS assessment, dated 12/01/2024, revealed the resident's BIMS was 0 which indicated he had severe cognitive impairment and was always incontinent of bowel and bladder. Record review of Resident #27's comprehensive care plan, dated 10/12/2022, revealed [Resident #27] has bowel and bladder incontinence related to immobility, and For intervention - check as required for incontinence. Wash, rinse, and dry perineum. Change clothing as need after incontinence episodes. Observation on 01/23/2025 at 3:25 p.m., revealed during incontinent care to Resident #27, CNA-E cleaned Resident #27's right and left groin area, and CNA-E and CNA-F turned Resident #27 to right side. CNA-E cleaned the resident's left buttock area and middle area, including anus. When CNA-E cleaned the middle area, including anus, the resident had small bowel movement. CNA-E cleaned the resident's bowel movement and changed gloves after sanitizing her hands. CNA-E put a new brief to the resident and closed it without turning the resident to his left side and without cleaning the resident's right buttock area. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/23/2025 at 3:36 p.m. with CNA-E stated she did not turn Resident #27 to his left side and did not clean the resident's right buttock area. Further interview with the CNA-E said that when she cleaned the resident's middle area, including anus, CNA-E wiped the resident's right buttock with only one time to clean the resident's bowel movement without turning the resident to left side. The CNA-E stated she though wiping the resident's right buttock with only one time was enough, and that was why the CNA-E did not turn the resident to left side and not clean the resident's entire right buttock area. CNA-E stated she should have turned Resident #27 to left side and cleaned the resident's entire right buttock area because the resident had bowel movement when CNA-E cleaned the resident. Interview on 01/24/2025 at 10:33 a.m. with DON stated CNA-E should have turned Resident #27 to his left side and cleaned the resident's entire right buttock area because the resident had bowel movement when CNA-E cleaned the resident to prevent possible unclean status of the resident. Record review of the facility policy and procedure, titled Incontinence Care, undated, revealed in part, . Staff will assemble equipment necessary to provide care. 7. Assist resident to turn and cleanse buttocks. 2. Record review of Resident #82's face sheet dated 1/22/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included obstructive and reflux uropathy (condition where urine flow is blocked due to obstruction in the urinary tract and reflux uropathy refers to kidney damage where urine flows backward from the bladder into the ureters and kidney), disorders of kidney and ureter, and disorders of bladder. Record review of Resident #82's most recent quarterly MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making skills and utilized an indwelling urinary catheter. Record review of Resident #82's Order Summary Report dated 1/22/25 revealed the following: - Catheter care every shift. Monitor urethral site for s/s of skin breakdown, pain/discomfort, unusual odor, urine characteristic or secretions, catheter pulling causing tension every shift, with order date 3/16/24 and no stop date. Record review of Resident #82's comprehensive care plan with revision date 7/9/24 revealed the resident had an indwelling catheter related to obstructive and reflux uropathy. Interventions included to provide catheter care every shift and as needed and secure the catheter with a leg strap/leg band or anchor to minimize catheter related injury and accidental removal or obstruction of urine outflow, check placement. Observation and interview on 1/21/25 at 12:03 p.m. revealed Resident #82 sitting up in the wheelchair at the doorway to her room with the indwelling urinary catheter bag and tubing touching the floor from underneath the wheelchair. Resident #82 asked for help and LVN M entered the resident's room. LVN M was made aware by the State Surveyor that Resident #82's indwelling urinary catheter and tubing were touching the floor. LVN M then moved Resident #82's wheelchair back while dragging the indwelling urinary catheter bag and tubing on the floor. LVN M revealed Resident #82's indwelling urinary catheter bag and tubing should not be touching the floor because it was considered an infection control issue and it could get kinked and trapped on the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/23/25 at 3:54 p.m., the DON stated Resident #82's indwelling urinary catheter and tubing should not be touching the floor because it was a break in infection control and the resident could run over it with the wheelchair. The DON stated the tubing could kink and prevent urine flow and it that should occur, the resident could retain urine. Record review of the facility policy and procedure titled Quality of Care, Catheter Care, Indwelling, undated, revealed in part, .It is the policy of this facility that each resident with an indwelling catheter will receive catheter care daily and PRN for soiling. Monitoring of leg strap and level of drainage bag as indicated . PURPOSE: To promote hygiene, comfort and decrease risk of infection for catheterized residents .May secure the tubing with securement device PRN to prevent migration of catheter/friction/tension . Record review of the facility policy and procedure titled Quality of Care, Catheter Drainage Bag, undated, revealed in part, .It is the policy of the facility to maintain continuously closed urinary drainage system whenever possible .Position the drainage bag below the level of the resident's bladder .Drainage bag, nor tubing should be directly on the floor .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 2 of 5 medication and nursing carts (300-hall nursing cart and 200-hall nursing cart) reviewed for pharmacy services. 1. There was one medication (Dakin's solution half strength for skin irrigation) expired on 11/2024 found inside the 300-hall nursing cart on 01/22/2025. 2. There was Resident #54's medication (Urea 20 intensive Hydrating cream for dry skin) expired on 11/13/2024 found inside the 200-hall nursing cart on 01/22/2025. This failure could place residents at risk of inaccurate drug administration and not having appropriate therapeutic effects. The findings included: 1. Observation on 01/22/2025 at 2:52 p.m. revealed one bottle of Dakin's solution half strength for skin irrigation was found inside the 300-hall nursing cart, and it was expired 11/2024. Interview on 01/22/2025 at 3:01 p.m. with nurse RN-G acknowledged one bottle of Dakin's solution half strength for skin irrigation was found inside the 300-hall nursing cart, and it was expired 11/2024. The RN-G said the nurse did not know what reason the expired medication was inside the 300-hall nursing cart, and nurses should discard all expired medications from the nursing carts as per the facility policy. Potential harm was nurses might use the expired medication, and the expired medication might not have therapeutic effects. 2. Record review of Resident #54's face sheet, dated 01/24/2025, revealed a [AGE] year-old male and admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body), type 2 diabetes mellitus (body not control blood sugar), hypertension (high blood pressure), cerebral infarction (disrupted blood flow to the brain), and need for assistance with personal care. Record review of Resident #54's most recent quarterly MDS assessment, dated 10/22/2024, revealed the resident's BIMS score was 9 which indicated he had moderate cognitive impairment, and the resident did not have any skin breakdown but was at risk of developing pressure ulcers/injuries in Section M - skin condition. Record review of Resident #54's comprehensive care plan, dated 11/13/2024, revealed [Resident #54] has potential impairment to skin integrity related to fragile skin, and For intervention - encourage good nutrition and hydration in order to promote healthier skin and educate resident and caregivers of causative factor and measures to prevent skin injury. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/22/2025 at 3:09 p.m. revealed one cream of Urea 20 intensive Hydrating cream for dry skin was found inside the 200-hall nursing cart, and it was expired 11/13/2024, and the label said, Discard after 11/13/2024. Interview on 01/22/2025 at 3:20 p.m. with nurse LVN-H acknowledged one cream of Urea 20 intensive Hydrating cream for dry skin was found inside the 200-hall nursing cart, and it was expired 11/13/2024, and the label said, Discard after 11/13/2024. The LVN-H said the nurse did not know what reason the expired medication was inside the 200-hall nursing cart, and nurses should discard all expired medications from the nursing carts as per the facility policy. Potential harm was nurses might use the expired medication, and the expired medication might not have therapeutic effects. Interview on 01/22/2025 at 3:42 p.m., the DON said facility nurses should discard all expired medications from the medication carts. Nurses had responsibility to make sure all expired medications should have been removed from carts. Record review of the facility policy, titled Pharmaceutical Services, undated, revealed All over-the-counter medications will be discarded as per manufacturer expiration dates and do not require an open date.

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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 service safety for 1 of 1 kitchen and 1 (Resident #33) of 4 residents personal refrigerators reviewed, in that: 1. DA B touched dessert dishes on the inside of the dish to place them on the tray, DA A touched the rim on the inside of the plate while serving food, and DA C placed her thumb on rim and on the inside of the plate when she placed the plate on the tray. 2. There was one sandwich covered in a plastic bag, provided by the facility, in the refrigerator inside Resident #33's room, and the sandwich was unlabeled and undated. These failures could place residents who received meals and/or snacks from the kitchen and their personal refrigerators at risk for food borne illnesses. Findings included: During observation on 1/22/2025 at 12:06PM Dietary Aide B grabbed a dessert dish, touching the inside rim of the dish and then grabbed two at the same time and repeated the action. Dietary Aide A touched the top of the rim of the plate while he placed food on the plates to be served to the residents. The DS (Dietary Supervisor) redirected and corrected the server. DA C was observed when she placed her thumb on the inside of the plate of food from DA A and placed the plate on the tray to be served to the residents. During an interview on 1/22/2025 at 12:15PM the DS said DA A was recently promoted to the position to serve the food on the plates and it was his second day. The DS said he was trained on how to place the food on the plate and for infection control, but he was nervous because of the state surveyor. The DS said touching the rim of the plates could cause contamination and food borne illnesses to the residents. DA D asked the state surveyor about wearing gloves in the kitchen. The DS responded that she would not use gloves because someone could get comfortable and walk away from their workstation with the gloves, return to their station, and not remove the gloves (after touching non-food items), wash their hands, and put on new gloves. She said that was a very big way of cross contamination and infection control issue. The DS said there would be an in-service for food service and infection control immediately. In an interview on 01/23/2025 at 10:04 AM Dietary Aide A said it was important not to touch the rim of the plate while handling food to avoid contamination of the residents' food that could make them sick. He said he had the in-service on how to handle the food yesterday. DA A said he learned not to touch the plates and to stay mindful of not to contaminate the residents' food. In an interview on 01/23/2025 at 10:15 AM Dietary Aide C said it was important not to touch the surfaces where food will be on plates, cups, or utensils or any place food can be served because it could cause contamination. DA C said food contamination could make the residents sick. She said she had the training yesterday on how to handle food correctly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676012	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mystic Park Nursing & Rehabilitation Center	8503 Mystic Park San Antonio, TX 78254

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/23/2025 at 10:22 AM Dietary Aide B said she had the in-service yesterday on how to handle food. She said she learned not to touch the inside of the plates or cups because it could cause illnesses for the residents. In an interview on 01/23/2025 at 11:26 AM the RD said she was contracted by the facility. The RD said it was important not to touch the plates because it was an infection control issue and could cause food borne illnesses. She said she did not allow gloves to be used on the line of serving food because they only protect the person wearing them and not the food. The RD said that when people where gloves, they had a false sense of security that they could touch everything because they wore gloves, don't change them, and then go back to touching food. During an interview on 1/24/2025 at 10:30 a.m., the DS said all employees that work in Dietary Services received the training on food handling and infection control. Facility policy, not dated, titled Preparing and Serving Food policy statement read: It is the policy of this facility to prepare and serve food safely. Procedure #7 stated: Serving food- No bare hand contact with food items, food area of serving utensils, eating area of plates or utensils, and rim or inside of glasses. 2. Record review of Resident #33's face sheet, dated 01/24/2025, revealed the resident was a [AGE] year old male and an admission date of 06/26/2023 with diagnoses that included: injury of head, cerebral infarction (disrupted blood flow to the brain), chronic obstructive pulmonary disease (block airflow and make it difficult to breathe), Alzheimer's disease (destroy memories and other important mental function), and dysphagia (swallowing difficulties). Record review of Resident #33's quarterly MDS assessment, dated 12/30/2024, indicated his BIMS score was 3 reflecting he had severe cognitive impairment. Further record review indicated the resident required setup or clean-up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) to eating in Section GG (Functional abilities). Record review of Resident #33's comprehensive care plan, dated 09/03/2024, reflected [Resident #33] has potential nutritional problem related to possible dislike, and the intervention was Refrigerator temperatures to be recorded for both fridge and freezer every night and provide, serve diet as ordered and monitor and record every meal. Observation on 01/21/2025 at 12:32 p.m. revealed Resident #33's refrigerator was in his room, and inside the refrigerator there was one sandwich covered in a plastic bag, and the sandwich had no label and no date. Interview on 01/21/2025 at 1:04 p.m. with LVN-I acknowledged Resident #33's refrigerator was in his room, and inside the refrigerator there was one sandwich covered in a plastic bag, and the sandwich had no label and no date. The LVN-I stated the sandwich was peanut butter sandwich, and the facility kitchen provided the sandwich. Further interview with the LVN-I said she did not know what reason the sandwich had no label and date. The facility staff who provided the sandwich as a snack had a responsibility to write date and label. (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 01/24/2025 at 10:33 a.m. with DON stated the staff who provide a sandwich to Resident #33 should have written the label and date. Without label and date, the resident might receive incorrect diet texture and expired sandwich, and it might cause food illness. Record review on 1/24/2025 of in-service dated 1/22/2025 titled How to Serve revealed 8 out of 8 employees in Dietary Services received the in-service. Record review of the facility policy, titled Dietary Services, undated, revealed It is the policy of this facility that food brought to the resident by family/visitors must be inspected before being provided to the resident.

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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** Based on observations, interviews, and record review, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 1 resident (Residents #148) of 21 residents reviewed for infection control. CNA-J entered Resident #148's room, who was on EBP, on 01/23/2025 at 11:02 a.m. and failed to put on a gown when the CNA-J was providing suprapubic catheter care to the resident. These deficient practices affect residents who require assistance treatments and could place residents at risk for cross contamination and infections. The findings included: Record review of Resident #148's face sheet, dated 01/24/2025, revealed the resident was a [AGE] year old male and an admission date of 01/08/2025 with diagnoses that included: anoxic brain damage (complete lack of oxygen to the brain), quadriplegia (paralysis of all four limbs), epilepsy (seizure), acute respiratory failure (inadequate gas exchange by the lung), and acute kidney failure (Kidney lose the ability to remove waste and balance fluids). Record review of Resident #148's admission MDS assessment, dated 01/15/2025, indicated his BIMS score was 0 reflecting he had severe cognitive impairment. Further record review indicated the resident had indwelling bladder catheter. Record review of Resident #148's comprehensive care plan, dated 01/09/2025, reflected [Resident #148] has suprapubic catheter, and the intervention was suprapubic catheter care every shift - monitor insertion site for skin breakdown and secure the catheter with a leg strap or anchor to minimize catheter related injury. Observation on 01/23/2025 at 10:55 a.m. revealed there was a sign posted on Resident #148's door, and the sign was Enhanced Barrier Precaution - EVERYONE MUST: Clean their hands, including before entering and when leaving the room. Wear gloves and a gown for the following High-Contact Resident Care Activities . Changing briefs and assisting with toileting .Wound Care: Any skin opening requiring a dressing. Observation on 01/23/2025 at 11: 02 a.m. revealed CNA-J sanitized her hands outside Resident #148's room and put on gloves. The CNA-J entered to Resident #148's room and provided suprapubic catheter care to the resident without putting on a gown, then the CNA-J went out the resident's room and took off the dirty gloves and sanitizing her hands. Interview on 01/23/2025 at 11:10 a.m. with CNA-J confirmed she did not wear a gown when she was providing suprapubic catheter care to Resident #148. The resident had Enhanced Barrier Precaution, so CNA-J should have put on a gown when providing the catheter care to the resident to prevent possible contamination. CNA-J stated she was nervous and forgot to wear a gown, and the potential harm was Resident #148 might have infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/24/2025 at 10:33 a.m. with the DON confirmed CNA-J should have put on a gown when entering Resident #148's room to provide the catheter care to the resident. The resident had Enhanced Barrier Precaution, which was Wear gloves and a gown for the following High-Contact Resident Care Activities .Changing briefs and assisting with toileting .Wound Care: Any skin opening requiring a dressing. The resident might get infection. Record review of the facility policy, titled Infection Prevention and Control Program, revised 01/2024, revealed Enhanced Barrier Precautions - during high-contact resident care activities: dressing, bathing/showering/transferring, changing linens, changing briefs, device care or use, and wound care: any skin opening requiring a dressing. Gloves and gown prior to the high contact care activity.