STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Wesleyan Skilled Nursing and Rehabilitation	4011 Williams Dr Georgetown, TX 78628

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 0550

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

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 promotes maintenance or enhancement of his or her quality of life for 3 of 10 residents (Resident #36, Resident #58, and Resident #67) reviewed for rights.

The facility failed to ensure LVN A and CNA B knocked on Resident #36, Resident #58, and Resident #67's doors when going into the residents' rooms.

These failures could place residents at risk of feeling like their privacy was being invaded or the facility was not their home.

Findings included:

Review of Resident #36's Face Sheet dated 04/29/2025 revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #36's diagnoses included chronic pain, constipation, depression, insomnia (difficulty sleeping), repeated falls, hypertension (high blood pressure), muscle weakness, multiple sclerosis (disease that causes breakdown of the protective covering of the nerves), dysphagia oropharyngeal phase (inability to empty from the throat to the esophagus), lack of coordination, need for assistance with personal care, hyperthyroidism (excessive production of thyroid hormones), benign prostatic hyperplasia with lower urinary tract symptoms (enlarged prostate), and anxiety (feeling of uneasiness or worry).

Record review of Resident #36's Quarterly MDS assessment dated [DATE] revealed Resident #36 had a BIMS score of 02 indicating severe cognitive impairment.

Review of Resident #58's Face Sheet dated 04/29/2025 revealed he was an [AGE] year-old male who was admitted to the facility on [DATE] . Resident #58's diagnoses included Parkinson's disease (a progressive disorder that affects the nervous system), dysarthria, and anarthria (severe speech sound disorder), other speech disturbances, anxiety (feeling of uneasiness or worry), hyperlipidemia (high cholesterol), insomnia (difficulty sleeping), muscle wasting, unsteadiness on feet, abnormalities of gait and mobility, history of falling, abnormal posture, and need for assistance with personal care.

Record review of Resident #58's Quarterly MDS assessment dated [DATE] revealed Resident #58 had a BIMS score of 15 indicating intact cognitive response.

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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: 676280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER: The Wesleyan Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 4011 Williams Dr Georgetown, TX 78628	

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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 - Some	Review of Resident #67's Face Sheet dated 04/29/2025 revealed she was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #67's diagnoses included end stage renal disease (kidney failure), type 2 diabetes mellitus with hyperglycemia (high blood sugar), heart disease, hypertensive heart disease with heart failure (damage to heart and heart failure due to chronic high blood pressure), heart failure, gastroesophageal reflux disease without esophagitis (reflux), muscle wasting, need for assistance with personal care, unsteadiness on feet, muscle weakness, dysphagia oropharyngeal phase (inability to empty from the throat to the esophagus), and cognitive communication deficit (problems with communication), Record review of Resident #67's Quarterly MDS assessment dated [DATE] revealed Resident #67 had a BIMS score of 11 indicating moderate cognitive impairment. Observation of 200 hall meal tray pass on 04/28/2025 at 11:34 a.m., revealed that LVN A did not knock on Resident #67's door before entering the room. Observation of hall 200 meal tray pass on 04/28/2025 at 11:43 am revealed CNA B did not knock on Resident #36 and Resident #58's door before entering the room. In an attempted interview with Resident #36 on 04/28/2025 at 12:06 p.m., he said that he did not want to talk to the surveyor. An interview with Resident #58 on 04/30/2025 at 11:07 a.m., revealed that staff do not knock on his door all the time. He said staff do not knock at least a couple of times a day; that he would like for them to knock before entering all the time. He said knocking was the appropriate thing to do. He said at times he did get upset when staff do not knock especially when he is getting dressed. He said he had not asked the staff to knock. An interview with Resident #67's on 04/30/2025 at 11:10 a.m., revealed that staff knock at times. He said that staff usually did not knock if his door was open. He said he would like for staff to knock all the time especially if the door was closed. He said it did upset him when staff did not knock because he would be changing his underwear and staff would just walk in. He said he never asked the staff to knock because it was not anything the staff had not seen before. During an interview with LVN A on 04/30/2025 at 10:57 a.m., she said she had been trained on resident rights. She said the policy for knocking was that staff were supposed to always knock before entering, introduce themselves and explain to the resident what they were going to do. She said that all staff were required to knock before entering the resident's room. She said that there was no time that the staff should not knock before entering. She said if staff did not knock, the resident may feel like staff do not respect them. She said that all staff monitored to ensure staff were knocking on the residents' doors. She said that staff monitored by observations. She said she was not aware that she was not knocking on the resident's room. (continued on next page)

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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 - Some	During an interview with CNA B on 04/30/2025 at 11:28 a.m., she said that she had been trained on resident rights. She said the policy for knocking was that staff were supposed to always knock before entering and wait for the resident to respond. She said that all staff were required to knock before entering the resident's room. She said she would expect someone to knock on her door. She said that there was no time that the staff should not knock before entering. She said if staff did not knock, the resident may feel uncomfortable. She said that the charge nurse monitored to ensure staff were knocking on the residents' doors. She said that the charge nurse monitored by observations. She said she did not remember knocking on the residents' doors. An interview with the DON on 04/30/2025 at 11:30 a.m., revealed she and staff had been trained on resident rights. She said the policy was that staff were to knock on the door and if the resident could speak the resident will tell the staff to come in. She said that staff were to knock except if it was an emergency. She said it was important for staff to knock because the resident might feel like staff are just going into their room without permission and get upset. She said that all management was responsible for monitoring to ensure staff were knocking. She said that management monitored it by doing observations. She said that the staff should have been knocking on the doors and she was not sure why they did not knock. An interview with the ADM on 04/30/2025 at 5:11 p.m., revealed that she and staff had been trained on resident rights. She said the policy was to knock on the door to uphold the resident's rights. She said that staff should knock, pause and introduce themselves before they go into the resident's room. She said that the staff needed to knock if the resident had their door closed or almost closed. She also said that if the resident's door was open, it was ok for the staff to walk into the room without knocking if they introduced themselves. She said that the resident may feel less safe in their space and like it was not their home if staff did not knock. She said that the managers were to monitor to ensure that staff were knocking on the Residents' doors. She said the managers monitored knocking by observation. She said she did not know why staff were not knocking on residents' doors before entering. Record review of Resident Rights Policy not dated revealed when providing resident care always provide privacy by knocking and announcing yourself. To ensure that resident rights are respected and protected. Residents do not leave their individual personalities or basic human rights behind when they move to a long-term care facility. To personal privacy.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 3 of 8 (Resident #15, #25, and #39) residents reviewed for accommodations. The facility failed to ensure call lights were within reach while in resident rooms for Resident #15 and Resident #39. The facility failed to ensure dining room tables were appropriate height for wheelchairs for Resident #25. These failures could place residents at risk of injury, for not receiving timely care, or a decreased quality of life. Findings included: 1. Record review of Resident #15's admission record, dated 04/30/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #15 had diagnoses which included: aphasia (difficulty using or comprehending language), pain in right shoulder, need for assistance of personal care, lack of coordination, atrial fibrillation (irregular heartbeat), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), rheumatoid arthritis (a chronic disorder where the body's immune system attacks itself and can cause inflammation of the joints and other body systems), unspecified dementia (a disease that causes a general decline in cognitive abilities that can affect the ability to perform everyday activities, memory loss, and poor judgement), neuropathy (damage or disease that affects the nerves causing pain and impaired sensation) and contracture of unspecified joint (the shortening of the muscles, tendons, skin and nearby soft tissue that prevents normal movement). Record review of Resident #15's comprehensive MDS, dated [DATE], reflected a BIMS score was not completed. Section C reflected short-term and long-term memory problems. Record review of Resident #15's care plan, dated 07/31/2020 and last revised on 04/28/2025, reflected Need: [Resident #15] is at increased risk for potential falls r/t impaired mobility, and poor balance/coordination. Requires assistance with ADLs. Approaches included: Be sure [Resident #15]'s call light is within reach and encourage the resident to use it for assistance as needed. Observation of Resident #15's call light on 04/28/2025 at 09:34 AM revealed her call light was not within Resident #15's reach. Her call light was draped across a stuffed teddy bears legs sitting on top of her recliner while she was sleeping in bed. She could not have reached the call light if she needed it. 2. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #25's admission record, dated 04/30/2025, reflected an [AGE] year-old female who was originally admitted to the facility on [DATE] with the most recent admission on [DATE]. Resident #25 had diagnoses which included: unspecified dementia (a disease that causes a general decline in cognitive abilities that can affect the ability to perform everyday activities, memory loss, and poor judgement), type 2 diabetes mellitus (a condition that affects the way the body processes blood sugar), and hx of right femur fracture with surgical repair (a break in the right upper leg bone requiring surgery). Record review of Resident #25's significant change MDS, dated [DATE], reflected a BIMS score of 03, which indicated severe cognitive impairment. Record review of Resident #25's order summary, dated 04/30/2025, reflected no orders for specialty reclining wheelchair. Record review of Resident #25's care plan, dated 9/10/2024 and last revised on 04/07/2025, reflected no care plan related to specialty reclining wheelchair. Observation of Resident #25 on 04/28/2025 at 12:16 PM revealed resident sitting up in a specialty reclining wheelchair in the main dining room. Resident #25's wheelchair was in a reclined position and resident was eating her lunch off of an over the bed table. Resident #25 was seated alone facing all the other resident's tables. All other residents were sitting at tables with 2+ other residents. Attempted to interview resident but received no verbal response. 3. Record review of Resident #39's admission record, dated 04/30/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #39 had diagnoses included: cerebral palsy (a group of disorders that affect movement and muscle tone or posture), spasmodic torticollis (the muscles of the neck contract uncontrollably), and pain in left shoulder. Record review of Resident #39's comprehensive MDS, dated [DATE], reflected a BIMS score of 05, which indicated severe cognitive impairment. Record review of Resident #39's care plan, dated 01/06/2020 and last revised 04/08/2025, reflected Need: [Resident #39] is at increased risk for potential falls r/t impaired mobility . Approaches included: be sure [Resident #39]'s call light is within reach and encourage [Resident #39] to use it for assistance as needed. Observation of Resident #39's call light on 04/28/2025 at 12:48 PM revealed her call light laying in the middle of her bed out of her reach. Resident #39 was sitting up in her specialty wheelchair on the right side of her bed. The call light was behind and to the left of the wheelchair. Resident #39 could not have reached the call light if she needed it. Resident #39's FM was standing at the doorway looking for staff to assist the resident. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/28/2025 with a family member, he stated he was standing in the doorway to try to find staff to assist Resident #39. He stated the call light was often out of reach for Resident #39. He stated he was not able to comment further on the care for Resident #39. Observation of Resident #39's call light on 04/30/2025 at 08:38 AM revealed her call light wrapped around the positioning rail and hanging down below the level of the bedframe. Resident #39 was lying in bed watching tv and could not have reached her call light if she needed it. Attempted to interview resident but received no verbal response. During an interview on 04/30/2025 at 12:37 PM with RN G, he stated he had been trained on resident rights and the policy was for call lights to be within reach of the resident when in their room. RN G stated that all staff were responsible for ensuring call lights were placed within reach of the residents. He stated having call lights out of the resident's reach could be detrimental because the resident could have a medical emergency or fall, and they would not be able to notify staff. During an interview on 04/30/2025 at 01:49 PM with CNA L, she stated she had been trained on resident rights. She stated that the call light was to be placed in the resident's reach, like clipped to them or placed in their hand, anytime residents were in their room or bathroom. She stated CNAs were responsible for doing this and the floor nurse will spot check as they performed their rounds. She stated not having the call light within reach of the resident could put the resident in danger because if the resident needed help the staff wouldn't know. CNA L stated Resident #25 sat alone in the dining room with an over the bed table because her specialty wheelchair was too big to fit under the regular dining room tables. CNA L stated the tables were too short and narrow. She stated that Resident #25 used the wheelchair to assist with positioning and comfort. She stated she didn't think it would affect Resident #25 by sitting alone in the dining room. During an interview on 04/30/2025 at 01:55 PM with CNA K, she stated she had been trained on resident rights. She stated the CNAs and nurses were responsible for ensuring call lights were within the resident's reach all the time. CNA K stated if the call light was not within the resident's reach, then they could possibly fall and hurt themselves. CNA K stated Resident #25 uses a specialty reclining wheelchair to help with positioning due to the contractures in her legs. She stated that Resident #25 sat alone in the dining room so that she could use the over the bed table. CNA K stated Resident #25 used the over the bed table because her chair was too high. She stated that the resident didn't seem to be affected by sitting alone at the over the bed table. During an interview on 04/30/2025 at 02:45 PM with the DOR, she stated she had been trained on resident rights. She stated the policy for call lights was to ensure the resident had their call light in their hand or on their person prior to leaving them in their room. The DOR stated the resident needed to be able to push the call light if they needed something or they could fall because they may need something and they can't get to it, or the resident may need to go to the bathroom. She stated it was the responsibility of any staff member who went into the resident's room to ensure the call light was within reach. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/30/2025 at 03:30 PM with the DON, she stated she had been trained on resident rights. She stated that the policy for call lights was to place call lights close by or within reach of the resident when the resident is in their room. The DON stated it was the responsibility of the staff member providing care to the resident, to put the call light within reach. She stated if the call light was not placed where the resident could reach it, then the resident wouldn't be able to call for assistance if needed. The DON stated she monitored this by spot checking any door she walked past. She stated she also expected for all staff to monitor as they are doing their rounds. The DON stated call lights were everyone's responsibility to ensure they were within reach of the resident. The DON stated Resident #25 used a specialty wheelchair for positioning because the resident couldn't sit up safely in a regular manual wheelchair. She stated Resident #25 sits alone with the over the bed table in the dining room because her chair is a little higher than the tables in the dining room. The DON stated she didn't think it would affect Resident #25 by sitting alone because Resident #25 liked to sit by herself. During an interview on 04/30/2025 at 05:40 PM with MA I, she stated call light policy was to place the call light within reach of the resident when leaving the resident in their room. She stated it was everyone's responsibility to ensure the call light was in reach. MA I stated if the call light wasn't in reach, then they would not be able to call for assistance if needed and they might try to do something independently and fall. She stated she wasn't sure who monitored this. During an interview on 04/30/2025 at 05:48 PM with RN J, she stated the policy on call lights was to make sure they were always within reach. RN J stated it was the responsibility of all staff members to ensure the call lights were within reach of the residents. She stated she monitored this when she went into the resident's room, and she always double checked the call light placement. RN J stated if the call light was not within reach of the resident, then they can't get the help they may need. During an interview on 04/30/2025 at 06:10 PM with the ADM, she stated she had been trained on resident rights. The ADM stated the policy for call light placement was the resident was to have their call light where the resident could utilize the call light when in their room. She stated it was the responsibility of all the staff who entered the resident's room to ensure the call light was within reach. The ADM stated if the call light was not within reach, then it could affect their ability to call for assistance when needed. She stated there was not a monitoring schedule for call lights but that everyone was responsible for call light placement and if there were concerns or grievances raised then frequent monitoring would be started. The ADM stated Resident #25 used the specialty reclining wheelchair for positioning and comfort. She stated she was unsure why Resident #25 was sitting alone in the dining room with an over the bed table, but it might have been because the chair didn't fit under the dining room tables. Record review of grievances revealed no complaints or concerns related to call lights for 01/01/2025-04/30/2025. Record review of the facility's, undated, policy titled Call Lights reflected: Procedure: Basic Responsibility (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed Nurse and Nursing Assistant, all Facility Staff Purpose To respond promptly to resident' call for assistance . Procedure 1. All facility personnel must be aware of call lights at all times . 8. When providing care to residents be sure to position the call light conveniently for the resident to use. Tell the resident where the call light is and show him/her how to use the call light . 11. Be sure all call lights are placed on the bed at all times or within reach of the resident. Record review of the facility's, undated, policy titled Resident Rights reflected: Purpose: To ensure that resident rights are respected and protected. To inform residents of their rights and provide an environment in which they can be exercised. Procedure: Residents do not leave their individual personalities or basic human rights behind when they move to a long-term care facility. Following is a list of resident rights recognized by management and employees as well as local, state and federal laws and regulations. The resident has the right: . To receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.

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F 0604

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on observation, interview, and record review, the facility failed to ensure residents were free from any physical restraints imposed for purposes of convenience and not required to treat the resident's medical symptoms for 1 (Residents #9) of 5 residents reviewed for restraints.

The facility failed to ensure that bedrails were not used on the side of Residents #9 bed as Resident #9 requested assistance getting out of bed when the rails were up.

This failure could result in residents having physical restraints used that limited their movement without being evaluated for the medical need.

Findings include:

Record review of Resident #9's face sheet dated 04/30/2025 reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (progressive disease that destroys memory and other important mental function), hypertensive heart disease with heart failure (damage to heart and heart failure due to chronic high blood pressure), dementia (memory, thinking, difficulty), hypothyroidism (excessive production of thyroid hormones), need for assistance with personal care, vitamin deficiency, weakness, repeated falls, hyperlipidemia (high cholesterol), heart failure, and dysphagia oropharyngeal phase (inability to empty from the throat to the esophagus).

Record review of Resident #9's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 03 indicating severe cognitive impairment. The MDS also indicated Resident #9 was independent for bed mobility and required maximal assist for transfers.

Record Review of Resident #9's Orders dated 4/30/2025 revealed that there were no orders for the 1/2 bed rails.

Record Review of Resident #9's Side Rail assessment dated [DATE] revealed the resident had an alteration in safety awareness due to cognitive impairment; the resident did not roll out of bed; the resident did not exhibit physical signs that could put them at risk for using side rails; the resident was on medications that could increase risk of injury (blood thinners/steriods/diabetic meds); the resident did not need side rails as a boundary marker; the resident did need side rails to assist with positioning; the resident was referred to the interdisciplinary team and was provided recommendations for a positioning rail for assistance getting in and out of bed and assistance with bed mobility; consent was given by the resident/legal representative regarding risk/benefit of side rails.

Record Review of Resident #9's Care Plan dated 02/19/2025 revealed that Resident #9 would benefit from positioning side rails and consent will be obtained from Resident #9's representative. Resident #9 had an actual fall related to poor balance and unsteady gait. Approaches included neuro-checks per facility protocol. Side rails up for safety and bed in low position and fall mat in place.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #9 on 04/29/2025 at 08:13 a.m., revealed that Resident #9's bed had a bed rail that was positioned in the middle of her bed. There was also a bedside table up against the resident's bed. Resident #9's bed was pushed up against the wall on the other side of the bed. Resident #9 had scooted to the end of her bed trying to get off the bed but was not able to due to the bedrail. The knob to lower the bed was at the bottom rail where the resident could not reach to lower. An interview with Resident #9 on 04/29/2025 at 08:14 a.m. revealed she wanted to get up and get dressed. She said that she needed help because she could not get up. When asked more about the bedrail she said she needed to change her clothes. She also asked the surveyors for help getting out of bed. During an interview with CNA B on 04/30/2025 at 11:36 a.m., she said that she had been trained on resident rights. She said that the facility had a no restraints policy. She said all staff were responsible for ensuring that no restraint was used on any residents. She said that the ½ bed rails were used on Resident #9 to keep the resident from falling. She said that she was not sure when the staff started to use them. She said the rationale was for protecting the resident from rolling off the bed. She also said some residents preferred to have the bed rails. She said she was not sure what interventions were used before the facility started using the bed rails. She said the risk of the bed rails was that the resident could get hurt trying to get out of the bed. She also said the bed rails could be considered a restraint. She said that the staff remove the bed rails when they get the residents up or when providing care. She said that the staff use the bed rails on Resident #9 every time staff put the residents to bed. She also said that staff check on the residents every two hours and that the residents do not get upset when the bed rails are on. She said that she did not know if the staff needed to have a doctor order for the bed rails. She also said that there were four residents that the facility used the bed rails on. During an interview with LVN A on 04/30/2025 at 10:57 a.m., she said that she had been trained on resident rights. She said that the facility had a no restraints policy. She said all staff were responsible for ensuring that no restraint was used on any residents. She said that the ½ bed rails were used on Resident #9 bed so they could reposition them selves. She said that she was not sure when the staff started to use them. She said she did not know the rationale of using the bed rails unless it was when the resident was asleep when they put them on . She said interventions for falls were beds in low position, fall mats in place and frequent rounding. She said the risk of the bed rails was that the resident could climb over them to get out of the bed and hurt themselves. She said that she was not sure how often staff used the bed rails on Resident #9. She also said that staff check on the residents every two hours and that the residents do not get upset when the bed rails are on. She said the bed rails could be a restraint. She said that staff needed to have a doctor order for the bed rails to be used. She said she did not know why the bed rails were being used. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 04/30/2025 at 3:24 p.m., she said she and staff had been trained on resident rights. She said that the bed rails for Resident #9 were used for positioning and that the facility did not use restraints. She said she did not know when the bed rails started being used. She said a restraint was when four rails were up, and that the facility did not use bed rails as a restraint. She said the risk of the bed rail was high and that the resident could fall. She also stated the bed rail was not keeping the residents in the bed because they were not being used as a restraint. She said interventions for falls used before the bed rails were that staff would check on the residents and use floor mats and beds in low position. She said that staff help the resident get up and down from the bed when the bed rails are on. She said all staff know that the bed rails were not to be used to prevent falls or restraints, which was something the facility did not even entertain. She said that she was not sure if the doctor was notified of the bed rails. She also said she did not think the facility needed an order since the facility did not use the bed rails as a restraint. She said that if the facility used the bed rails as a restraint, then the facility would need a doctor's order. She also said that the position of Resident #9's beds and the bed rails on in the middle of the bed did not prevent the residents from getting out of the bed. She said she did not know how Resident #9 would have gotten out of the bed, but the bed rail was not used as a restraint. During an interview with the ADM on 04/30/2025 at 5:24 p.m., she said she and staff were trained on resident rights. She said that the bed rails were used for positioning. She said if the rail was on it would be considered a restraint. She also said with positioning it could depend on the person and it might be harder for them to get to the bed rail if it was by their head. She also said that she did consider the bed rail to be a restraint if the bed was up against the wall on one side, and the bedside table blocked the top of the bed. She said that the bed rail can get in the way of providing care to the residents. She said she was not sure when the bed rails started to be used on Resident #9. She said there were several things that could factor in such as for residents that had physical limits it would help the residents get up. She said bed rails any type of length could impact the residents from getting in and out of bed. She said the residents could also get tangled up in the bed rails. She said that bed rails were not on the list for interventions for falls because of the risk. She said the facility did not use restraints. Record review of the Restraints Policy not dated revealed the facility is a restraint free facility. Also included as restraints as facility practices that meet the definition of a restraints such as using side rails to keep a resident from voluntarily getting out of bed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents who were unable to carry out Activities of Daily Living receive the necessary services to maintain grooming and personal hygiene for 4 of 12 residents (Resident #19, Resident #22, Resident #28 and Resident #6) reviewed for Activities of Daily Living. The facility failed to ensure Resident #19 and Resident #28's facial hair was shaved from 04/28/2025 and 04/29/2025. The facility failed to ensure Resident #6 and Resident #22 were provided their showers 3 times a week as scheduled. This failure could place residents at risk of not receiving services or care, diminished quality of life, and decreased self-esteem. Findings included: On 04/28/25 at 11:13 AM an observation was conducted of Resident #19 Resident #19 was observed to have approximately quarter inch length facial hair. On 04/28/2025 at 11:13AM an interview was conducted with Resident #19. Resident #19 reported not being offered to have her facial hair shaved. Resident #19 reported that she wishes the staff would provide her with tweezers and a mirror so she could fix her facial hair. Record review of Resident #19's face sheet indicated Resident #19 is an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #19 has diagnoses of Compression fracture of fourth lumbar vertebra (a break in the bones on the spine), subsequent encounter for fracture with routine healing (follow up after injury in the process of healing), and hypo-osmolality (low concentration of sodium and electrolytes), hyponatremia and muscle weakness (low blood sodium that causes muscles to weaken). Record review of care plan dated 04/21/2025 indicated that Resident #19 requires setup assistance for ADLs as of 04/21/2025. This care plan indicated that as of 04/21/2025 Resident #19 requires set up and clean up assist with her personal hygiene and oral care. Record review of MDS sheet dated 04/08/2025 indicated that Resident #19 required set up and clean up assistance for hygiene. According to the MDS, set up and clean up assistance is defined as Helper set up or cleans up; resident completes the activity. Helper assists only prior to or following the activity. Resident #19's MDS dated [DATE] reflected a BIMS score of 11 which indicates moderate cognitive impairment. On 04/28/25 at 01:52 PM an interview was conducted with Resident #22. Resident #22 stated he does not get his showers regularly. He said he is only getting two showers a week. He said he had asked for his showers and the staff told him that there was no one working that could give him a shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #22's face sheet indicated Resident #22 is an [AGE] year-old male admitted to the facility initially on 11/02/2022 with a re-admission on [DATE]. Resident #22 has a diagnosis of fracture of unspecified part of neck (broken bone in the neck), hypertensive heart disease without heart failure (heart complications caused by high blood pressure) and paroxysmal atrial fibrillation (irregular heart beat). Record review of care plan dated 04/22/2025 indicates that Resident #22 is at increased risk for potential ADL self-care performance deficit related to history of impaired mobility, falls prior to admission and requires assistance with ADLs. According to this care plan, Resident #22 requires extensive x1 staff assist with bathing and showering as necessary. Record Review of MDS sheet dated 04/10/2025 indicated that Resident #22 required substantial/maximum assist for showering/bathing. According to this MDS, substantial/maximum assist is defined as Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. Resident #22 has a BIMs of 15 which indicates no cognitive impairment. Record Review of Resident #22 shower log revealed that his shower days were Tuesday, Thursday and Saturday. He was admitted on [DATE] and did not get a shower until 04/09/2025. He did not get another shower until 4/12/2025. He then had a shower on 04/15/2025 and did not get another shower until 04/24/2025. Record review of Resident #22's progress notes revealed that the resident did not refuse any showers. On 04/29/2025 at 11:45AM an observation was made of Resident #28. Resident #28 was observed to have quarter of an inch length facial hair. Record review of Resident #28's face sheet indicated that Resident #28 is a [AGE] year-old female who was admitted into the facility on [DATE] with a re-admission on [DATE]. Resident #28 has a diagnosis of laceration without foreign body, hypokalemia and chronic diastolic heart failure. Record review of care plan dated 04/25/2025 indicated Resident #28 depends on staff to help with ADLs as of 04/25/2025. This care plan indicated Resident #28 was dependent and required x1 staff assist with personal hygiene and oral care. Record review of MDS sheet dated 03/31/2025 indicated that Resident #28 was dependent and required help for personal hygiene needs. According to MDS, dependent is defined as staff to provide total support for Resident #28 in order to complete ADLs. Resident #28 has a BIMS of 4 which indicated severe cognitive impairment. On 04/29/25 at 03:32 PM an interview was conducted with Resident #6 Resident #6 stated that she does not get her showers regularly. She said that she only gets one shower a week. She said she had asked for her showers, but they still did not give them to her. Record review of Resident #6' face sheet indicated that Resident #6 is an [AGE] year-old woman who was admitted to the facility on [DATE]. Resident #6 has a diagnosis of depressive episodes (depression that lasts two weeks), hypertension (high blood pressure), and a history of falling. Resident #6 has a BIMS of 6 which indicates severe cognitive impairment. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of care plan dated 03/06/2020 indicated that Resident #6 is at risk of ADL self-care performance deficit relating to impaired mobility and unsteady gait. This care plan indicated that Resident #6 requires supervision and 1 person assist for bathing and showering per schedule as necessary. Record review of MDS dated [DATE] indicated that Resident #6 required substantial/maximum assist for showering/bathing. According to this MDS, substantial/maximum assist is defined as Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. Record Review of Resident #6's shower log revealed shower days are Tuesday Thursday and Saturday. Resident had a shower on 04/03/25 and did not get another shower until 04/08/2025. After the resident got a shower on 04/08/2025 the resident did not get another shower until 04/15/2025. The resident did not get another shower until 04/22/2025. The resident got a shower on 04/24/2025 and did not get another shower until 04/29/2025. Record review of Resident #6's progress notes revealed that the resident had not refused any showers. This document revealed the following: 04/01/2025- Resident received a shower. 04/03/2025- Resident received a shower. 04/05/2025- Resident did not receive a shower. 04/08/2025- Resident received a shower. 04/10/2025- Resident did not receive a shower. 04/12/2025- Resident did not receive a shower. 04/15/2025- Resident received a shower. 04/17/2025- Resident did not receive a shower. 04/20/2025- Resident did not receive a shower. 04/22/2025- Resident received a shower. 04/24/2025- Resident received a shower. 04/26/2025- Resident did not receive a shower. 04/29/2025- Resident received a shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/30/2025 at 10:49AM an interview was conducted with MA A who reported they have received trainings on ADL care. MA A reported that in the ADL training, it covered transfers, charting and level of care for residents. MA A stated the training was provided on their online learning database last month. MA A reported the policy for showers is to offer showers on resident's designated shower days. This policy, according to MA A, reflects residents being scheduled for showers 3 times a week. MA A reported that if a resident refuses a shower, it should be documented. MA A reported the policy for grooming residents is to provide shaving care during showers for both men and women. MA A reported that it is the responsibility of the assigned CNA to provide showers and grooming. MA A reported it is important to ensure ADL care is provided because it helps prevent skin breakdown. MA A reported the potential negative affect this could have on residents is the potential for residents to feel awful. MA A reported that there should be no reason a resident is not provided a shower other than refusing. MA A reported it is the responsibility of the Charge Nurse to ensure that ADL care is being monitored. MA A reported that ADL care is monitored by filling out documentation and reporting to the nurse if there is a refusal. On 04/30/2025 at 11:02AM an interview was conducted with CNA B who reported they have received trainings on ADL care. CNA B reported that the trainings covered hygiene, peri care and resident rights. CNA B reported that the trainings are provided on their online learning database. CNA B reported that the policy for providing showers is to follow the schedules on the hall for showers, which are provided 3 times a week. CNA B stated if a resident refuses a shower, they have a document to fill out. CNA B stated that the policy for grooming/shaving residents is they should provide it when they offer care every day. CNA B stated that they will offer to shave residents during their shower days. CNA B stated that CNAs are in charge of completing showers and shaving residents. CNA B stated it is important to provide ADL care because it could cause an infection. CNA B stated that a negative impact this could cause a resident is that they could feel terrible. CNA B stated is the responsibility of the DON to ensure that ADLs are being monitored. CNA B stated this is monitored by completing a sheet that they should turn in everyday as well as notifying the nurse if a resident refuses care. On 04/30/2025 at 11:30AM an interview was conducted with CNA C who confirmed they have received trainings on ADLs. CNA C stated that ADL training covers what care should be provided to the residents as well as how to provide the care. CNA C stated that they received this training a couple of months ago on their online learning database. CNA C stated that the policy for showers is that residents should be showered 3 times a week and it should be documented. CNA C stated that the policy for grooming/shaving residents is to provide this care during shower days for men, and once a week for women. CNA C stated that the CNAs are responsible for providing showers and ADL care to residents. CNA C reported that it is important to provide ADL care to maintain the resident's hygiene. CNA C stated that a negative impact this could cause a resident is the resident could feel uncomfortable. CNA C stated that is it the Charge Nurse's responsibility to ensure that ADLs are being monitored. CNA C stated that this is monitored by watching the staff complete these tasks. CNA C stated that if a resident refuses a shower, that could be why a resident did not receive one despite it being on their scheduled shower day. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/30/2025 at 12:00PM an interview was conducted with LVN D who reported receiving trainings on ADL care. LVN D stated that in this training it covered the needs of ADLs. LVN D stated that this training was completed recently. LVN D stated that the policy for showers is that all residents have scheduled days for showers consisting of 3 days. LVN D stated that the policy for grooming and shaving is to provide this while residents are still in the shower room. LVN D stated this is also provided when the residents request it. LVN D stated that it is the responsibility of the shower aides to ensure that showers and grooming are provided to residents. LVN D reported that it is important to provide ADL care to meet the needs of the residents. LVN D stated that a negative impact this could cause residents is for them to feel unhappy. LVN D stated that it is the responsibility of the nurses to ensure monitoring of ADL care. LVN D stated ADL care is monitored by CNAs notifying the nurse if a resident refuses a shower or ADL care, and the nurse will report it to the family. LVN D stated a reason a resident was not provided a shower despite them not refusing a shower on their scheduled shower day, could be because the resident is out of the facility. On 04/30/2025 at 03:52PM an interview was conducted with the DON who reported being trained on ADL care. DON stated that the facility provides trainings to the staff. DON stated that this training was provided in an in-service throughout the calendar year. DON stated that the policy for showers is residents are scheduled 3 showers per week and have the ability to ask for more or less. DON stated the policy for grooming/shaving residents is that the shower aide should be providing this ADL on shower days. DON stated that it is the responsibility of the shower aides to ensure showers are provided. DON stated it is important to provide ADL care because it provides the resident an opportunity to be clean. DON stated that a negative impact this could have on a resident is being unhappy. DON stated it is the responsibility of the nurses and DON to ensure monitoring of ADL care. DON stated that monitoring of ADLs consists of completing shower sheets during shower days and notifying the nurse. IF the resident refuses a shower more than 3 times on their designated shower days, then the facility will notify the family. DON stated that residents may not be provided showers on their scheduled days if the residents refuse but it should be documented. On 04/30/2025 at 6:15PM an interview was conducted with the ADM who reported that ADL trainings are provided to staff by the nursing department. The ADM stated that the trainings consist of technique, frequency, and support for hygiene. The ADM stated that these trainings are provided during new hire, skills fairs and throughout the year especially if there is a change in resident condition. The ADM stated the expectation for showers is that they are provided to residents. The ADM stated that hygiene is important, and the responsibility of the staff is to help provide this for them if needed. The ADM stated the expectation for grooming and shaving residents is that it should be offered to residents. The ADM stated that it is the CNA and shower aides' responsibility to ensure that showers and grooming is offered and provided to residents. The ADM stated it is important to provide ADL care for residents because it is the resident's rights. The ADM stated that this could affect the resident by not feeling happy, clean or proud of how they look. The ADM stated that women with facial hair may feel bothered that this is not taken care of. The ADM stated that the nurses are responsible for monitoring and ensuring ADL care is provided, as well as managers. The ADM stated that ADLs are monitored by documentation and shower sheets. The ADM stated that the reason a resident may not receive a shower despite not refusing could be lack of communication between shifts, scheduling and potentially time management could affect it. Record review of an undated document labeled Personal Care - Activities of Daily Living provided by the facility indicated the following: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. The facility will make every reasonable effort to ensure that each resident receives the appropriate personal care assistance necessary to support their health and well being, and to maintain their personal dignity. Personal care will consist of bathing, toileting hygiene, dressing, and grooming, including hair, nail and oral care, and hand and face washing. Residents will be encouraged to participate in activities of daily living which they are able. 2. Residents will be scheduled to bathe at a minimum of three times per week unless otherwise requested by the resident. 3. The bathing attempts and resident refusals will be documented on the ADL record and the Director of Nursing or designee will be notified. 4. Hair will be washed with showers, or per resident preference with assistance as needed from staff members, or at the facility hair salon, or a salon of the resident's choice. Hair will be combed daily in the morning, and as necessary throughout the day.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for 1 of 8 residents (Resident # 15) reviewed for range of motion. The facility failed to ensure treatment and interventions for Resident #15's contractures of the right hand. This failure could place the resident at risk for not receiving the care and services to prevent worsening contractures that can cause pain and a decreased quality of life. Findings included: Record review of Resident #15's admission record, dated 04/30/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #15 had diagnoses which included: aphasia (difficulty using or comprehending language), pain in right shoulder, need for assistance of personal care, lack of coordination, atrial fibrillation (irregular heartbeat), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), rheumatoid arthritis (a chronic disorder where the body's immune system attacks itself and can cause inflammation of the joints and other body systems), unspecified dementia (a disease that causes a general decline in cognitive abilities that can affect the ability to perform everyday activities, memory loss, and poor judgement), neuropathy (damage or disease that affects the nerves causing pain and impaired sensation) and contracture of unspecified joint (the shortening of the muscles, tendons, skin and nearby soft tissue that prevents normal movement). Record review of Resident #15's comprehensive MDS, dated [DATE], reflected a BIMS score was not completed. Section C-Cognitive Patterns reflected short-term and long-term memory problems. Section GG-Functional Abilities reflected functional limitations in range of motion to one side for upper extremity. Record review of Resident #15's multidisciplinary care conference, dated 03/28/2025, reflected No current therapy or restorative programs at this time. Record review of Resident #15's order summary, dated 04/30/2025, reflected acetaminophen-codeine tablet 300-30mg give 1 tablet by mouth four times a day for pain, rheumatoid arthritis not to exceed 3000mg/24h from all resources. No orders reflected for range of motion exercises. Record review of Resident #15's care plan, dated 07/31/2020 and last revised on 04/28/2025, reflected Need: [Resident #15] is at increased risk for potential falls r/t impaired mobility, and poor balance/coordination. Requires assistance with ADLs. Approaches included: encourage [Resident #15] to participate in activities that promote exercise, physical activity for strengthening and improved mobility such as: AROM/PROM exercises, chair aerobics. Record review of Resident #15's nurses' progress notes for 01/01/2025-04/30/2025, reflected no noted related to ROM exercises or any interventions for the contracture to Resident #15's right hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/28/2025 at 09:34 AM, Resident #15 was lying in bed sleeping with right hand laying on top of the blanket. Resident #15's hand was observed to be contracted with no interventions in place. During an observation on 04/29/2025 at 12:00 PM, Resident #15 was sitting up in bed eating independently with left hand. Observation of right hand with contracture revealed no interventions in place. An interview was attempted with Resident #15, but no verbal response was received. During an observation on 04/30/2025 at 01:26 PM, Resident #15 was receiving pericare. No interventions to right hand that had a contracture were observed before, during, or after peri care. During an observation on 04/30/2025 at 06:23 PM, Resident #15 was sleeping in bed. Her right hand was laying on top of the blanket and no interventions observed to right hand. During an interview on 04/30/2025 at 01:49 PM, CNA L stated she had worked at the facility for about 3 ½ years. She stated the process if a resident starts developing a contracture is to notify the nurse who reports it to therapy for an evaluation. She stated they were to follow the instructions from therapy. CNA L stated Resident # 15 had contractures to her right hand. She stated she didn't think Resident #15 was receiving any therapy for her contracture. CNA L stated she placed a rolled towel in Resident #15's right hand when she provided care to the resident. She stated Resident #15's contractures had remained the same since she first started working with Resident #15. CNA L stated if a resident had contractures and wasn't receiving any interventions then the resident could become more contracted causing pain and difficulty with providing ADLs. During an interview on 04/30/2025 at 01:55 PM, CNA K stated she had worked at the facility for 12 years. She stated the process for newly identified contractures was to put a rolled towel in the affected hand and notify the nurse. CNA K stated Resident #15 had a contracture to her right hand. She stated she thought Resident #15 was receiving restorative rehabilitation services. CNA K stated she placed a rolled towel in Resident #15's right hand when she provided care to her. CNA K stated she didn't know how it might affect a resident if they were not receiving ROM exercises. During an interview on 04/30/2025 at 02:45 PM, the DOR stated the expectation for a resident who had contractures was for nursing to refer the resident for a therapy evaluation. She stated that therapy would do a screening to determine needed services and acquire the necessary funding. The DOR stated therapy would then provide services to maintain and/or increase ROM and obtain the necessary devices. The DOR stated she was not familiar with Resident #15 and after a brief record review revealed Resident #15 was not on therapy services. The DOR stated if a resident had contractures and wasn't receiving services it could be really bad. She stated the contracture could cause skin breakdown, pain, and or difficulty with ADLs. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Wesleyan Skilled Nursing and Rehabilitation	4011 Williams Dr Georgetown, TX 78628

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/30/2025 at 3:30 PM, the DON stated if a resident had started developing contractures or was admitted with a contracture, then her expectation was to recognize the change in condition, the nurse was expected to get an order for a therapy evaluation and initiate ROM exercises. The DON stated the nurse was responsible for obtaining the order to initiate services for the resident. She stated she was aware that Resident #15 had a contracture to the left arm. The DON stated Resident #15 was receiving therapy and wasn't making any improvements in ROM so Resident #15's FM refused the aggressive therapy. She stated that happened a while ago but wasn't sure exactly when. The DON stated she didn't know if there was anything in place to prevent Resident #15's contracture from worsening. She stated if a resident didn't receive restorative or therapy for a contracture then it could get worse. During an interview on 04/30/2025 at 06:10 PM with the ADM, she stated she expected staff to report new contractures to the nurse, and the nurse would then report it to the nurse manager who would possibly obtain a therapy referral. The ADM stated that therapy would then make a choice if splints or devices were needed. She stated she couldn't recall if Resident #15 was on therapy services. She stated that she knew Resident#15 has been on occupational therapy and speech therapy within the last year and a half but didn't know the status of therapy at the time. The ADM stated she didn't know the plan to prevent Resident #15's contracture from worsening, but she didn't think there was a device or splint associated. She stated the nursing staff should have been positioning the resident to prevent further decreased ROM. The ADM stated the goal was to prevent the contracture from occurring but that wasn't always possible. She stated if the resident didn't receive the appropriate services, then the contracture could get worse, cause pain, or affect the resident's ability to do things for themselves. Record review of the facility's, undated, policy titled Range of Motion Exercises reflected: Basic Responsibility Licensed Nurse and Nursing Assistant, Restorative Aide, Physical Therapy, Occupational Therapy Purpose To maintain or improve joint flexibility, prevent stiffness, reduce risk for injury and maintain and or improve functional mobility .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure drugs were labeled in accordance with currently accepted professional principles, store all drugs in locked compartments, and provide separately locked, permanently affixed compartments for storage of controlled drugs for 3 of 6 (100-hall medication care, 100-hall wound care cart and 100-hall nurses' cart) medication carts reviewed for drug storage and labeling. 1. The facility failed to ensure all medications that required a prescription we labeled with a resident name for 2 of 6 medications carts (100-hall wound care cart and 100-hall nurses' cart). 2. The facility failed to ensure the 100-hall wound care cart was locked when unattended by the IP nurse, who also was the facility's wound care nurse. 3. The facility failed to ensure controlled medications were secured by 2 locks in the 100-hall medication cart for Resident #15, Resident #17, Resident #18 and Resident #57. These failures could place residents at risk of harm due to unauthorized access and potential ingestion of medications not intended for use orally. These failures could also place the residents at risk of not receiving the appropriate medications, missed dosages, or drug diversions. Findings included: 1. Record review of Resident #15's admission record, dated 04/30/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #15 had diagnoses which included: aphasia (difficulty using or comprehending language), pain in right shoulder, need for assistance of personal care, lack of coordination, atrial fibrillation (irregular heartbeat), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), rheumatoid arthritis (a chronic disorder where the body's immune system attacks itself and can cause inflammation of the joints and other body systems), unspecified dementia (a disease that causes a general decline in cognitive abilities that can affect the ability to perform everyday activities, memory loss, and poor judgement), neuropathy (damage or disease that affects the nerves causing pain and impaired sensation) and contracture of unspecified joint (the shortening of the muscles, tendons, skin and nearby soft tissue that prevents normal movement). Record review of Resident #15's comprehensive MDS, dated [DATE], reflected a BIMS score was not completed. Section C reflected short-term and long-term memory problems. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #15's order summary, dated 04/30/2025, reflected acetaminophen-codeine tablet 300-30mg give 1 tablet by mouth four times a day for pain, rheumatoid arthritis not to exceed 3000mg/24h from all resources. Record review of Resident #15's care plan, dated 07/31/2020 and last revised on 04/28/2025, reflected Need: [Resident #15 is on pain medication therapy, r/t hx of rheumatoid arthritis and neuropathy. Approaches included: administer analgesic medications as ordered by physician. Monitor/document side effects and effectiveness q-shift. 2. Record review of Resident #17's admission record, dated 04/30/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #17 had diagnoses which included: chronic pain, diverticulitis of intestine (an inflammation of one or more balloon-like sacs in the large intestine), restless leg syndrome (a condition that causes a very strong urge to move the legs and can be painful), carpal tunnel and osteoarthritis (a joint disease that causes breakdown of cartilage and bone). Record review of Resident #17's comprehensive MDS, dated [DATE], reflected a BIMS score of 12, which indicated moderate cognitive impairment. Record review of Resident #17's order summary, dated 04/30/2025, reflected tramadol hcl tablet 50mg give 1 tablet by mouth three times a day for osteoarthritis. Record review of Resident #17's care plan, dated 07/13/2020 and last revised on 04/15/2025, reflected Need: [Resident #17] is at risk for pain/discomfort r/t hx of chronic pain, osteoarthritis, RLS, and carpal tunnel. She has routine and prn pain medication available. Approaches included: administer analgesia (pain medication), Tramadol/APAP/Lidocaine as per orders. Give ½ hour before treatments or care. 3. Record review of Resident #18's admission record, dated 04/30/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #18 had diagnoses which included: unspecified dementia (a disease that causes a general decline in cognitive abilities that can affect the ability to perform everyday activities, memory loss, and poor judgement) and neuropathy (damage or disease that affects the nerves causing pain and impaired sensation). Record review of Resident #18's quarterly MDS, dated [DATE], reflected a BIMS score of 04, which indicated severe cognitive impairment. Record review of Resident #18's order summary, dated 04/30/2025, reflected tramadol hcl tablet 50mg give 1 tablet by mouth three times a day for pain. Record review of Resident #18's care plan, dated 02/24/2025, reflected Need: [Resident #18] has increased risk for (acute/chronic) pain r/t neuropathy. Approaches included: administer medications as per orders. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Record review of Resident #57 admission record, dated 04/30/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #57 had diagnoses which included: lymphedema (tissue swelling caused by fluid buildup in the lymphatic system), unspecified atrial fibrillation (irregular heartbeat), chronic pain syndrome (pain that lasts for greater than 3-6 months), hypertension (high blood pressure), and chronic diastolic heart failure (a condition when the heart is unable to adequately pump blood). Record review of Resident #57's quarterly MDS, dated [DATE], reflected a BIMS score of 15, which indicated no cognitive impairment. Record review of Resident #57's order summary, dated 04/30/2025, reflected: 1) Metoprolol tartrate tablet 25mg give 1 tablet by mouth two times a day for afib hold for SBP less than 110 and/or HR less than 60. 2) Torsemide oral tablet 40mg give 1.5 tablet by mouth one time a day for CHF. 3) Tramadol hcl oral tablet 50mg give 1 tablet by mouth four times a day for chronic pain. Record review of Resident #57's care plan, dated 03/15/2025, reflected Needs: [Resident #57] is on pain medication therapy r/t chronic pain syndrome. Approaches included: Administer analgesic medications as ordered by physician. Monitor/document side effects and effectiveness q-shift. During an interview and observation of wound care set up, at the 100-hall wound care cart, on 04/30/2025 at 09:32 AM, the IP used a tube of mupirocin 2%, with Rx only written on the corner of the box, in the setup of materials needed for wound care. The IP stated the medication was obtained through a third-party source without a prescription therefore she thought it was an over-the-counter medication that didn't require a prescription. She stated all medication that required a prescription are required to have a label on it indicating which resident the medication belonged to. During an observation and interview on 04/30/2025 at 11:02 AM, the 100-hall wound care cart was left unlocked and unattended outside of room [ROOM NUMBER]. The IP came out of room [ROOM NUMBER] and directly to the 100-hall wound care cart to lock it. She stated it was her responsibility to secure that cart and that all carts that contained any medication were supposed to be locked when not supervised. The IP stated that if a cart with medication was left unsecured that a resident could get into the cart and take something they are not meant to. During an observation on 04/30/2025 at 11:08 AM, the 100-hall medication cart had 4 different envelopes with controlled substances secured in the top drawer with only the lock for the medication cart securing it. The envelopes contained: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Apap/codeine tab 300mg-30mg 1 tablet labeled for Resident #15 2. Tramadol hcl tab 50mg 1 tablet labeled for Resident #17 3. Tramadol hcl tab 50mg 1 tablet labeled for Resident #18 4. Tramadol hcl tab 50mg 1 tablet labeled for Resident #57. During an observation on 04/30/2025 at 11:34 AM, of the 100-hall nurse cart revealed a tube of mupirocin 2% ointment with a small portion of a resident label that was illegible on it. No resident name was able to be identified on the ointment. During an interview on 04/30/2025 at 11:11 AM, MA E stated the policy for storing controlled medication in the medication cart was to put the medication in the lock box drawer, so that the medication was secured behind 2 locks. He stated he was responsible for securing the medication behind 2 locks. MA E stated if the medication was not secured with 2 locks, then the medication could get taken by someone it wasn't intended for easier or a resident could miss a dose. During an interview on 04/30/2025 at 11:37 AM, LVN M stated all medications that required a prescription to obtain, needed to have a label indicating the resident it was prescribed for. She stated that if a label fell off or was damaged in any way then it needed to be relabeled by the pharmacy or a designated sticker needed to be completed and applied. LVN M stated it was the responsibility of the medication aide or the nurse in charge of the cart to ensure all medications were labeled appropriately. She stated if the medication wasn't labeled then the medication could be used for the wrong resident. During an interview on 04/30/2025 at 11:47 AM, MA F stated all carts that contained medications were to be locked when unattended. She stated all medications that were controlled were supposed to be stored in the lock box on the cart so that they are secured with 2 locks. MA F stated failure to secure the medications appropriately could lead to a resident taking medication that was not prescribed or intended for them. She stated that the person who accepted responsibility for the cart at the beginning of their shift was responsible for securing all medication in the correct spot of the cart throughout their shift. During a phone interview on 04/30/2025 at 01:35 PM, the consultant pharmacist stated mupirocin 2% ointment required a valid prescription from a physician to obtain. She stated that medication should have been labeled with a resident name from the pharmacy. The consultant pharmacist stated the nurse who received and administered the medication was responsible for ensuring that the medication was adequately labeled with the resident name. She stated a resident with an order for the medication may not receive their dose of medication if it isn't labeled properly. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/30/2025 at 03:10 PM, LVN D stated all medications were supposed to be secured behind a lock on the medication cart when unattended. She stated all controlled medication were required to be placed in the separate lock box and secured behind 2 locks when unattended. LVN D stated the person accepting responsibility for the cart at the beginning of the shift (i.e. MA, LVN, RN) was responsible for ensuring all medications were secured in their cart throughout their shift. She stated if the cart was left unlocked or controlled medications were left in the top drawer and not secured with 2 locks then someone may be able to take and ingest medication that was not intended for them. LVN D stated the DON did spot checks while walking around the facility on a daily basis. LVN D stated that anything with the words Rx only required a label with the resident's name that indicated who it was prescribed for. She stated that if a label were to fall off or get damaged then the nurse needed to alert the pharmacy to obtain a new label. LVN D stated if a medication was missing a label, then the wrong medication might be given. During an interview on 04/30/2025 at 03:30 PM, the DON stated that it was her expectation to have all medications locked when left unattended. She stated the medication aide or nurse who assumed responsibility of the cart at the beginning of their shift was responsible for ensuring it remained locked. The DON stated she did visual spot checks daily while walking through the facility. She stated if a cart that contained medication was left unlocked then a resident could get into the medication and get something that was not for them. The DON stated the policy for storing controlled medication in the medication cart was to secure it behind a second lock in the lock box drawer. She stated the person responsible for the cart was responsible for securing the medication in the locked drawer. She stated not securing the controlled medication behind a second lock wouldn't affect the residents in any way because the medications were secured by the first lock. The DON stated the policy for medications with Rx only written on them, required a label which indicated what resident the medication was prescribed for. She stated if the label fell off or was damaged then she expected staff to discard the medication. She stated the staff that is responsible for the medication cart was responsible for ensuring all medications were labeled appropriately with a resident's name. She stated if a medication wasn't labeled properly then it leaves the possibility for the medication to be administered to someone it wasn't prescribed for. During an interview on 04/30/2025 at 05:40 PM, MA I stated the policy when leaving a cart with medications was to lock it before walking away. She stated the staff member with the key to the medication cart was responsible for ensuring the medications were secured. MA I stated the DON monitored this by visually inspecting as she walked around the facility on a daily basis. She stated if a medication cart was left unlocked and unsupervised then a resident might go into the cart and grab some medication that isn't meant for them. MA I stated that all controlled medication was expected to be secured in the locked box on the medication cart. MA I stated if the controlled medication was stored in the top drawer and the cart was accidentally left unsecured, then a resident might have access to the medication and suffer from side effect from taking a controlled medication, like poisoning, or a drug diversion if the medication goes unaccounted for. She stated that all medications that require a prescription to obtain needed a label from the pharmacy which indicated what resident the medication was prescribed to. MA I stated, if a medication was found without a label, then she was expected to take it to the nurse. She stated the staff member with keys to the cart was responsible for ensuring all medications were labeled appropriately with a resident's name. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/30/2025 at 05:48 PM, RN J stated the policy for securing carts with medication was to lock the cart any time it is unattended. She stated the staff with the keys to the cart was responsible for ensuring it was locked when unattended. RN J stated that nursing administration was constantly doing visual spot checks when they were walking through the facility. She stated that if a cart with medications was left unlocked, then a resident who was curious may have access to open the drawer with medications and help their self to whatever medication is inside the cart. She stated that medication could get lost or even stolen. RN J stated the policy for securing controlled medications in the medication cart was to secure the controlled medication in the lock box drawer. She stated the staff member with the keys to the cart was responsible for ensuring the controlled medications were kept in the lock box that required 2 locks to access. RN J stated if controlled medication was kept in the top drawer and the cart was inadvertently left unlocked then a resident's medication may be stolen which would cause a drug diversion. RN J stated that all medications that had Rx only printed on it, required a prescription from the provider and a label from the pharmacy with the resident's name the medication was prescribe for on it. She stated that the staff member with the keys to the cart was responsible for ensuring all medication was labeled appropriately and this was monitored by each on coming shift at shift change. RN J stated if a medication was found that didn't have a label or had a damaged label then the medication would need to be discarded. During an interview on 04/30/2025 at 06:10 PM, the ADM stated that it was her expectation that any cart that contained medication was locked when not being used. She stated that the person passing medications from the cart was responsible for ensuring the cart was locked. The ADM stated that all staff monitors to ensure the carts are locked as they walk by because it is the responsibility of all staff members to ensure compliance. She stated that leaving a medication cart unlocked could affect the resident because their HIPAA information could be seen by someone it wasn't intended for, the medication could be taken or even a drug diversion could occur. The ADM stated that all controlled medications should be secured with a double lock at all times. She stated that on the medication carts, the controlled medication should have been secured in the lock box drawer. She stated the staff member passing medications from the cart was responsible for ensuring the controlled medications are stored properly. The ADM stated this was monitored through the narcotic (controlled) drug count at the beginning and end of each shift. She stated that because of the nature of the controlled medication, the extra level of security was needed for the controlled medication for the resident's safety. The ADM stated that all medications that required a prescription to obtain should have been labeled by the pharmacy with the resident's name, the name of the medication, and the directions for administration. She stated if the label fell off or was damaged then she expected the staff to contact the pharmacy that dispensed the medication. She stated that labelling the medication with the resident's name was a very important process. The ADM stated the staff that was responsible for administering the medication was also responsible for ensuring the medication was labeled correctly. She stated that once a month the nursing administrators were responsible for conducting medication cart audits to ensure compliance. Record review of the facility's, undated, policy titled Storage of Medication reflected: Purpose: Ensure that medications are stored in a safe, secure, and orderly manner. Procedure: . 2. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Drug containers that have soiled, illegible, worn, makeshift, incomplete, damaged, or missing labels are returned to the pharmacy for proper labeling before storing . 5. Compartments containing medications are locked when not in use. Trays or carts used to transport such items are not left unattended. (Compartments include, but are not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) . 8. All controlled drugs are stored under double-lock and key.

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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. Based on observation, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for one of one kitchen reviewed for sanitation. 1. The facility failed to dispose of open stored perishable food products and damaged food. 2. The facility failed to properly label and date food products in the dry storage pantry, refrigerator, and freezer. 3. The facility failed to ensure Dishwasher H and General Manager wore beard restraints properly while performing duties throughout the kitchen. These failures could place residents who were served from the kitchen at risk for consuming contaminated food and developing foodborne illnesses. Findings include: In an observation on 04/28/2025 at 8:40 AM of the kitchen, it was found that there was food not dated in the dry food area, refrigerator, and freezer. The following food products were found not labeled or dated in the dry food storage: brown gravy mix, chocolate syrup, Worcestershire sauce, barbeque sauce, and tortillas. The following food products were found not labeled or dated in the refrigerator: a carton of milk, lemonade and tea, broth, loaves of bread, bread sticks, Boston cream pie, and butterscotch pudding. The following food products were found not labeled and dated in the freezer: frozen cookie dough, and frozen chopped potatoes. The following food products were found open: apple cider vinegar with no lid located in the dry food storage and frozen chicken breast located in the freezer. There was a broken egg found leaking in the refrigerator. General Manager followed Investigator around and removed the items that were of concern. In an interview on 04/29/2025 at 10:50 AM conducted with [NAME] I, she stated she is trained in labeling and dating. [NAME] I stated she labels and dates all food products. [NAME] I stated all kitchen staff are trained on labeling and dating, and how to properly store food and drinks in the appropriate storing areas. [NAME] I stated she has been trained in food sanitation and foodborne pathogens that can harm residents. [NAME] I stated if she sees broken eggs, she will get rid of them because it can cause salmonella and foodborne pathogen contamination in residents. [NAME] I stated unproperly stored food can make the residents sick. [NAME] I stated it's the kitchen staff's responsibility to get rid of the unlabeled and undated food because the kitchen staff won't know if the food is good or not to serve residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/29/2025 at 11:18 AM conducted with Kitchen Manager, she stated she has been trained in labeling and dating. Kitchen Manager stated labeling and dating are done once the facility receives food and the kitchen staff place dates on all food products. Kitchen Manager stated everything is to be labeled and dated depending on the product of food such as if food or drinks have manufacture date's and is expiring. The Kitchen Manager stated kitchen staff place dates on food products when they are opened, and the kitchen staff get rid of the food that is not labeled or dated . Kitchen Manager stated staff label the food and the date it should be used by and what it's for based on the menu. Kitchen Manager stated some food products have longer hold times and will be labeled that day with the hold time of when it should be used. Kitchen Manager stated that kitchen staff will throw away food that does not have a date as it can pose a risk of consumption for the resident. Kitchen Manager stated, kitchen staff providing improperly stored food could ruin the residents' experience or potentially make residents sick. The Kitchen Manager, Dietician, and General Manager are in charge of checking food in the dry food storage, refrigerator, and freezer. The Kitchen Manager, Dietician, and General Manager do walk throughs of the food supply, which is done daily, and Dietician conducts its monthly walk throughs at random. Kitchen Manager stated an open bag of chicken in the freezer is a cross contamination issue and would need to go . Kitchen Manager stated a broken egg can be an issue in the refrigerator for cross contamination and may cause food borne pathogens in residents. In an interview on 04/29/2025 at 11:20 AM conducted with General Manager, he stated he has been trained in labeling and dating. General Manager stated labeling and dating are done once the facility receives food and the kitchen staff place dates on all food products. General Manager stated everything is to be labeled and dated depending on the product of food such as if food or drinks have manufacture date's and is expiring. The Kitchen Manager stated kitchen staff place dates on food products when they are opened, and the kitchen staff get rid of the food that is not labeled or dated. General Manager stated staff label the food and the date it should be used by and what it's for based on the menu. General Manager stated some food products have longer hold times and will be labeled that day with the hold time of when it should be used. General Manager stated that the food products he saw that were pulled out when Investigator discovered them, should have been labeled and dated and General Manager advised the staff as well as removed them. General Manager stated that kitchen staff will throw away food that does not have a date as it can pose a risk of consumption for the resident. General Manager stated, kitchen staff providing improperly stored food could ruin the residents' experience or potentially make residents sick. The Kitchen Manager, Dietician, and General Manager are in charge of checking food in the dry food storage, refrigerator, and freezer. The Kitchen Manager, Dietician, and General Manager do walk throughs of the food supply, which is done daily, and Dietician conducts its monthly walk throughs at random. General Manager stated an open bag of chicken in the freezer is a cross contamination issue and the exposed chicken would need to go . General Manager stated a broken egg can be an issue in the refrigerator for cross contamination and may cause food borne pathogens in residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/29/2025 at 11:25 AM conducted with Dietician, she stated the following: She has been trained in labeling and dating. Dietician stated labeling and dating are done once the facility receives food including the kitchen staff place dates on all food products. Dietician stated everything is to be labeled and dated for food products. It was stated that the food products the General Manager saw and pulled out when Investigator discovered them, should have been labeled and dated in which General Manager advised it to the staff as well as removed them. Dietician stated that kitchen staff should throw away food that don't have a date as it can pose a risk of consumption for the resident. Dietician stated kitchen staff providing either expired or not properly stored food could ruin the residents experience or potentially make residents sick. The Kitchen Manager, Dietician, and General Manager are in charge of checking food in the dry food storage, refrigerator, and freezer. The Kitchen Manager, Dietician, and General Manager do walk throughs of the food supply, which is done daily, and Dietician conducts its monthly at random. Dietician stated an open bag of chicken in the freezer is a cross contamination issue. Dietician stated a broken egg can be an issue in the refrigerator for cross contamination and may cause food borne pathogens to residents. Dietician stated kitchen staff are to have proper education to prevent potential sickness or harm to the residents. In an observations on 04/30/2025 at 10:19 AM of Dishwasher H, it revealed him wearing a ballcap hat with hair length to his mid-neckline not tucked into the hat nor wearing a hair restraint to keep the hair restrained. Observation revealed Dishwasher H was wearing a beard restraint to cover and restrain his beard, but his beard restraint was pulled down and his mustache was fully exposed while washing and drying dishes. In an interview on 04/30/2025 at 10:20 AM with Dishwasher H, he stated he's been trained on wearing hair and beard restraints, and it's important to follow wearing proper hair restraints for resident safety and so hair won't get in the resident's food or kitchen ware. Dishwasher H stated if a hair or facial hair restraint is not worn properly, it can affect the resident's quality of life and pose risk to the residents. Dishwasher H stated he doesn't know what the policy says about either wearing a hat or hair restraint while being in the kitchen. Dishwasher H stated the policy for wearing beard restraints is to cover the entire facial hair. Dishwasher H stated he admits that his mustache part of his beard wasn't covered and stated it's supposed to cover the mustache too, but he moved it down because the beard restraint got wet and felt swampy. Dishwasher H stated the facility provided him with training and all kitchen staff are trained in hair and beard restraints, and labeling and dating. In an observation on 04/30/2025 at 10:21 AM revealed that General Manager was wearing a beard restraint to cover and restrain his beard, but his beard restraint was pulled down and his mustache was fully exposed while observed coming out of the kitchen refrigerator and walking through the main kitchen preparation area into the dry food storage. General Manager's mustache was observed to be exposed and observation at 10:30 AM revealed he covered his mustache. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/30/2025 at 10:31 AM conducted with General Manager, General Manager stated the policy for labeling and dating per his knowledge is if kitchen staff open food, the kitchen staff need to put a date on it and if kitchen staff receive food shipments, then a date needs to be put on it. General Manager stated if food is being prepped for the day or night, kitchen staff won't require a label or date since it's being used that day, unless it is reused for another day, then kitchen staff have to label and date the food or drinks for proper storage. General Manager stated the policy for hair and beard restraints per his knowledge is anyone who is in the kitchen area is to wear hair and facial hair or beard restraints. General Manager stated everyone that comes in the kitchen area is required to always wear restraints while remaining in the kitchen. General Manager stated kitchen staffs' hair has to be pulled back out of the way and stuffed into hair restraints or a hat. General Manager stated he would need to see if Dishwasher H has longer hair that needs to be tucked in the hat or hair restraint. General Manager admitted he sometimes forgets to cover his mustache when wearing a beard restraint. In an interview on 04/30/2025 at 3:25 PM conducted with Director of Nursing, she stated she would have concerns for kitchen staff not wearing hair or beard restraints as all staff who enter the kitchen are to utilize them. Director of Nursing stated it's her expectation that kitchen staff and all staff in the kitchen need to wear beard and hair restraints. Director of Nursing stated she is trained on hair restraints and beard restraints and all staff are to wear them. Director of Nursing stated if kitchen staff prepare food or are washing and cleaning dishes, the staff are supposed to wear hair restraints. Director of Nursing stated if facial hair or hair is not properly covered while in the kitchen, it would depend on the length of the staff's hair in terms of the potential health issues to residents. Director of Nursing stated it can be an infection control issue and she would not want a resident to eat off dishes or the prepared food by any kitchen staff that doesn't wear a hair or facial hair restraint properly. Director of Nursing stated if vulnerable residents are exposed to anything prepared by the kitchen staff that aren't wearing beard restraints it is a potential infection control issue. Director of Nursing stated it's the kitchen staff who are in charge of all food products being labeled and dated as well as the quality for health consumption issues if residents are eating food that is not labeled or dated. Director of Nursing stated if the unlabeled or not dated food products are getting out to the dining room during resident meal service, it can potentially affect the vulnerable population the facility serves. Director of Nursing stated if the food products are not properly stored, or labeled and dated, it can get a resident sick and affect their health. Director of Nursing stated it's her expectation for residents to receive quality food products. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/30/2025 at 6:30 PM with Administrator, she stated she has been trained in proper hair and beard restraint and is aware of the policy. Administrator stated not all staff are trained in hair and beard restraints, it's mainly the kitchen staff who undergo the training and other staff are aware of the need to wear hair restraints when entering the kitchen area. Administrator stated the kitchen staff should have the proper training to use hair and beard restraints and they are to practice what they learned when in the kitchen. Administrator stated the policy for hair restraint and beard restraints is for anyone who is in the kitchen area to wear their hair up in a restraint or hat. Administrator stated the policy for facial hair was it should be covered with a beard restraint in order for it to be effective. Administrator stated it can be a risk to the residents if the facial hair or any hair is not properly restrained and if it was her dishes being cleaned and food being prepped for her to eat, she would prefer for the kitchen staff to have all hair restraints properly worn in order for her to eat the food. Administrator stated it can potentially be an infection control issue if a resident consumes food prepared with hair in it. Administrator stated all food products such as, carton of milk, lemonade and tea, broth, loaves of bread, bread sticks, brown gravy mix, chocolate syrup, Worcestershire sauce, barbeque sauce, apple cider vinegar with no lid, tortillas, Boston cream pie, butterscotch pudding, cookie dough, chopped potatoes, chicken breast, and a broken egg that were found is not quality healthy food to provide to residents. Administrator stated labeling and dating food products is important to know if it can be consumed or not. Administrator stated it's the policy and her expectation for kitchen staff to be labeling and dating food products. Administrator stated if the food products are not labeled and dated correctly, it can lead to residents consuming the contaminated food and it's a concern for foodborne pathogens or illnesses to residents. Record review of the facility's Kitchen Labeling and Dating policy (with no revision or policy date) stated: All food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. Most, but not all, products contain an expiration date. The words sell-by, best-by, enjoy-by or use-by should precede the date. The sell-by date is the last date that food can be sold or consumed; do not sell products in retail areas or place on patient trays/resident plates past the date on the product. Foods past the use by, sell-by, best-by, or enjoy by date should be discarded. Cover, label and date unused portions and open packages. Products are good through the close of business on the date noted on the label. Date and rotate items; first in, first out. Discard food past the use-by or expiration date. Wrap food tightly to prevent cross contamination. Food prepared in-house, and then stored frozen should be kept no longer than 3 months. Commercially produced foods may be held frozen until the manufacturer's expiration date, or for 3 months if no expiration date on the package. Once the packaging around the food has been opened, food must be used within 3 months. Record review of the facility's Hair Restraints policy (with no revision or policy date) stated: Consumers are particularly sensitive to food contaminated by hair. Hair can be both a direct and indirect vehicle of contamination. Food employees may contaminate their hands when they touch their hair. A hair restraint keeps dislodged hair from ending up in the food and may deter employees from touching their hair. Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, which are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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 provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Volunteer P) of 3 volunteer members and 4 of 8 residents (Resident # 8, #15, #33, and #57) reviewed for infection control. The facility failed to ensure Volunteer P conducted hand hygiene during resident dining services. 1. The facility failed to ensure 2 of 3 staff (MA E and MA F) disinfected the blood pressure cuff between resident use for 3 of 4 residents (Resident # 8, #33, and #57) reviewed during medication pass. 2. The facility failed to ensure 1 of 2 staff (CNA K) followed proper infection control procedures by folding the disposable wipes and reusing the wipe and not performing proper hand hygiene at the appropriate times during peri care for 1 of 1 resident (Resident # 15) observed during peri care. These failures could place residents at risk for transmission of disease and infection. Findings include: In an observation on 04/28/2025 at 12:30 PM during resident dining room services, there was a volunteer member (Volunteer P) observed going around filling up residents' drinks and not sanitizing their hands. Volunteer member was placing cups on top of their head to balance them while walking to the residents to hand to them without hand sanitization in between residents. 1. Record review of Resident #8's admission record, dated 04/30/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #8 had diagnoses which included: chronic kidney disease (a disease in which kidneys are damaged and can't filter blood properly), unspecified dementia (a disease that causes a general decline in cognitive abilities that can affect the ability to perform everyday activities, memory loss, and poor judgement), hypertension (high blood pressure) and hypothyroidism (a condition where the thyroid gland doesn't produce enough thyroid hormone leading to a slowdown in metabolism). Record review of Resident #8's quarterly MDS, dated [DATE], reflected a BIMS score 15, which indicated no cognitive impairment. Record review of Resident #8's care plan, dated 02/20/2025, reflected Need: [Resident #8] has a dx of hypertension. Approaches included: give antihypertensive (medication used to lower blood pressure) medications as ordered. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #15's admission record, dated 04/30/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #15 had diagnoses which included: aphasia (difficulty using or comprehending language), pain in right shoulder, need for assistance of personal care, lack of coordination, atrial fibrillation (irregular heartbeat), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), rheumatoid arthritis (a chronic disorder where the body's immune system attacks itself and can cause inflammation of the joints and other body systems), unspecified dementia (a disease that causes a general decline in cognitive abilities that can affect the ability to perform everyday activities, memory loss, and poor judgement), neuropathy (damage or disease that affects the nerves causing pain and impaired sensation) and contracture of unspecified joint (the shortening of the muscles, tendons, skin and nearby soft tissue that prevents normal movement). Record review of Resident #15's comprehensive MDS, dated [DATE], reflected a BIMS score was not completed. Section C reflected short-term and long-term memory problems. Record review of Resident #15's care plan, dated 07/31/2020 and last revised on 04/28/2025, reflected Need: [Resident #15] has a hx of incontinence and requires assistance with toileting. Approaches included: Clean peri-area with each incontinence episode. 3. Record review of Resident #33's admission record, dated 04/30/2025, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #33 had diagnoses which included: hypertension (high blood pressure), hyperlipidemia (high cholesterol), and hypothyroidism (a condition where the thyroid gland doesn't produce enough thyroid hormone leading to a slowdown in metabolism). Record review of Resident #33's admission MDS, dated [DATE], reflected a BIMS score of 12, which indicated moderate cognitive impairment. Record review of Resident #33's order summary, dated 04/30/2025, reflected amlodipine besylate oral tablet 5mg give 1 tablet by mouth one time a day for hypertension hold for SBP <110. Record review of Resident #33's care plan, dated 03/28/2025 and revised on 04/28/2025, reflected Need: [Resident #33] has dx of hypertension. Approaches included: evaluate blood pressure. 4. Record review of Resident #57 admission record, dated 04/30/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #57 had diagnoses which included: lymphedema (tissue swelling caused by fluid buildup in the lymphatic system), unspecified atrial fibrillation (irregular heartbeat), chronic pain syndrome (pain that lasts for greater than 3-6 months), hypertension (high blood pressure), and chronic diastolic heart failure (a condition when the heart is unable to adequately pump blood). Record review of Resident #57's quarterly MDS, dated [DATE], reflected a BIMS score of 15, which indicated no cognitive impairment. Record review of Resident #57's order summary, dated 04/30/2025, reflected: 1) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Metoprolol tartrate tablet 25mg give 1 tablet by mouth two times a day for afib hold for SBP less than 110 and/or HR less than 60. 2) Torsemide oral tablet 40mg give 1.5 tablet by mouth one time a day for CHF. 3) Enhanced barrier precautions involve gown and glove use during high-contact resident care activities. EBP are required for resident for the following reason: wounds. Examples of high contact resident care activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs every shift. Record review of Resident #57's care plan, dated 07/26/2024 and last revised on 03/18/2025, reflected Needs: [Resident #57] requires enhanced barrier precautions due to: wound. Approaches included: Incorporate periodic monitoring and assessment of adherence to recommended infection prevention practices, such as hand hygiene and PPE use, to determine the need for additional training and education. In an observation on 04/29/2025 at 07:32 AM of MA E administering medications to Resident #57 MA E gathered the blood pressure cuff from the drawer of the medication cart and proceeded to check Resident #57's blood pressure without disinfecting the blood pressure cuff. MA E then placed the blood pressure cuff on top of the medication cart without disinfecting it after checking Resident #57's blood pressure. In an observation on 04/29/2025 at 07:54 AM of MA F administering medications to Resident # 8 MA F gathered the blood pressure cuff from the drawer of the medication cart and proceeded to check Resident #8's blood pressure without disinfecting the blood pressure cuff. MA F then placed the blood pressure cuff back in the drawer of the medication cart without disinfecting if after checking Resident #8's blood pressure. In an observation on 04/29/2025 at 08:08 AM of MA F administering medications to Resident #33 MA F gathered the blood pressure cuff from the drawer of the medication cart and proceeded to check Resident #33's blood pressure without disinfecting the blood pressure cuff. MA F then placed the blood pressure cuff back in the drawer of the medication cart without disinfecting if after checking Resident 33's blood pressure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 04/30/2025 at 01:26 PM of CNA L performing peri care on Resident #15 with assistance from CNA K, CNA L and CNA K knocked on the door and entered the room. CNA L and CNA K washed their hands then donned (put on) gown and gloves and pulled the curtain closed to provide privacy for Resident #15. CNA L introduced self and explained procedure. CNA L pulled the covers down and unlatched Resident #15's brief and pushed the front part of the brief between Resident #15's legs. CNA L grabbed a disposable wipe from the package and wiped Resident #15's left groin, then threw the wipe in the trash. CNA L obtained a new wipe from the package and wiped Resident #15's vaginal area from front to back and threw the wipe in the trash. CNA L obtained a new wipe from the package and wiped Resident #15's right groin and threw the wipe in the trash. CNA K assisted resident to turn on right side. CNA L obtained a new wipe from container and wiped Resident #15's buttocks, she then folded the wipe over and used the same wipe to wipe Resident #15's buttocks again. The dirty brief was removed by CNA L from behind the resident and placed in the trash. A new brief was placed under Resident #15 (without hand hygiene or gloves changed) by CNA L. CNA L then doffed (removed) dirty gloves and donned new gloves (without performing hand hygiene). Resident #15 was positioned on her back by CNA K. CNA K and CNA L pulled the front of the brief up between Resident #15's legs and secured with tabs. Resident was then positioned for comfort on her left side. Trash was gathered by CNA L and placed by the door to the room. CNA K and CNA L doffed gown and gloves and washed their hands. In an interview on 04/29/2025 at 08:39 AM, MA E stated the policy for sanitizing medical equipment that is shared between residents was to sanitize the equipment between residents. MA E stated he didn't sanitize the cuff before or after measuring the blood pressure on Resident #57 because he forgot to. MA E stated it was his responsibility to sanitize the blood pressure cuff he used to check the blood pressure of the residents. He stated not sanitizing the blood pressure cuff before and/or after use could transmit disease and infection between the residents. In an interview on 04/29/2025 at 11:18 AM conducted with Kitchen Manager, she stated she has been trained in hand hygiene, and there are signs posted and all staff are to follow them. Hand hygiene goes over washing hands with hot water, scrubbing wrist and arms for 20 seconds, washing hands and sanitizing when changing gloves or touching other equipment as well as products. Kitchen Manager stated all staff are to follow hand hygiene to prevent cross contamination. Kitchen Manager stated hand hygiene is to be followed in the kitchen and dining room by staff members. Kitchen Manager stated all staff are trained in hand hygiene and when it comes to residents or volunteers it is the Nursing staff responsibility to check on hand hygiene to prevent cross contamination. Kitchen Manager stated volunteers or staff going table to table touching resident's drinks to refill them or touch things can pose a risk to residents. Kitchen Manager stated it's a risk because it can be a cross contamination and infection control issue. Kitchen Manager stated if staff and volunteers don't perform hand hygiene, it can affect the resident's quality of life by getting them or other individuals sick. (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

In an interview on 04/29/2025 at 11:20 AM conducted with General Manager, he stated he has been trained in hand hygiene, and there are signs posted and all staff are to follow them. General Manager stated hand hygiene goes over washing hands with hot water, scrubbing wrist and arms for 20 seconds, washing hands and sanitizing when changing gloves or touching other equipment as well as products. General Manager stated all staff are to follow hand hygiene to prevent cross contamination. General Manager stated hand hygiene is to be followed in the kitchen and dining room by staff members. General Manager stated all staff are trained in hand hygiene and when it comes to residents or volunteers it is the Nursing staff responsibility to check on hand hygiene to prevent cross contamination. General Manager stated volunteers or staff going table to table touching resident's drinks to refill them or touch things can pose a risk to residents. General Manager stated it's a risk because it can be a cross contamination and infection control issue. General Manager stated if staff and volunteers don't perform hand hygiene, it can affect the resident's quality of life by getting them or other individuals sick.

In an interview on 04/29/2025 at 11:25 AM conducted with Dietician, she stated she has been trained in hand hygiene, and there are signs posted and all staff are to follow them. Hand hygiene goes over washing hands with hot water, scrubbing wrist and arms for 20 seconds, washing hands and sanitizing when changing gloves or touching other equipment as well as products. Dietician stated all staff are to follow hand hygiene to prevent cross contamination. Dietician stated hand hygiene is to be followed in the kitchen and dining room by staff members. Dietician stated all staff are trained in hand hygiene and when it comes to residents or volunteers it is the Nursing staff responsibility to check on hand hygiene to prevent cross contamination. Dietician stated volunteers or staff going table to table touching resident's drinks to refill them or touch things can pose a risk to residents. Dietician stated it's a risk because it can be a cross contamination and infection control issue. Dietician stated if staff and volunteers don't perform hand hygiene, it can affect the resident's quality of life by getting them or other individuals sick.

In an interview on 04/29/2025 at 11:54 AM conducted with Licensed Vocational Nurse E, she stated she's been trained in hand hygiene and sanitation; it went over making sure hands are washed under fingernails and completely scrubbed, and this includes if removing gloves as it can be a cross contamination issue to the residents and during dining services. Licensed Vocational Nurse E stated all staff and volunteers are to utilize hand sanitizer pumps. Licensed Vocational Nurse E stated all staff are to follow hand hygiene and Nursing staff in the dining room are in charge of making sure it's followed. Licensed Vocational Nurse E stated staff or volunteers not conducting appropriate hand hygiene and sanitation can cause potential for illness, it can pass on bacteria, spread sickness and germs, cross contamination, and it can affect residents who are vulnerable. Licensed Vocational Nurse E stated volunteers or staff going table to table touching resident's drinks to refill them or touching other things in the dining room can pose a risk to residents. Licensed Vocational Nurse E stated all staff are trained on hand hygiene and volunteers go through the same training as staff. Licensed Vocational Nurse E stated volunteers should be following hand hygiene the same as staff for resident safety and to limit infection control issues. Licensed Vocational Nurse E stated the Nurse assigned to the kitchen that day such as herself today, is in charge of making sure everyone in dining is following hand hygiene and proper sanitation. Licensed Vocational Nurse E stated in her professional opinion, it is an issue if someone is not following hand hygiene and sanitation during dining services for vulnerable residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview attempt on 04/29/2025 at 12:19 PM, Volunteer P from dining services observed not conducting hand sanitization on 04/28/2025 was not volunteering today nor was there another volunteer located for questions on dining hand hygiene and sanitation. In an interview on 04/29/2025 at 12:28 PM conducted with Certified Nurse Aide F, she stated she's been employed at the facility for 3 years. Certified Nurse Aide F stated she's been trained in hand hygiene, and staff are to sanitize their hands in between residents. Certified Nurse Aide F stated facility staff remind all staff about hand hygiene and sanitization every day. Certified Nurse Aide F stated there are monthly in services as well as annual trainings for hand hygiene. Certified Nurse Aide F stated staff are to wash hands thoroughly in the washroom areas or utilize the hand sanitizer pumps throughout the facility if not able to perform hand washing at the moment. Certified Nurse Aide F stated there are enough hand sanitizing pumps throughout the facility and all staff have access to them in the dining room area and there are not any barriers from using them. Certified Nurse Aide F stated all staff are to wash hands as much as possible or to use the hand pump stations for sanitization before providing resident dining care. Certified Nurse Aide F stated hand sanitization is to be followed by all staff including volunteers as well as residents. Certified Nurse Aide F stated it's a risk if staff or volunteers aren't following hand hygiene because it can spread Covid, germs, and infections. Certified Nurse Aide F stated the Nursing staff, Director of Nursing, and Administrator are in charge of monitoring hand hygiene and sanitization. Certified Nurse Aide F can't recall any staff or volunteers not following hand hygiene. Certified Nurse Aide F stated all staff have been trained and should follow it to prevent infection spreading throughout the facility. In an interview on 04/29/2025 at 12:30 PM conducted with Certified Nurse Aide G, she stated she's been trained in hand hygiene, and staff are to sanitize their hands in between residents. Certified Nurse Aide G state facility staff remind all staff about hand hygiene and sanitization every day. Certified Nurse Aide G stated there are monthly in services as well as annual trainings for hand hygiene. Certified Nurse Aide G stated staff are to wash hands thoroughly in the washroom areas or utilize the hand sanitizer pumps throughout the facility if not able to perform hand washing at the moment. Certified Nurse Aide G stated there are enough hand sanitizing pumps throughout the facility and all staff have access to them in the dining room area and there are not any barriers from using them. Certified Nurse Aide G stated all staff are to wash hands as much as possible or to use the hand pump stations for sanitization before providing resident dining care. Certified Nurse Aide G stated hand sanitization is to be followed by all staff including volunteers as well as residents. Certified Nurse Aide G stated it's a risk if staff or volunteers aren't following hand hygiene because it can spread Covid, germs, infections, and it can 100 percent affect the quality of life for residents. Certified Nurse Aide G stated the Nursing staff, Director of Nursing, and Administrator are in charge of monitoring hand hygiene and sanitization. Certified Nurse Aide G stated the facility staff conduct biweekly meetings and go over hand hygiene education with all residents. Certified Nurse Aide G stated the hand hygiene training the facility provided to all staff is sufficient for the resident's safety and their quality of life. Certified Nurse Aide G can't recall any staff or volunteers not following hand hygiene. Certified Nurse Aide G stated all staff have been trained and should follow it to prevent infection spreading throughout the facility. In an interview on 04/29/2025 at 4:30 PM conducted with Administrator, she stated all volunteers receive the same training as staff except it's not as intense; the training goes over hand hygiene and sanitization. She will see if it is possible to provide the volunteers' contact information since they weren't at the facility today. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER The Wesleyan Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4011 Williams Dr Georgetown, TX 78628	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/30/2025 at 10:20 AM with Dishwasher H, he stated he's been trained in hand hygiene and sanitation, and it went over washing hands thoroughly and as well as in between glove changes. Dishwasher H stated dining Nursing and other staff should be hand sanitizing or washing hands in between residents and this goes for volunteers, residents, or guests to limit anything being spread that can cause illness. Dishwasher H stated touching other resident's cups and refilling them without proper hand hygiene can pose harm to the resident such as make them sick and affect their health. In an interview on 04/30/2025 at 11:47 AM, MA F stated she had been trained on infection control. She stated the policy for shared medical equipment was to sanitize the equipment before and after use. She stated she was responsible for sanitizing the blood pressure cuff before and after using it on a resident. She stated that she did sanitize the blood pressure cuff prior to checking the blood pressure for Resident #8 but forgot to sanitize it after checking the blood pressure for Resident #8. She stated she forgot to sanitize the blood pressure cuff before and after checking the blood pressure for Resident #33. MA F stated not sanitizing the blood pressure cuff could spread germs and infections, like COVID, to other residents. In an interview attempt on 04/30/2025 at 12:18 PM, Volunteer P from dining services that wasn't hand sanitizing on 04/28/2025 was not volunteering today nor was there another volunteer located for questions on dining hand hygiene and sanitation. Volunteer phone number was not provided by facility. In an interview on 04/30/2025 at 12:37 PM, RN G stated he had been trained on infection control. He stated the policy for shared medical devices was to sanitize all medical devices between use with different residents. He stated the staff that was checking vital signs was responsible for sanitizing the equipment used. RN G stated not sanitizing the equipment between uses could cause transmission of bacteria or infection from one resident to another and they could get sick. In an interview on 04/30/2025 at 01:49 PM, CNA L stated she had been trained on infection control. She stated the policy for shared medical equipment was the staff using the equipment was responsible for sanitizing the equipment before and after use on a resident. She stated not doing so could expose residents to germs and they could get sick. CNA L stated the policy for peri care was to use the disposable wipes one time and throw them in the trash. She stated she did fold the disposable wipe and wiped again while performing peri care on Resident #15. CNA L stated gloves should be changed and hand hygiene performed after cleaning the resident and before placing a new brief. She stated she forgot to change her gloves and use hand sanitizer after cleaning Resident #15 and before placing a new brief down. CNA L stated they are checked two times a year by a checkoff performed by the IP to ensure peri care was being performed correctly. She stated not following infection control procedures during peri care could put the resident at an increased risk of infections, like UTI s. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/30/2025 at 01:55 PM, CNA K stated she had been trained on infection control. She stated the policy for shared blood pressure cuffs was to clean them after use. She stated that the staff member using the blood pressure cuff was responsible for cleaning it. CNA K stated cleaning the blood pressure cuff prevented the transmission of germs between residents. CNA K stated the policy for peri care included using the disposable wipes once and throwing them in the trash and to change gloves after cleaning the resident and before putting down a new brief. She stated during the observation of peri care for Resident #15 the disposable wipes were folded over and used again. CNA K stated gloves were changed after the clean brief was placed and hand hygiene was not performed at that time. She stated she didn't know that hand hygiene, including using hand sanitizer, was required when changing gloves during peri care. CNA K stated not following policy could cause transmission of germs and infection to the resident. In an interview on 04/30/2025 at 03:10 PM, LVN D stated she had been trained on infection control. She stated the policy for shared medical equipment was to wipe it down with sanitizing wipes before and after use by the person who used the equipment. LVN D stated not wiping the equipment down could cause a transmission of infection to the resident. LVN D stated that during peri care the policy is to use the disposable wipe once and throw it away. She stated gloves were supposed to be changed and hand hygiene performed when gloves were visibly soiled and after cleaning the resident and prior to placing a clean brief. She stated not performing hand hygiene appropriately so could mean the cleaning was not effective because dirty gloves touched a clean surface. In an interview on 04/30/2025 at 3:25 PM conducted with Director of Nursing, she stated all aides, Nursing staff, Kitchen staff, and all staff are in charge of monitoring hand sanitization due to it being an infection control issue. Director of Nursing stated she has been trained in hand hygiene and sanitization, and the facility conducts monthly trainings in hand hygiene. Director of Nursing stated there are hand sanitation pumps throughout the facility as well as the dining area has access to hand pump sanitizing stations. Director of Nursing stated all staff are trained in hand sanitization including volunteers undergo the training. Director of Nursing stated the volunteers aren't assigned to residents and they don't encourage them to assist residents with dining services. Director of Nursing stated it's a concern if a volunteer or any staff member is refilling drinks and walking resident to resident without any hand sanitizing occurring. Director of Nursing stated it's a concern if a volunteer is going to residents with a cup of drink on their head to deliver it to residents since there is no sanitization occurring. Director of Nursing stated she hasn't witnessed this prior until admitting witnessing on Monday, 04/28/2025 there was a previous staff member that worked at this facility that is a volunteer now that was doing these things, and she advised Volunteer P not to do that and this is the first time it happened during dining services. Director of Nursing stated it can be harmful to residents since she didn't see the volunteer perform hand washing or sanitation as it can be cross contamination and pose issues affecting the resident's quality of life. Director of Nursing stated it's not acceptable and it's her expectation for volunteers not to do that and hand sanitize. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/30/2025 at 03:30 PM, the DON stated it was her expectation that staff sanitize all shared medical equipment after every use. She stated it was the responsibility of the staff member that is using the equipment to sanitize it. The DON stated if the equipment is not sanitized between residents, then it could cause cross contamination and infection. She stated she visually monitored this daily when she was walking around the facility. She stated it was her expectation for staff to use the disposable wipes one time during peri care and throw them away. The DON stated by folding the wipe and reusing it, infection could occur. She stated that staff was expected to change gloves and perform hand hygiene after cleaning the resident and disposing of the old brief during peri care, but before touching the new, clean brief. The DON stated that not changing gloves and performing hand hygiene at the correct times during peri care, the resident could get an infection. She stated staff perform annual checkoffs to ensure proficiency of the task and spot checks, as needed, are done by herself and the IP. In an interview attempt on 04/30/2025 at 5:09 PM conducted with a confidential resident at different dining table while waiting for dining services, resident was confirmed nonverbal and didn't respond to questions about a staff or volunteer not hand sanitizing. In an interview attempt on 04/30/2025 at 5:11 PM conducted with confidential resident at different dining table while waiting for dining services, resident didn't understand questions when attempted to ask about staff or volunteers not hand sanitizing. Resident mumbled and didn't state anything on topic. The resident looked at the surveyor and smiled without stating anything. In an interview attempt on 04/30/2025 at 5:12 PM conducted with confidential resident at a different dining table, resident was confirmed nonverbal and didn't look at the surveyor or respond during attempt to ask question about the volunteer member from 04/28/2025. In an interview attempt on 04/30/2025 at 5:13 PM conducted with additional confidential resident at different dining table in the dining room area, resident slowly moved around in their wheelchair and didn't respond to Investigator when asked questions. In an interview on 04/30/2025 at 05:40 PM, MA I stated she had received training on infection control. She stated it was policy to clean all shared medical equipment before going into the resident's room with it. She stated it was the responsibility of the staff member using the equipment to sanitize it. MA I stated that failure to sanitize the equipment, like blood pressure cuffs, could cause cross contamination of germs and infection. MA I stated when performing peri care on a resident, the expectation is to use the disposable wipe once and toss it in the trash. She stated that if a wipe was folded and used again that the bacteria from one part of the wipe might transfer to another part of the wipe due to the moisture associated with the wipe. She stated the bacteria might seep through. MA I stated it was policy to change gloves and perform hand hygiene before placing the clean brief under the resident during peri care. She stated not doing so could result in increased risk of infection for the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/30/2025 at 05:48 PM, RN J stated she had received training on infection control. She stated that it was policy to clean/wipe all shared medical equipment between each resident. RN J stated not sanitizing the equipment between residents could lead to spread of infection and disease. RN J stated during peri care the wipes should only be used once and thrown away. She stated using the wipes and folding them to reuse them could increase the risk of infection for the resident. RN J stated that gloves should be changed, and hands sanitized after cleaning the resident, during peri care, and before placing the new, clean brief on the resident. She stated not changing gloves and performing hand hygiene at the appropriate time could lead to an infection in the resident. In an interview on 04/30/2025 at 06:10 PM, the ADM stated she had received training on infection control. She stated that it was her expectation for staff to clean all shared medical equipment between usage and at the end of their shift. The ADM stated not doing so could potentially cause an increased risk of infection. She stated there wasn't a formalized monitoring process for this, but the IP was responsible for focusing on needed areas of education for the staff. The ADM stated she wasn't sure what the policy was related to peri care, but stated in general staff should change gloves and sanitize/wash hands, after touching something that was dirty and before touching something that was clean. She stated not changing gloves at the appropriate times could lead to an infection. The ADM stated competency skills checks were performed annually by the staff and as needed. She stated the IP was responsible for monitoring the checkoffs. In an interview on 04/30/2025 at 6:30 PM with Administrator, she stated she has been trained in hand hygiene and sanitization and it went over the duration of hand washing and proper hand sanitizing as well as when to do it. Administrator stated hand hygiene should be done before providing services with a resident and in between residents. Administrator stated all staff undergo hand hygiene training and those practices should be utilized when they are conducting services with all residents. Administrator stated volunteers review the hand hygiene and infection control procedures when train[TRUNCATED]